



**DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMPENSATION PROGRAMS
DIVISION OF FEDERAL EMPLOYEES' COMPENSATION**

**FEDERAL EMPLOYEES' COMPENSATION ACT PROGRAM
PROCEDURE MANUAL**

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FECA Part 0 – Overview: Describes the organization of the OWCP and the Division of Federal Employees' Compensation.

Chapter 0-0100, Introduction to FECA

1. Purpose and Scope. This chapter provides a brief overview of the Federal Employees' Compensation Act (FECA) and the background and structure of the Office of Workers' Compensation Programs (OWCP) and the functions of the National Office, FECA Offices and Claims Units.

2. FECA. In 1908, President Theodore Roosevelt signed legislation to provide workers' compensation for certain Federal employees in unusually hazardous jobs. The scope of the law was very restricted and its benefits were quite limited. However, it was the first workers' compensation law to pass the test of constitutionality applied by the U. S. Supreme Court.

The FECA, 5 U.S.C. 8101 *et seq.*, which superseded the 1908 statute in 1916, is a workers' compensation law for all civilian Federal employees who have suffered work-related injuries or occupational diseases. It provides for wage-loss compensation, schedule award benefits, vocational rehabilitation, medical care, and survivors' benefits; however, the FECA is not a retirement program. Employees who fully or partially recover from their injuries are expected to return to work.

Federal civilian employees are covered by virtue of their employment status. Benefit costs are paid from the Employees' Compensation Fund, which OWCP administers. Federal employers reimburse the Fund for the amounts paid to its employees in workers' compensation benefits through the chargeback system. See 5 U.S.C. 8147

Benefits provided under the FECA constitute the sole remedy against the United States for a work-related injury or death. A Federal employee or surviving dependent is not entitled to sue the United States or recover damages for such injury or death under any other law for a work injury (5 U.S.C. 8116). The FECA is intended to be remedial in nature, and proceedings under it are non-adversarial. There are, however, penalties for filing a false claim. Federal law provides severe penalties, including forfeiture and termination of benefits, for knowingly and willfully falsifying, concealing or covering up a material fact. See 5 U.S.C. 8148; 5 U.S.C. 1920.

3. Organization. OWCP includes four workers' compensation programs, of which the FECA program is one. The other three are the Longshore and Harbor Workers' Compensation Program, the Division of Coal Mine Workers' Compensation, and the Division of Energy Employees' Occupational Illness Compensation.

The OWCP Director, along with the OWCP Deputy Director, have authority for the administrative management of the four programs. The division directors work directly for OWCP; therefore, the Division of Federal Employees' Compensation (DFEC) Director reports to OWCP.

The Employees' Compensation Appeals Board (ECAB) is a distinct body under the jurisdiction of the Secretary of Labor, entirely separate from OWCP. It is authorized to hear and determine appeals from claimants involving questions of law or fact after DFEC has issued a final decision on the issue in question. See 5 U.S.C. 8149.

4. FECA Program Leadership and Branches. The Director for DFEC, along with the FECA Program's Deputy Director of Program and System Integrity and Deputy Director of Operations and Claims Management are tasked with the implementation and oversight of the entire FECA program. This includes setting program goals and oversight.

Final authority over FECA program matters remains with the Director for DFEC. Under the immediate supervision of the Director are two Deputy Directors. Under the Deputy Directors are six specific branches along with the National Administrator(s) of Field Operations that provide specialized oversight and guidance to FECA staff. Each branch has a Branch Chief.

a. Branch of Regulations, Policies, and Procedures. This Branch develops recommendations for new FECA operational policies, regulations and procedures consistent with the overall policies of OWCP. Changes in operational policies and procedures may be the result of new legislation, court decisions, ECAB decisions, program audits and studies, or precedent setting claims under the FECA. The Branch formulates procedures and maintains a FECA Procedure Manual to be used by the FECA offices in adjudicating FECA claims and paying benefits. This branch also conducts ongoing claims audits and develops training materials for claims personnel. The Branch also manages the field nurse and vocational rehabilitation programs.

b. Branch of Technical Assistance. This Branch is responsible for developing, preparing, and distributing FECA technical assistance materials and guides to Federal agencies, labor organizations, employees and their representatives. These materials are designed to educate and inform Federal employees of their responsibilities in reporting injuries and to inform Federal agencies of their responsibilities in processing claims under the FECA. This Branch reviews and analyzes Federal agencies' injury compensation programs, performance statistics, progress, and trends, and then makes recommendations for overall improvement. Employees of this branch conduct training sessions with various groups to advance understanding of the Program. This Branch also oversees and implements all communication strategies for the program.

c. Branch of Information Technology. This Branch is responsible for the coordination and control of all information technology (IT) requirements, systems relating thereto, and supporting documentation. The Branch operates, maintains and enhances the integrated Federal Employees' Compensation System (iFECS) and coordinates with OWCP to ensure it meets the data needs of the program and conforms to Federal and OWCP guidelines and operational procedures. In conjunction with OWCP, the Information Technology Branch directs and coordinates activities of IT support contractors in the development, operation and maintenance of DFEC IT systems and hardware. Toward that end, the Branch maintains liaison with the Offices in regard to the operation of iFECS and other information systems and provides technical oversight and assistance.

d. Branch of Fiscal Operations. This Branch is responsible for formulating and monitoring all financial operations for DFEC on a national level, handling items such as Chargeback and the monitoring of program debt performance. This Branch performs a variety of functions to ensure the financial integrity of the program. Specifically, the Branch directs the efforts of to train or otherwise advise all Offices and branches on billing, payment, and fiscal practices. Formulation and monitoring of all fiscal policy and procedures is conducted by this Branch, including national oversight of agency automated compensation and bill payment systems. This Branch houses Fiscal Officers who assist with fiscal-related matters and are responsible for the maintenance of financial management records, changes in health benefits coverage, etc. This Branch also houses Medical Coding Specialists who are responsible for providing technical coding expertise in reviewing, resolving, and auditing billing problems; assisting claims staff with correctly coding accepted condition(s) of injured workers; and monitoring payments for overutilization and abuse. They routinely audit medical bill processing transactions to ensure amounts paid through the medical billing contractor are accurate.

e. Branch of Hearings and Review (H&R). This Branch issues appellate-level decisions on claims involving hearings or requests for review of the written record, which affirm, reverse, modify, or remand cases to any of the Offices. Hearing representatives are responsible for conducting the hearings, which are primarily telephonic although other formats may be used.

f. Branch of Program Integrity, Fraud Prevention and Prescription Management. This branch is responsible for developing and adjudicating claims for benefits for injured workers under the FECA, as well as medical treatment requests to include pharmaceuticals such as opioids and compounded medications. Medical Benefit Claims Examiners (MBE) also work to eliminate barriers that could impede necessary medical treatment and manage ongoing claims to include the verification of continuing entitlement to benefits. This Branch also houses Investigative and Program Analysts who analyze data to look for anomalies and potential vulnerabilities with medical and compensation payments. The Branch works closely with the FECA Branch of Fiscal Operations, the OWCP Branch of Medical Standards and Rehabilitation, and the Offices of Inspectors General when potential vulnerabilities or fraud is suspected.

5. FECA Program Offices.

a. Field Operations. FECA Program Offices are administered by an Office Director (OD), who reports to the FECA program's National Administrator(s) of Field Operations. The National Administrator(s) of Field Operations presides over Field Operations nationwide.

The OD is responsible for operations within that office and for seeing that that FECA claims functions are administered in a timely and efficient manner.

b. Office Staff. Employees in the Offices administer the FECA and work to achieve the goals set by the Director.

c. FECA Office Functions.

(1) Claims Functions. Each office will have Supervisory Claims Examiners, who are responsible for the operation of individual claims units. Each claims unit generally has a Quality Assurance and Mentoring Examiner (QAM) and Claims Examiners (CE). CEs have the primary responsibility for adjudicating claims, authorizing medical treatment, making compensation payments, and overseeing disability management. Individuals at each level of authority are delegated specific responsibilities for issuing decisions on claims.

(2) Disability Case Management Functions. CEs also have a vital role in the management of disability claims.

In addition to claims staff, the FECA program employs Staff Nurses who are responsible for helping ensure contract Field Nurses and Triage (COP) Nurses service the needs of the OWCP claimant. Both Triage (COP) Nurses and Field Nurses are professionals contracted by OWCP to provide disability case management services; however, they do not provide clinical treatment. The Triage (COP) Nurse is assigned early in the life of a traumatic injury case and works each case telephonically. The Field Nurse monitors the claimant's medical progress and assists with the return to work effort by coordinating efforts with the CE, treating physician, employing agency, and claimant.

The Rehabilitation Specialists (RS) is responsible for helping ensure that contract Vocational Rehabilitation Counselors service the needs of the FECA claimants. The RS manages the counselors, who work under contract with OWCP, to help claimants obtain employment.

Chapter 0-0200, Program Directives

1. Purpose and Scope. This chapter describes the communications and directives system used by the Division of Federal Employees' Compensation (DFEC). It focuses on the structure of the Procedure Manual governing claims under the Federal Employees' Compensation Act (FECA) and addresses its relationship to the program's other written directives.

2. Directives. DFEC is charged with identifying areas where new directives should be developed or existing directives updated. The purpose of this paragraph is to describe the publications relating to the Federal employees' compensation program. There are multiple avenues by which program information is disseminated.

a. External Directives. These may consist of either legal or informational releases.

(1) Federal Register. This publication contains notices and rules pertaining to new or revised policy. Notices advise the public of proposed changes and invite comments on them, while rules state the final changes adopted by the program. The FECA regulations are periodically updated through the Federal Register.

(2) Informational Web Site Postings. Such postings are intended to give claimants and their representatives, agencies and medical providers new or updated information on a particular topic. The FECA program website also contains links to publications such as the Injury Compensation for Federal Employees (CA-810) which serves as a handbook for Federal agency personnel specialists and Questions and Answers about the Federal Employees' Compensation Act (CA-550) which describe the basic provisions of FECA.

b. Other Directives. DFEC uses these directives to provide staff with internal policy, procedures and other information. There are three primary types of issuances: Transmittals, Bulletins and Circulars.

(1) FECA Transmittals are permanent (unless superseded) directives. They convey updates to the FECA Procedure Manual (PM). FECA Program Memoranda (FECA ProMs) are historical and used to convey such changes.

(2) FECA Bulletins are usually time-limited directives that require action. They may involve changes to procedures, special reports, or pilot programs. Bulletins require or invite action from the Offices and usually include reference to procedure manual chapters affected.

(3) FECA Circulars are primarily used to call attention to standing instructions or procedures which may require compliance or improvement; to announce proposed plans or anticipated program changes; to clarify program policies; and to keep the FECA Offices informed of the activities and interests of the National Office.

3. FECA Procedure Manual. The purpose of this paragraph is to describe the sections of the FECA Procedure Manual.

a. Part 0, Overview. Part 0 of the FECA PM is an introduction to the FECA, the program that administers it, and the directives issued to implement it. This section provides employees with a quick look at operations, and it also contains an index to all parts of the PM.

b. Part 1, Mail and Files. This section discusses how reports of injury and occupational disease are made into case files, and how case files are maintained and combined. It also contains guidelines for transferring files between DFEC FECA Offices and Branches. Procedures for transferring and disposing of inactive files and records, as well as how to retrieve retired and closed cases from the Federal Records Center (FRC), are also included.

c. Part 2, Claims. This section describes policies, responsibilities and procedures for adjudicating and managing claims filed under the FECA. Used mostly by claims personnel, Part 2 describes the handling of claims as they are screened, developed, accepted or denied, tracked, managed, appealed (if applicable), and administered in all respects.

d. Part 3, Medical. This section discusses the functions and responsibilities of the medical advisory staff and other medical related topics such as schedule awards, authorizing examination and treatment, medical services and supplies, requirements for medical reports and exclusion of

medical providers. It also addresses the responsibilities of the Staff Nurse with regard to nurse contract certification. Part 3 is also used by claims staff.

e. Part 4, Special Case Procedures. This section addresses groups of claims covered under the FECA by virtue of special legislation, such as Non-Federal Law Enforcement Officers, War Hazards Compensation Act and Civil Air Patrol.

f. Part 5, Benefit Payments. This section sets forth the policies and procedures for administering the financial aspects of the FECA program. Used primarily by fiscal staff, this part includes procedures for handling health benefit and life insurance matters; maintaining fiscal registers, records, and reports; and charging back to employing agencies the amounts of their expenditures from the compensation fund.

g. Part 6, Debt Management. This section describes the responsibilities of the program regarding computation, waiver and recovery of overpayments under the FECA.

4. OWCP Procedure Manual. The purpose of this paragraph is to describe the sections of the OWCP Procedure Manual that should be referenced when processing FECA claims.

a. Chapter 1-400 (Privacy Act). This chapter addresses the Freedom of Information Act (FOIA), which provides the public with a procedure for obtaining records from the Federal government, and the Privacy Act, which assures private citizens the right to confidentiality of certain personal information.

b. Part 3 of the OWCP Procedure Manual. This section describes the vocational rehabilitation services which are available to injured employees and discusses the procedures by which they may be obtained.

c. Part 4 of the OWCP Procedure Manual. This section contains procedures for evaluating the quantity and quality of work in the Federal employees' compensation program, including procedures to be used for accountability reviews.

NOTE: OWCP may also issue OWCP bulletins where more than one program's activities are implicated or where OWCP wishes to issue program guidance on a particular issue.

5. Citations to the Procedure Manual (PM). Each part of the PM consists of several chapters, which in turn are divided into paragraphs, subparagraphs, and sometimes sub-subparagraphs. Chapters and subdivisions should be cited as follows:

Citation to a part of the FECA PM: FECA PM Part 0

Citation to a chapter: FECA PM 0-200

Citation to a paragraph: FECA PM 0-200.5

Citation to a subparagraph: FECA PM 0-0200.5b

Citation to a sub-subparagraph: FECA PM 0-200.5b(1)

6. Maintenance and Revision. New material will usually be distributed electronically. The FECA PM is available on the Department of Labor's website.

Because transmittal of the FECA PM is primarily electronic, DFEC does not insert page numbers when updated Paragraph citations, as opposed to page numbers, are used thereafter when updates are made.

FECA Part 1 - Mail and Files: Addresses the jurisdiction of cases and the movement of mail and case files within the District Office. It also discusses how to create, maintain, transfer and retire case files.

Chapter 1-0100, Introduction

1. Purpose and Scope. This part of the FECA PM addresses the jurisdiction of cases and the movement of mail and case files within and between the FECA Offices. It also discusses how to create, maintain, transfer and retire case files. A list of indexing abbreviations is found at Exhibit 1.

Related material can be found in FECA PM 2-0300, which discusses how to prepare responses to priority and routine correspondence; FECA PM 2-0400, which addresses file maintenance and management for claims staff; and FECA PM 2-0401, which describes status codes used in the automated system.

2. Responsibilities. Effective handling of mail and files requires cooperation within the Office. Responsibilities of the various units are as follows:

a. Mail Room Staff. Mail room staff are located in a centralized location for the FECA Program. They process mail, make up and maintain physical case files, pull and deliver files to various locations, transfer cases as necessary, and retire closed files to the Federal Records Center.

b. Automated System Support Staff. Systems support staff enter data, create case files on the automated system, and produce reports to support case processing. The System Manager trains the operators and supports all users of the automated system.

c. Claims and Other Staff. Personnel in claims and other units key location and status changes and forward each file to its next location. Only files with pending action are kept in the claims units or other units in the FECA Offices.

d. Managers. The District Director authorizes any local changes to the procedures described in these chapters needed because of variations in staff size or the number of claims handled.

3. Contents of Part 1. The chapters and their subjects are:

a. Chapter 1-0200, Jurisdiction. This chapter describes the jurisdictions of the FECA Offices.

b. Chapter 1-0300, Processing Mail. This chapter describes the kinds of mail which the Offices receive, and how to handle each kind. It also addresses sorting, recording, and searching for mail. Finally, it describes how to process cash received and how to process outgoing mail.

c. Chapter 1-0400, Creation of Cases. This chapter describes the contents of new cases and how to create them.

d. Chapter 1-0500, Maintenance of Cases. This chapter describes how to maintain case files. It includes procedures for dividing file material, doubling cases, and repairing damaged folders. It addresses how to send cases out of the office and process them on return.

e. Chapter 1-0600, Transfer, Loan, and Retirement of Cases. This chapter describes how to send files from one Office to another, or to the National Office, on either a permanent or temporary basis. It also addresses retirement of closed case files to the Federal Records Center (FRC), and handling of cases retrieved from the FRC.

4. **Automated Systems Support.** The work of the Mail and File Unit is closely tied to the automated system support functions within the DO, and many of those functions are referenced in the chapters that follow. Specific instructions for using the system are set forth in the FECS Users Manuals.

a. **Mail and File Staff.** These individuals most often use the Query function, which allows the user to obtain case numbers (using Name Search, option 1, or Case Status Info, option 15, with the Social Security number) and case locations (using Case Search, option 2).

b. **Data Entry Staff.** These individuals, including Case Create Clerks, use the Case Management subsystem to perform a variety of tasks. The most commonly used options are:

01 Create	16 TPCUP
02 Change	19 Location Change
03 Name Change	20 Group Location Change
04 Address Change	21 Location/Status Change
05 Double/Duplicate	23 Department Change
06 CA-800 Print	24 Agency Change
07 Loan/Transfer	25 Organization
08 Delete	26 Central Case Add
09 Adjudication Status	27 Central Case Locate
14 Status Change	28 Central Case Request

Data entry staff also use the Retirement subsystem.

Exhibit 1: Indexing Abbreviations

INDEXING ABBREVIATIONS

Abdomen	ABD
About	ABT
Abrasion	ABR
Accepted	ACC
Account	ACCT
Acting	ACTG
Active	ACT
Administration	ADMIN

Administrator	ADM
Aeronautics	AERO
Afternoon	P.M.
Agency	AGCY
Agency for International Development	AID
Agriculture	AGRI
Agricultural Marketing Service	AMS
Agricultural Research Service	ARS
Air Force Base	AFB
Alley	ALY
American Red Cross	ARC
Amputate	AMP
Apartment	APT
Arms Control and Disarmament Agency	ACDA
Army Post Office	APO
Asbestosis	ASB
Assistant	ASST
Assistant District Director	ADD
Attendant	ATT
Avenue	AVE
Average	AVG
Beginning of business	BOB
Bill Pay Clerk	BPC
Boulevard	BLVD
Branch	BR
Branch of Hearings and Review	H&R
Bruise	BRU
Building	BLDG
Burden of proof	BOP
Bureau of Labor Statistics	BLS
Bureau of Old Age and Survivors Insurance (Social Security Administration)	BOASI
Bureau of Retirement & Insurance, Office of Personnel Management	BRI
Case Create Clerk	CCC
Case in transit to D. O.	CIT
Causal relationship	CR
Central Intelligence Agency	CIA
Circle	CIR
Civil Air Patrol	CAP
Civil Works Administration	CWA
Civilian Conservation Corps	CCC
Claimant Advocate Project	CAP
Claims Branch	CLBR
Claims Examiner	CE
Clerk	CLK

Close of business	COB
Code of Federal Regulations	CFR
Commission	COMM
Company	CO
Concussion	CONC
Conjunctivitis	CONJ
Consumer Price Index	CPI
Continuation of pay	COP
Contusion	CONT
Corporation	CORP
Council of Economic Advisers	CEA
Court	CT
Daily roll	DR
Data entry clerk	DEC
Date disability began	DDB
Date of injury	DOI
Date of recurrence	DOR
Department	DEPT
Dept. of Veterans Affairs	VA
Diagnosis	DX
Director	DIR
District	DIST
District Director	DD
District of Columbia Compensation Act	DCCA
District Office	DO
District Medical Advisor	DMA
District Medical Director	DMD
Division of Federal Employees' Compensation	DFEC
Doctor	DR
Doubled case	DDD
Drive	DR
Duplicate	DUP
East	E.
Employees' Compensation Appeals Board	ECAB
Employer I.D. number	EIN
Employing agency	EA
Engineer	ENGR
Executive Office of the President	EX OFF of the PRES
Executor	EXEC
Expressway	EXPY
Fact of injury	FOI
Farm Credit Administration	FCA
Farmers Home Administration	FFHA
Federal	FED
Federal Aviation Agency	FAA
Federal Bureau of Investigation	FBI

Federal Communications Commission	FCC
Federal Deposit Insurance Corporation	FDIC
Federal Emergency Management Administration	FEMA
Federal Employees' Compensation Act	FECA
Federal Employees' Health Benefits	FEHB
Federal Maritime Commission	FMC
Federal Mediation and Conciliation Service	FMCS
Federal National Mortgage Association	FNMA
Federal Personnel Manual	FPM
Federal Power Administration	FPA
Federal Records Center	FRC
Federal Reserve System	FRS
Federal Retired Employees Health Benefits	FREHB
Federal Trade Commission	FTC
Field Nurse	FN
Fiscal Officer	FO
Fit for duty	FFD
Fit for light duty	FFLD
Fleet Post Office	FPO
Food and Drug Administration	FDA
Foot	FT
Foreign Agricultural Service	FAS
Foreign body	FB
Forest Service	FORSERV
Form Letter	FL
Fracture	FX
General	GEN
General Accounting Office	GAO
General Services Administration	GSA
Government	GOVT
Government Printing Office	GPO
Health and Human Services	HHS
Health benefits	HB
Health Benefits Subscription	HBS
Hearing loss	H/L, HL
Helper	HLPR
Highway	HWY
Hospital	HOSP
Hour	HR
Incised	INC
Infection	INF
Inguinal	ING
Injury	INJ
Internal Revenue Service	IRS
International	INTERNAT
International Development Cooperation Admin.	IDCA

Interstate Commerce Commission	ICC
Job application	JA
Job description (position description)	PD
Junior	JR
Laborer	LAB
Laceration	LAC
Lane	LA
Left	LT
Legal	LEG
Letter carrier	L.C.
Longshore and Harbor Workers' Compensation Act	LS/HWCA
Loss of wage-earning capacity	LWEC
Machinist	MACH
Machine operator	MACH OPR
Mailroom	MRM
Maritime Administration	MA
Mechanic	MECH
Medical evidence	ME
Medical history	HX
Medical Management Assistant	MMA
Medical report	MR
Messenger	MESSGR
Military Sea Transportation Service	MSTS
Month	MO
Morning	A.M.
National	NATL
National Aeronautics and Space Administration	NASA
National Guard Bureau	NGB
National Institute of Standards and Technology	NIST
National Institutes of Health	NIH
National Labor Relations Board	NLRB
National Science Foundation	NSF
National Security Agency	NSA
National Security Council	NSC
Neighborhood Youth Corps	NYC
North	N.
Not fit for duty	NFFD
No time lost	NTL
Office of Personnel Management	OPM
Office of Workers' Compensation Programs	OWCP
Old Age and Survivors Insurance	OASI
Operator	OPR
Optional Life Insurance	OLI
Ordnance	ORD
Organization of American States	OAS

Organization for Economic Cooperation and Development	OECD
Overpayment	OP
Parcel post	PP
Parkway	PKWY
Performance of duty	POD
Periodic roll	PR
Periodic roll review	PRR
Place	PL
Post office	PO
Public Health Service	PHS
Puncture	PUNC
Railroad Retirement Board	RRB
Railway	RY
Rehabilitation Counselor	RC
Rehabilitation Specialist	RS
Regional Director	RD
Return to duty	RTD
Right	RT
Road	RD
Route	RT
Rural Electrification Administration	REA
Schedule award	S/A, SA
Securities and Exchange Commission	SEC
Selective Service System	SSS
Senior	SR
Senior Claims Examiner	SrCE
Shoulder	SHLDR
Small Business Administration	SBA
Social Security Administration	SSA
Solicitor	SOL
South	S.
Sprain	SPR
Square	SQ
Staff Nurse	SN
Statement of Accepted Facts	SOF, SOAF
Strain	STR
Street	ST
Substitute	SUB
Superintendent	SUPT
Supervisor	SUP
Supervisory Claims Examiner	SCE
Tax I.D. Number	TID
Technical Assistant	TA
Technician	TECH
Temporary	TEMP

Tennessee Valley Authority	TVA
Terrace	TERR
Tuberculosis	TB
Turnpike	TPKE
United States	U.S.
United States Coast Guard	USCG
United States Code	USC
United States Employment Service	USES
United States Information Agency	USIA
United States Marine Corps	USMC
U. S. Postal Service	USPS
Veterans Affairs Medical Center	VAMC
Volunteers in Service to America	VISTA
Wage-Earning Capacity	WEC
Week	WK
Weight	WT
West	W.
Workers' Compensation Assistant	WCA
Works Projects Administration	WPA
Year	YR
Young Adult Conservation Corps	YACC

Chapter 1-0200, Jurisdiction

<u>Paragraph and Subject</u>	<u>Date</u>	<u>Trans. No.</u>
Table of Contents	09/20	20-05
1. Purpose and Scope	09/20	20-05
2. General Jurisdiction	09/20	20-05
3. Special Jurisdiction	11/24	25-02
<u>Exhibits</u>	<u>Date</u>	<u>Trans. No.</u>
Exhibit 1: Prefixes Used for FECA Cases	12/21	22-03
Exhibit 2: Case Designations Used for FECA Cases	12/21	22-03



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1. Purpose and Scope. This chapter describes the jurisdictions within the FECA Offices. Although the rules set forth below are designed to apply to virtually all claims arising under the Federal Employees' Compensation Act (FECA), the Director for DFEHLWC or FECA Deputy Director(s) have the authority to assign a specific claim to any office, unit or branch, either before or after initial adjudication, regardless of where the claim would normally be handled.



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2. General Jurisdiction. Case jurisdiction is no longer governed by the claimant's home address. Even so, a FECA claimant is expected to provide the home address where he or she resides. A Post Office (PO) Box or attorney/representative address does not suffice for this purpose.

When cases are created they are placed in rotation and subsequently assigned to a claims examiner by rotation within the offices. A new case prefix of 55 (550000000 = 1st case assigned) is established for new cases effective September 28, 2020. All of the cases for an individual claimant will stay together, assigned to one Claims Examiner (CE). Cases with paper and physical evidence will remain in the office where the case file/evidence is physically located.

There are two specialty claims units, a Special Claims Unit and a Department of Labor Claims Unit. The Special Claims Unit in the Consolidated Office will be assigned a Unit Type Code "S." The DOL Claims Unit in the Consolidated Office will be assigned a Unit Type Code "D." These units are addressed further in paragraph (3) of this section.

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3. Special Jurisdiction. Some cases are assigned by nature of employment or nature of injury, or because compensation coverage is provided by a special provision of the FECA or by a law other than the FECA. Many of these cases have special prefixes, which are shown in Exhibit 1.

a. Adjudicated and Managed in the National Operations Office, Washington, DC. Cases involving security considerations (and similar considerations), including those arising from the National Security Agency, Defense Intelligence Agency and the Central Intelligence Agency.

b. Adjudicated and Managed in the FECA Special Claims Unit. All claims filed by employees who work for the agencies listed below are adjudicated and managed by the Special Claims Unit.

(1) All claims arising outside the United States, its possessions, territories and trust territories. This group includes claims by U.S. citizens and residents; all foreign nationals, wherever employed, and employees of the former Panama Canal Commission.

Adjudicated cases of American citizens in this group, except those of employees of the former Panama Canal Commission, will be transferred to a Claims Examiner in a non-specialized Office once the claimant returns to the U.S.

(2) All claimants who move outside the U.S.

(3) Non-Federal law enforcement officers (These cases are prefixed with "LE".)

(4) Former Office of Economic Opportunity (OEO) administrative employees only

(5) Americorps VISTA (Volunteers in Service to America)

- (6) Reserve Officer Training Corps (cases prefixed TC)
- (7) Civil Air Patrol (cases prefixed CP)
- (8) Civilian Conservation Corps (cases prefixed CC)
- (9) Civilian War Benefits (cases prefixed CB)
- (10) Civil Works Administration (cases prefixed CW)
- (11) Contractors, Pacific Naval Air Bases (cases prefixed EA)
- (12) Federal Emergency Relief Administration (cases prefixed FE)
- (13) Florida Hurricane (cases prefixed FH)
- (14) National Youth Administration (cases prefixed NY)
- (15) Old Law (cases prefixed OL)
- (16) War Claims (cases prefixed WC)
- (17) War Hazards Compensation Act (cases prefixed WH)
- (18) War Relocation Authority (cases prefixed RA)
- (19) Members of the Coast Guard Auxiliary and temporary members of the Coast Guard Reserve
- (20) Radiation and similar high energy injury cases
- (21) Agent Orange exposure
- (22) Contract Observers on Vessels (cases prefixed OB)
- (23) Employees of the former Panama Canal Commission
- (24) Gulf War Syndrome
- (25) Death Gratuity Claims under section 8102a (case prefixed DG)
- (26) Federal Firefighters (case designation FIR)

c. Processed in the Special Claims Unit of DFEC until Adjudication. All cases listed below are serviced in the FECA Special Claims Unit until they are adjudicated. They may then be reassigned to a claims examiner in a non-specialized office.

- (1) Agency for International Development (AID)
- (2) Department of State American Foreign Service Officers (FSOs) and foreign national employees who have moved to the United States. Claims by non-FSOs may be filed in a non-specialized office.
- (3) U.S. Information Agency (USIA)
- (4) Extended Occupational Disease Claims for Emotional Conditions

Other types of cases may periodically be assigned to the Special Claims unit based on operational needs.

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Exhibit 1: PREFIXES USED FOR FECA CASES

The following prefixes are used for the creation of cases. The prefixes are reflected in the case number itself.

1. 1 to 1,200,000 - Cases created from September 7, 1916 to September 1944.
2. 01 (or A1) - Prefix used for FECA cases created prior to September 2020 in previous District Office 1, Boston, MA
3. 02 (or A2) - Prefix used for FECA cases created prior to September 2020 in previous District Office 2, New York, NY
4. 03 (or A3) - Prefix used for FECA cases created prior to September 2020 in previous District Office 3, Philadelphia, PA
5. 06 (or A6) - Prefix used for FECA cases created prior to September 2020 in previous District Office 6, Jacksonville, FL
6. 07 (or A7) - Prefix used for FECA cases created in previous District Office 7, New Orleans, LA
7. 09 (or A9) - Prefix used for FECA cases created prior to September 2020 in previous District Office 9, Cleveland, OH
8. 10 (or A10) - Prefix used for FECA cases created prior to September 2020 in previous District Office 10, Chicago, IL
9. 11 (or A11) - Prefix used for FECA cases created prior to September 2020 in previous District Office 11, Kansas City, MO

10. 12 (or A12) - Prefix used for FECA cases created prior to September 202 in previous District Office 12, Denver, CO

11. 13 (or A13) - Prefix used for FECA cases created prior to September 2020 in previous District Office 13, San Francisco, CA

12. 14 (or A14) - Prefix used for FECA cases created prior to September 2020 in previous District Office 14, Seattle, WA

13. 15 (or A15) - Prefix used for FECA cases created in previous District Office 15, Honolulu, HI

14. 16 (or A16) - Prefix used for FECA cases created prior to September 2020 in previous District Office 16, Dallas, TX

15. 25 (or A25) - Prefix used for FECA cases created prior to September 2020 in previous District Office 25, Washington, D.C.

16. 50 (or A50) - Prefix used for FECA cases created in previous District Office 50, Washington, D.C.

17. C - Prefix used for cases originating with the former Panama Canal Commission.

18. CA - Prefix used for cases containing report of injuries sustained by employees of the Civil Works Administration.

19. CB - Prefix used for cases containing reports of injuries of those people applying for Civilian War Benefits.

20. CC - Prefix used preceding the number for cases containing reports of injuries sustained by enrollees of the Civilian Conservation Corps. This group of cases was jacketed in the same folder as was used for FECA cases and were numbered in the same number series.

21. CP - Prefix used for cases containing reports of injuries sustained by members of the Civil Air Patrol.

22. DG - Prefix used for cases created as a result of claims made under section 8102a of the FECA by eligible survivors of federal employees and Non-Appropriated Fund Instrumentality (NAFI) employees who died of injuries incurred in connection with service with an Armed Force in a contingency operation.

23. DX - Prefix used for cases containing report of injuries sustained by employees as a result of exposure to Agent Orange.

24. EA - Prefix used for covering employees of contractors who were building defense bases and were taken prisoners by the Japanese during World War II. Originally, these cases were assigned

a block of numbers in the same numbering series as the FECA cases; however, at a later date, as additional cases were received, they were assigned a number in the regular FECA series with the prefix "EA" added.

25. ECC - Prefix used for a group of cases docketed in Manila, PI, after World War II. These cases were later transferred to the National Office where they were assigned new numbers in the regular FECA series.

26. FE - Prefix used for cases containing reports of injuries sustained by employees of the Federal Emergency Relief Administration.

27. FH - Prefix used for cases containing reports of injuries sustained by employees who applied for benefits under the Florida Hurricane Act.

28. LE - Prefix used for cases containing reports of injuries sustained by Law Enforcement Officers not employed by the United States.

29. OB - Prefix used for cases involving contract observers working on vessels under the Magnuson-Stevens Fishery Conservation and Management Act or the Marine Mammal Protection Act of 1972.

30. OL - Prefix used for cases containing reports of Injuries sustained prior to September 7, 1916.

31. PI - Prefix used for a group of cases jacketed in Manila, PI, other than War Claims. When these cases were transferred to the National Office they were rejacketed and assigned numbers in the FECA series.

32. R - Prefix used for cases containing reports of injuries to seamen employed on vessels chartered by the War Shipping Administration.

33. RA - Prefix used for cases containing reports of injuries sustained by internees while employed in the Relocation Centers during World War II.

34. SS - Prefix denoting Civilian War Benefits (CWB) cases in the Social Security Administration series. When the Civilian War Benefits were transferred from the Social Security Administration, they were jacketed in letter-size folders. Some of these were immediately transferred to cases and assigned C.W.B. numbers. However, some of these did not develop into cases. Rather than re-jacket and assign new numbers, the last section of four or five digits of the Social Security number was used for filing purposes and the prefix "SS" identified the group.

35. TC - Prefix used for cases containing reports of injuries sustained by members of the Reserve Officers Training Corps (ROTC).

36. TH - Prefix used in the Honolulu Office for FECA cases processed there during World War II. When these cases were transferred to the National Office they were assigned numbers in the FECA series.

37. WC - Prefix used for cases containing reports of injuries sustained by employees who applied for benefits under the War Claims Act.

38. WH - Prefix used in War Hazard Compensation cases containing reports of injuries, death or detention of employees of contractors with the United States, where such injuries occurred outside the United States.

39. WCA - Prefix assigned to War Claims cases in the Manila, PI office. When these cases were transferred to the National Office, the cases were assigned numbers in the WC series.

40. WP - Prefix assigned to cases containing reports of injuries sustained by employees of the Work Projects Administration.

41. X - Prefix used on FECA cases after 1,200,000 cases. When FECA had jacketed 1,200,000 cases, it was deemed advisable to start a new series in order that there might be fewer digits in the number.

42. 2,000,000 - Numbering series used to identify fully-imaged case records from the inception. (Note – Other cases may also be fully imaged if the existing paper file has been converted to an electronic file.) Ifecs contains a notation of Y (yes) or N (no) to indicate whether a file is fully imaged.

43. 55 - Prefix used for FECA cases created in or after September 2020 that do not require a special designation otherwise indicated in this exhibit.

44. 19 - Prefix used for COVID-19 cases covered under American Rescue Plan Act (ARPA) of 2021.

Exhibit 2: CASE DESIGNATIONS USED FOR FECA CASES

The following case designations are used to identify related cases. The designations are viewable only in the Integrated Federal Employees Compensation System (iFECS). They are not reflected in the case number.

1. OKC - Case designation used to identify cases containing reports of injuries related to the bombing of the Alfred P. Murrah Federal Building in Oklahoma City on April 19, 1995.

2. NAI - Case designation used to identify cases containing reports of injuries related to the bombing of the United States embassy in Nairobi on August 7, 1998.

3. 911 - Case designation used to identify cases containing reports of injuries related to the terrorist attacks of September 11, 2001. The numbering series previously used was 3,000,000.

4. IQW - Case designation used to identify cases containing reports of injuries sustained by federal employees during the conflict in Iraq. The numbering series previously used was 3,002,000.
5. ATX - Case designation used to identify cases containing reports of injuries related to anthrax exposure, beginning with the claims of October 2001. The numbering series previously used was 3,005,000.
6. HKT - Case designation used to identify cases containing reports of injuries related to Hurricane Katrina and its aftermath. The numbering series previously used was 3,006,000.
7. AFW - Case designation used to identify cases containing reports of injuries sustained by federal employees during the conflict in Afghanistan. The numbering series previously used was 3,007,000.
8. HIN - Case designation used to identify cases containing reports of injuries related to the H1N1 virus. The numbering series previously used was 3,010,000.
9. DWH - Case designation used to identify cases containing reports of injuries related to the April 20, 2010 fire and explosion at the Deepwater Horizon Facility operated by BP Exploration & Production, Inc. and the resulting clean-up efforts. The numbering series previously used was 3,020,000.
10. CLJ - Case designation used to identify cases containing reports of injuries related to contaminated water in Camp Lejeune, North Carolina. (Reference the August 6, 2012, "Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012").
11. HSA - Case designation used to identify cases containing reports of injuries related to Hurricane Sandy (which made landfall in October 2012) and its aftermath.
12. NYS - Case designation used to identify cases containing reports of injuries related to the Navy Yard shootings at the headquarters of the Naval Sea Systems Command inside the Washington Navy Yard in Southeast Washington, D.C. on September 16, 2013.
13. LAX - Case designation used to identify cases containing reports of injuries related to the shootings inside Terminal 3 of the Los Angeles International Airport on November 1, 2013.
14. COR - Case designation used to identify cases containing reports of injury related to the COVID-19 Pandemic of 2020.
15. C19 - Case designation used to identify cases containing reports of injuries related to COVID-19 claims covered under the American Rescue Plan Act (ARPA) of 2021.
16. COV - Case designation used to identify cases containing reports of injuries related to COVID-19 vaccines.

17. AHI - Case designation used to identify cases containing reports of injuries related to Anomalous Health Incidents (i.e. Havana Syndrome cases).

18. FIR - This case designation will be used to identify cases containing reports of injuries sustained by federal Firefighters

Chapter 1-0300, Processing Mail

1. Purpose and Scope. This chapter addresses the kinds of mail and the priority given to each kind. It also discusses how to sort, open, date-stamp, and search for mail; how to process cash received; and how to process outgoing mail.

2. Kinds of Mail. Most mail is received via the U.S. Postal Service (USPS). However, some mail is received by private overnight mail service, some arrives by facsimile transmission (fax), and some is hand-delivered. Mail is grouped as follows:

a. Priority Correspondence. The Department of Labor (DOL) considers mail from the following parties to be priority correspondence:

- (1) The President and White House Staff.
- (2) The Vice President and members of the Vice President's staff.
- (3) The President Pro Tempore of the Senate.
- (4) The Speaker of the House of Representatives.
- (5) Other Members of Congress.
- (6) Members of the Cabinet.
- (7) Heads of independent Federal establishments.
- (8) Governors of States.
- (9) Foreign government officials (Prime Ministers, Cabinet-level officers, Ambassadors, etc.)
- (10) Heads of employee organizations.
- (11) Heads of national and international labor organizations.
- (12) Members of the press.

(13) Requests made under the Freedom of Information and Privacy Acts.

b. Primary Claim Forms. These forms, which contain information on new claims, include:

- (1) CA-1, Report of Traumatic Injury.
- (2) CA-2, Report of Occupational Disease.
- (3) CA-5, Claim for Compensation by Widow/Widower and/or Children.
- (4) CA-5b, Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren.
- (5) CA-6, Official Superior's Report of Employee's Death
- (6) Death certificates, telegrams or faxes notifying OWCP of an employee's death.
- (7) CA-16, Authorization for Examination and/or Treatment.
- (8) A letter with words of claim (see FECA PM 1-0400).

c. Other Claim Forms. These forms are usually submitted for existing claims:

- (1) Form CA-2a, Notice of Recurrence of Disability.
- (2) Form CA-7, Claim for Compensation on Account of Traumatic Injury.

d. Bills. Forms OWCP-1500 and HCFA-1500 are normally used to bill the OWCP for medical services and supplies. Hospital bills are usually submitted on Form UB-82 or UB-92. Bills for vocational rehabilitation services and for services rendered in other countries may be sent on other forms.

e. Routine Mail. This group includes many kinds of mail for case files. Designated claims staff will screen mail if Mail and File staff cannot decide on the proper routing:

- (1) Letters from claimants and their representatives.
- (2) Letters from employing agencies.
- (3) Medical reports from attending physicians, including Forms CA-17, CA-20, CA-20a, and OWCP-5;
- (4) Mail from contractual sources, including medical reports from second opinion and referee specialists, and progress reports from field nurses and vocational rehabilitation counselors;

(5) Requests for information from the Office of Personnel Management (OPM), the Veterans Administration (VA), and other Federal, state and local government agencies; and

(6) Health Benefits Forms SF-2809 and SF-2810.

f. Other Mail. This group includes mail which does not concern specific claims.

3. Initial Sort. The Mail and File (M&F) Clerk should separate certain envelopes from the rest of the incoming mail, as follows:

a. Mail for Delivery Without Opening. This mail includes:

(1) Certified mail (the M&F Clerk will need to sign a receipt for the USPS);

(2) Mail for the Regional Director or District Director;

(3) Material from the National Office; and

(4) Mail marked "Do not open in Mail Room" or the like (at district office option).

b. Mail for a Party Outside of the OWCP. If the party is located in the same building, the mail should be delivered to him or her. If not, it should be returned to the USPS.

4. Opening and Date-Stamping Mail.

a. Opening Mail. The M&F Clerk should:

(1) Check the contents of each envelope carefully to ensure that all contents are removed.

(2) Circle the case number with a colored pencil.

b. Date-Stamping Mail. The stamp shows receipt by the OWCP, the district office (DO), and the month, day, and year of receipt. All mail must be date-stamped before leaving the Mail Room. The M&F Clerk should date-stamp each piece of mail on the front.

(1) The stamp should not be placed over any writing.

(2) The stamp may be placed on back of a form if it will not be legible on the front.

(3) The stamp machine should be secured when not in use.

5. Processing Cash. The term "cash" includes paper money, coins, checks, and money orders. Letters containing cash should be separated from all others. Cash received must be processed according to the DOL's accounting and control procedures. [See Section 942, Collections, in Chapter 6-900, Financial Management, of the DOL Manual Series (DLMS)].

a. Cash Receipts Register. The designated M&F Clerk should record each cash item in the Cash Receipts Register, Form DL 1-301, initialing and dating each item. All entries should be made in ink.

(1) Line out incorrect entries rather than erasing or obscuring them. The M&F Clerk making the change should initial the entry.

(2) If the M&F Clerk cannot record the cash on the day it is received, it should be placed in a locked container and recorded on the next workday.

(3) Retain Cash Receipt Registers for two years.

b. Cash Transfer Receipt. After recording all cash receipts on Form DL 1-301, the M&F Clerk may also record them on Form DL 1-303, Cash Transfer Receipt, at DO option. The M&F Clerk should initial and date this form if used.

As with Form DL 1-301, if the M&F Clerk cannot record the cash on the day it is received, it should be placed in a locked container and recorded on the next workday.

c. Disposing of Cash. After completing Form DL 1-301 and DL 1-303 (if used), the M&F Clerk should hand-carry the cash to the DO's Cash Accounting Clerk, who will also sign and date the form(s), indicating receipt of the cash. The M&F Clerk keeps the original and pink copy of Form DL 1-303, and the Cash Accounting Clerk keeps the blue copy.

d. Cash Not Received. If a letter stating that cash is enclosed does not actually contain cash, the M&F Clerk should write on the envelope or letter:

CASH NOT ENCLOSED AT TIME OF RECEIPT
IN THE MAIL ROOM _____

Clerk's Initials and Date

The M&F Clerk should then give the letter to the Cash Accounting Clerk for reply.

6. Identifying Case Locations. The M&F Clerk must determine the location of each piece of mail before searching for cases.

a. Unnumbered Mail. If the mail is not numbered, the M&F Clerk should find the number by using the Name Search option in the Query function (see FECS Users Manual).

(1) If a match is found, the M&F Clerk should note the case number and current location code in the upper right corner of the mail, then place the piece of mail in the proper location to be sorted and attached.

(2) If a match is not found, the M&F Clerk should write "NID" (not in database) in the upper right corner and give it to the appropriate Supervisor or Team Leader. He or she will need to decide whether to create a case, route the mail within the DO without creating a case, or return it to the sender.

b. Numbered Mail. The M&F Clerk should use the Case Search function (option 02) in Query to obtain the current location and/or Unit ID and note it in the upper right corner of the mail.

(1) If an error message is received when the case number is entered, the M&F Clerk should use the Name Search function (option 02) in Query to verify that the mail contains the proper number. If it does not, the M&F Clerk should note the correct number on the mail.

(2) If the correct case number cannot be identified, the M&F Clerk should give the mail to the appropriate individual (see paragraph a(2) above).

c. Mail for Transferred and Loaned Cases. Mail always follows the case file, whether transferred or loaned. (However, if the case has been retired to the Federal Records Center (FRC), the case should be requested from the FRC.) Mail for other DOs should be collected and forwarded on a daily basis by certified mail.

7. Searching Mail. After checking the mail for case number and location, the M&F Clerk handles it according to type.

a. Groups of Mail. After date-stamping the mail, the M&F Clerk should sort it into the following groups, which are described in paragraph 2 above:

(1) Priority Correspondence. The M&F Clerk should hand-carry the letter with the case file to the person handling priority correspondence as soon as possible.

(2) Primary Claim Forms. Unless a case has already been created and closed code "C", a new case will need to be created (see FECA PM 1-0400.) The M&F Clerk then keys and delivers it to the claims unit, sorted according to responsible Claims Examiner (CE).

(3) Other Claim Forms.

(a) Forms CA-7 received after case creation are entered into the Timely Payment of Compensation (TPCUP) program and given directly to the responsible CE.

(b) Forms CA-2a are entered into the Disability Tracking System beginning with option 01 and given directly to the responsible CE.

(4) Bills. Bills for medical services and supplies are handled as stated in FECA PM Chapter 5-0200.8-10 and FECA Bulletins 99-21 and 99-31.

Bills from other countries should be forwarded through the Fiscal Unit to the National Office for payment.

Copies of bills from Field Nurses are delivered to the Staff Nurse or the CE. Copies of bills from Vocational Rehabilitation Counselors are delivered to the Vocational Rehabilitation Specialist or the CE.

(5) Routine Mail. Such mail should be placed in the case, wherever located, unless the DO elects to have CEs screen mail prior to placement with the case. At DO option, the following kinds of mail may be delivered directly to the unit responsible for processing it:

- (a) Third party actions--to Third-Party Examiner.
- (b) Requests for action when a check was lost or never received--to Fiscal Unit.
- (c) Transactions or other documents from the Department of the Treasury--to Fiscal Unit.

(6) Other Mail.

(a) Letters from potential service providers should be routed as follows: Physicians and Clinical Psychologists, to the Medical Unit; Registered Nurses, to the Staff Nurse; and Vocational Rehabilitation Counselors, to Vocational Rehabilitation Unit.

(b) General inquiries may include questions about the OWCP's practices and requests for technical assistance. Letters in this category will be routed according to district office policy.

(c) Interoffice memorandums should be routed according to the party addressed.

b. Requests for Case Files. In addition to searching for mail, the M&F Clerk will need to look for cases requested from within and outside the DO.

(1) From Within the DO. Form CA-33, Case File Release or Call Request, is used to request case files within the DO. The person desiring the case or the M&F Clerk may prepare the form.

If the M&F Clerk receives a telephone request for a case, and the case cannot be located and delivered immediately, the Clerk should prepare a Form CA-33 and place it in the mail.

(2) From Outside the DO. Case files requested by the Employees' Compensation Appeals Board (ECAB) and the Branch of Hearings and Review (H&R) are identified by computer-generated case lists. Case files requested by the National Office (NO) and other DOs are identified on Form CA-58, Case File Transfer. The M&F Clerk should take these cases to the location designated by the District Director.

c. Searching and Placing Mail. Mail should be searched each day, and 75% of mail should be properly placed in case files within two work days of receipt. For mail not placed within that time, appropriate follow-up should be made at five-day intervals until all mail is placed.

(1) When mail is placed, the folders may remain where they are, or they may be given to the person working at that location, according to local practice.

(2) The M&F Clerk should not remove a case file from its location without notifying the person responsible for it at that location. The M&F Clerk must enter a location change for any case picked up.

8. Outgoing Mail. Outgoing mail is processed as follows:

- a. Envelopes. All envelopes must show the addressee's ZIP code. Some post offices require a further separation of local mail, and such requirements must be honored.
- b. Heavy Envelopes and Packages. Such parcels must be securely wrapped with heavy-duty plastic tape or twine. Likewise, boxes of case files must be packed securely.
- c. Postage. A postage meter is used to affix postage. Airmail letters for overseas delivery will be bundled separately from regular mail.
- d. Registered and Certified Mail. These types of mail are processed according to USPS regulations and the procedures established in each district office.
- e. Overnight Express Mail. The services of the designated contractor may be used according to the practices of the DO.

9. Timeliness Report. Each office is required to sample its mail for one month each year.

- a. Groups. The five categories of mail sampled include:

- (1) Claims (including recurrences);
- (2) Bills;
- (3) Mail from contractual sources (including second opinion and referee specialists, field nurses, and rehabilitation counselors);
- (4) Faxes; and
- (5) Routine mail, which includes certified mail; letters from claimants; medical reports from attending physicians; and documents hand-carried to the DO.

- b. Size of Sample. The number of pieces of mail to be sampled is based on management review criteria, which require a sample of 42 for any universe over 3000 items.

- (1) All DOs receive at least 3000 bills and pieces of "other" mail per month. While the number of claims, items of mail from contractual sources, and faxes varies among DOs, the amount of mail to be sampled in all groups has been set at 42 pieces so that an actual count of mail in each category will not be required.

(2) In the "routine" group, the sampling should include 10 pieces of certified mail; 10 letters from claimants; 10 medical reports from attending physicians; and 12 hand-delivered documents.

c. When to Sample. The sampling process should begin at least 60 days before the DO's next accountability review or management review. Using a log such as the one shown in [Exhibit 1 \(Link to Image\)](#), the DO should do the following:

(1) Once a week, randomly select 10-12 pieces of date-stamped incoming mail in each group and copy the contents. Return the originals to the work area and place the copies in a folder.

(2) Two work days from date of receipt, check the case files to see if the items sampled appear in the files. (For bills, see if the bill has been entered into the Bill Pay System.)

(a) If so, record this date in the log.

(b) If not, check the pending mail, pending bills, or pending claims (if CA-2a or CA-7 is involved).

(3) For mail which remains unplaced, check the case files another five work days later. If the case file does not contain the piece of mail, provide a written memorandum to the person responsible for placing the mail, with a copy of the item, requiring that the case be located and examined to determine why the mail was not placed or could not be found.

(4) For any items not found, repeat this process at five-day intervals until 30 work days from date of receipt. At this time the items should be considered lost absent a good reason for delay in placement (the case is in the FRC, on appeal, etc.)

(5) At the end of the month, prepare a report which shows:

(a) How many pieces of mail were placed in the following intervals from date of receipt: 0-2; 3-5; 6-10; 11-15; 16-20; 21-25; and 26-30.

(b) The number of items sampled and the number of items not placed after 30 days. This last category should be further subdivided to show the number of items not yet placed and the number of items lost.

(6) Forward the completed report to the District Director.

Chapter 1-0400, Creation of Cases

1. Purpose and Scope. This chapter describes the contents of new cases and the bases for creating them. It also discusses how to create the physical files and in general how to create the electronic records (detailed instructions are given in the FECS Users Manual).

2. New Cases. A new case usually consists of official reports of injury or death, with accompanying letters.

a. Written Notice. A new case may be made up based on any of the following:

- (1) Form CA-1, Federal Employee's Report of Traumatic Injury.
- (2) Form CA-2, Federal Employee's Notice of Occupational Disease.
- (3) Form CA-5, Claim for Compensation by Widow, Widower, and/or Children.
- (4) Form CA-5b, Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren.
- (5) Form CA-6, Official Superior's Report of Employee's Death.
- (6) Form CA-7, Claim for Compensation on Account of Traumatic Injury.
- (7) Form CA-16, Request for Examination and/or Treatment (accompanied by a medical report and a bill).
- (8) A telegram or facsimile transmission (fax) advising OWCP of the death of a Federal employee while in the performance of duty.
- (9) Any letter or document containing words of claim.
- (10) A death certificate, if approved by a supervisor or other manager.
- (11) A claim filed in error as a recurrence on Form CA-2a which is really a claim for a new injury or occupational illness. In this situation, it is not necessary to request a new CA-1 or CA-2.

b. Verbal Notice. In some instances, cases may be created based on telephone calls:

- (1) If a claimant cannot act on his or her own behalf (for example, due to critical condition), the record of telephone call may be made into a case on approval of a supervisor or other manager. Information needed to create the case can be secured by telephone from the employing agency. At a minimum, this information should include the injured person's name, date of injury, date of

birth, and Social Security number (SSN), along with the name and address of the employing agency.

(2) If an employee has died, the record of telephone call may be made into a case. The person receiving the call should obtain as much information as possible about the deceased and how the death occurred. At a minimum, this information should include the deceased's name, date of injury, date of birth, and SSN, along with the name and address of the employing agency.

c. Information Lacking. Mail Room staff will return to the sender any forms or letters which do not contain enough information to create a case. The cover letter should explain the reason for return and ask the sender to re-submit all materials along with the missing information.

3. No Time Lost Cases. Certain Forms CA-1 and CA-2 will show that the claimant lost no time from duty and/or had no medical expenses from the injury.

a. First Aid Injuries.

(1) A case is defined as a first aid injury if:

(a) The upper right corner of the supervisor's part of Form CA-1 is marked "First Aid", and

(b) Items 24 and 26 of Form CA-1 are blank, showing that the employee has not been charged leave or continuation of pay.

(2) These cases are made up in the usual way, but they are counted separately.

b. No Time Lost/No Medical Expense Injuries (NTL-NME).

(1) A case is defined as NTL-NME if:

(a) Item 39 of Form CA-1 is checked and Item 24 is blank.

(b) Item 27 of Form CA-2 is blank, and no medical bill is included with the form.

(2) NTL-NME cases should be handled as follows:

(a) For Form CA-1, the M&F Clerk should return the form and any related letters to the employing agency for inclusion in the Employee Medical Folder, using Form CA-1420 or a similar letter. All letters should contain the full return address of the district office, and photocopied letters should be of good quality.

The M&F Clerk should enter the date of the letter, date of injury, and the name and address of the employing agency at the top of the letter, and the name and address of the injured employee at the bottom of the letter. It is not necessary to keep copies of Form CA-1420 or Form CA-1.

(b) For Form CA-2, a case should be created. If correspondence relating to the case is received before Form CA-2, a supervisor will decide whether to create a case.

c. Job Corps Enrollees. ETA Form 6-61, "Notice of Termination", should accompany any Form CA-1 or CA-2 for a Job Corps enrollee. Form 6-61 shows that enrollment with the Job Corps has ended. A notice of injury from a person whose enrollment in the Job Corps has not ended should be returned to the Job Corps center. The cover letter should ask that the claim be sent to OWCP only after enrollment has ended, since that is when entitlement to benefits under the FECA begins.

4. Administrative Authorization of Limited Benefits. Certain cases which are considered very simple/minor traumatic injuries, and are not expected to involve large medical expenses, may be administratively closed without formal adjudication by claims staff. Medical expenses up to \$1,500 may be paid on these cases without any adjudication by the claims examiner (CE).

a. Criteria. When the case is created, the system screens it to determine whether it meets the criteria for Administrative Authorization of Limited Benefits. Most of these involve non-controverted traumatic injury cases received within six months of the injury date.

However, if the case has certain codes for source, nature, cause and extent of injury or certain employing agency codes (for certain special legislation coverage cases such as VISTA Volunteers, or the Coast Guard Auxiliary), the system will not allow this type of closure.

Reference Exhibit 1 for general Administrative Authorization of Limited Benefits criteria.

b. Status Codes. For Administrative Authorization of Limited Benefits cases, the system sets the adjudication and case status codes to AM/C1 if the case had "No Lost Time", or to AC/C4 if the case had "Lost Time." The system sets the accepted flag to "C" for both types of closure cases.

If a traumatic injury case cannot be closed in this manner, the case status is set to "UN" and will need formal adjudication by claims staff.

NOTE: If the case is closed in this manner, a letter will be sent to the employee advising of his/her claim number and providing information regarding how to access case information and how to submit documentation and medical reports in the event that medical bills are expected to exceed the established threshold or they will be disabled for more than 45 days (which would necessitate the case be reopened for formal adjudication by claims staff). The claimant may also request formal adjudication of their case for any other reason. If such request is received, the CE should proceed with development, as necessary, and issue a formal decision.

c. Mail. Regular mail for Administrative Authorization of Limited Benefits cases that are coded AM/C1 or AC/C4 will continue to be placed into the imaged file. The rest of the mail, including all claims for compensation and recurrence claims (Forms CA-7 and CA-2a), should be processed as for any other case. Note that any CA-7 or CA-2a received will also result in the case being automatically reopened for adjudication.

5. Creating Physical Cases. Case files are letter-size (8 1/2" x 11") half-cut Kraft folders. They are pre-numbered, and each digit appears on a bright-colored background. New cases contain the following:

a. Forms. Starting from the bottom, forms should be filed on a spindle as follows:

(1) Non-Fatal Cases. Form CA-7, CA-2, CA-1, CA-16, and CA-20.

(2) Fatal Cases. Form CA-6, CA-5b, CA-5, CA-2, and CA-1. All material on the right side of the folder should be fastened together.

b. Other Material. Medical reports, letters, and other claim forms should be placed in the case folder loose.

c. Summary Sheets. Each case must have a summary sheet.

(1) Non-Fatal Summary, Form CA-800. The information requested in the upper left corner of Form CA-800 is produced on a sticker during the case create process. The sticker is then placed on Form CA-800.

(a) When an employee suffers two or more injuries on the same date, a separate Form CA-800 must be prepared for each injury. (A separate case file is also made up for each injury. For doubling cases, see FECA PM 1-0500.6.)

(b) When Form CA-800A (Medical and Related Expenses) or CA-800B (Periodic Roll for FECA Death Cases) is needed, the M&F Clerk should enter just the employee's name and case number at the top. The Form CA-800A or 800B should be stapled to Form CA-800 or CA-105.

(2) Fatal Summary, Form CA-105. The information requested in the upper left corner of Form CA-105 is produced on a sticker as part of the case creation process. The sticker is then placed on Form CA-105.

6. Creating Automated Cases. Case Create Clerks (CCCs) create new cases and add them to the automated system. The Case Management Users Manual (Option 01) describes how to create new cases.

a. Social Security Numbers (SSN). The database record for each case should contain the employee's SSN.

(1) When a new case (or an existing one just being added to the database) does not include the employee's SSN, the CCC should try to obtain the SSN by letter or telephone. However, such an attempt is not needed if the case has been retired, or if it is clear that the employee has no SSN (for example, the employee is a foreign national).

(2) A "dummy" SSN should be created if the actual SSN cannot be obtained or does not exist. The dummy SSN will consist of four 9's, the two-digit district office prefix, and a unique three-digit number. The triple terminal digits should be 000 for the first "dummy" SSN, 001 for the second "dummy" SSN, and so forth.

(3) District Offices approaching the terminal digits 999 should contact the National Office for instructions on creating SSNs beyond 9999XX999.

b. After Case Creation. When a batch of cases has been created, the following actions are taken:

(1) The CCC separates cases closed using adjudication code "C" from those to be sent to claims units. Cases closed with adjudication code "C" will remain in the file room. The CCC will note the next locations of cases to be sent to claims staff on the case jackets and key the cases to those locations.

(2) The Systems Manager (or designee) transmits newly created records to the central site. (Each new case record should appear on the local database the day after the case has been created.)

c. Form CA-801. When a case is created, a postcard (Form CA-801) is generated to advise the claimant and employing agency of the case file number and information on submitting correspondence to OWCP. If the case has been closed short form, the phrase "Limited Medical Only" will appear on the line immediately below the case number on the postcard to the agency. Postcards for all other cases will have a blank line immediately after the case number.

7. Duplicate Cases. The automated system checks for duplicate cases. However, duplicates may still be created due to human error. If this happens, the duplicate case should be deleted from the automated system, unless a bill has been paid on it.

The following steps should be taken after the duplicate record is deleted from the automated system:

a. Notation on Case Jacket. The M&F Clerk should:

(1) Write "Duplicate of 00-0000000" (number of other file) on the outside of the duplicate jacket;

(2) Draw a diagonal red line across the front of the duplicate Form CA-800, and writes "Duplicate of 00-0000000" in the upper right corner of this form; and

(3) Initial and date this statement.

b. Forms. The M&F Clerk should re-number Form CA-800 and all other forms in the upper right corner with the number of the case to be retained. These forms should then be attached to the inside front cover of the retained case.

c. Advising the Claimant. The M&F Clerk should advise the claimant by letter that the duplicate case was created in error and that only the number of the retained case should be used.

d. Bill Paid in Duplicate Case. If this occurs, a short memorandum explaining that bills have been paid in both cases should be prepared for the file, and the steps described above should be followed.

8. Deleting Case File Records. Removing cases from the automated system leaves gaps in case numbering, which may create concern about the security of the records in the system. Also, if a no-time-lost injury develops into a lost-time injury after a case record is removed, a new case has to be created, and issuing a second number for the same injury may lead to confusion.

Therefore, a case record may not be deleted unless it is a duplicate of a previously-created case. District office staff must ensure that no lost time/no medical expense cases are not created (paragraph 3 above discusses these kinds of injuries).

The case deleted should usually be the one with the most recent "received" date. However, if all compensation and bill payments were made in the later case, the earlier case should be deleted.

Exhibit 1: Edit Criteria for Administrative Authorization of Limited benefits Cases

CASE CREATE EDIT CRITERIA FOR ADMINISTRATIVE AUTHORIZATION OF
LIMITED BENEFITS

All of the following must apply, based on the data entered at the time of case create, for the claim to receive administrative authorization of limited benefits:

The claim involves a traumatic injury,
The claim was not controverted by the employing agency,
The claim was created within six months of the injury,
The claim does not involve a fatality, and
The claim does not involve a claim for wage loss compensation.

The coded "source" of injury is not one of the following:

Radiation; Tobacco Smoke; Stress (Emotional); Vehicle; Privately Owned Vehicle (POV); POV As Driver; POV As Passenger; Government Owned Vehicle (GOV); GOV As Driver; GOV As Passenger; Common Carrier (Airplane, Bus, etc.); Aircraft (Not Commercial); Boat, Ship; Asbestos; Needle; Animal; Animal (Dog); Animal (Other); Human (Violence); Human (Communicable Disease); or Bacteria, Virus.

The coded "cause" of injury is not one of the following:

Railroad and Street Cars; Aircraft; Vehicle (Driver); Vehicle (Passenger); Vehicle (Pedestrian); Drowning; Violence; Accidental Shooting; or Enemy Action.; Dog Bites

The coded "nature" of injury is not one of the following:

Amputation; Traumatic Food Poisoning; Traumatic Tuberculosis; Traumatic Virological/Infective/Parasitic Diseases; Traumatic Cerebral Vascular Condition, Stroke; Traumatic Hearing Loss; Traumatic Heart Condition; or Traumatic Mental Disorder, Stress, Nervous Condition.

The employing agency is not one of the following:

VISTA Volunteers; or Coast Guard Auxiliary.

The case number prefix is not one of the following:

CC; CP; CW; EA; FH; LE; NY; RA; WB; WC; WH; or WP.

Note: Where the Secretary of the Department of Health and Human Services has declared a Public Health Emergency, the President of the United States has declared a National Emergency or has identified an emergency situation under the Stafford Act, or a unique event or circumstance has been identified by the Secretary of Labor or their designee that may impact the safety of members of the Federal workforce, the criteria under which a case may receive administrative authorization of limited benefits and the list of excluded coded source of injury, cause of injury, and nature of injury may be adjusted at the discretion of the Director of OWCP or their designee..

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Chapter 1-0500, Case Maintenance

1. Purpose and Scope. This chapter describes how to maintain case files. It addresses how to divide file contents, double cases, and repair damaged folders. It also discusses how to send case file contents out of the office and process them on return, (However, see FECA PM 1-0600 for loaning and transferring cases.) Finally, the chapter addresses adjustments to the database.

2. Case Movement. Mail Room staff pick up outgoing cases from each unit at least once each day and bring them to the Mail Room, where they are sorted and moved to their next

locations. Mail Room staff then deliver the cases to their next locations. All cases must be keyed to the proper specific location (as opposed to a general section location) before being moved.

3. Filing Cases. The file room contains closed cases (those needing no further action). Closed cases are retained until their transfer to the Federal Records Center in accordance with OWCP Records Disposal Schedule and GSA General Schedules (see FECA PM 1-0600). Open cases (those needing further action) may be housed either in the file room or in other locations throughout the district office (DO).

a. Method of Filing. Folders are kept in the File Room on open shelves. The M&F Clerk should observe the following:

(1) Folders are filed by triple terminal digit. Each digit has a distinct, brightly-colored background, allowing searchers to locate and shelve the folders with greater ease and accuracy. Folders are filed first by prefix, then by the last three digits of the claim number, then by the first three digits.

(2) Triple terminal digits often identify the claims unit to which the case is assigned. For example, in a DO with four claims units, Unit 1 would handle triple terminal digits 000-249, Unit 2 would handle 250-499, and so forth. However, in DOs which assign claims by geographical area, triple terminal digits do not identify the claims unit.

b. Criteria for Filing. Case folders should not be filed in the File Room unless:

(1) All locations have lines drawn through them, with initials and dates; and

(2) No loose mail appears in the folder, unless "drop file" is written on it, along with the initials of the person making the notation and the date of the notation;

c. Misfiled Cases. If a case keyed to the File Room cannot be located, the Mail and File (M&F) Clerk should first check the number on the database. If the number is correct, the M&F Clerk should do the following:

(1) Look in the files 10 triple terminal digits above and below the missing number, and at every number in between;

(2) Look at every file in the shelf within 12 inches or so of the missing number;

(3) Look under each prefix used in the office, one at a time, and look for the missing number without any prefix;

(4) Look in the files 100 triple terminal digits above and below the missing number, and at every number in between.

If the case cannot be located, a special search is required. If the special search is not successful, claims staff will need to reconstruct the file.

4. Doubling Cases. When an employee sustains more than one injury, it may be necessary to combine all of the records into one case folder. The case records are kept separate but travel under one case number, which is known as the "master number." The subsidiary and master cases are cross-referenced in the DFEC database.

a. Case Type Code. Each case file is assigned a case type code, as follows:

- I Independent (neither a master or subsidiary file)
- M Master file (has at least one other file associated with it)
- S Subsidiary file (has been associated with another file)

When cases are created and CASE615 is run, a CASE632 is also produced. This report shows all cases already existing for a claimant. Each page of the report should be placed in the corresponding newly created case file, just above the CA-1 or CA-2. If a case contains such a report, it must be sent to the responsible Claims Examiner (CE), even if it is a short-form closure case. The responsible CE may ask that the other cases listed on the report be pulled as well.

b. When and How to Double. The criteria for doubling are stated in FECA PM 2-0400.8. Cases may be identified for doubling through use of CASE632, New and Prior Injuries Report, or through review by CEs. When cases approved for doubling by a Supervisory Claims Examiner or other person designated by the District Director arrive in the Mail Room, the M&F Clerk should:

(1) Decide which case number should be the master number, using the following criteria:

- (a) The master case file number should be the oldest (by file number) case in the DO.
- (b) A case which has been closed and has had no medical payments for two years should not be the master case file.
- (c) Cases recalled from the Federal Records Center should not be the master case file.
- (d) Cases that already have a master number should not be undoubled and redoubled under another master case file number.

(2) Keep separate spindles for the cases, even though they are contained within the same jacket. The master file number should be written on the CA-800(s) of the subsidiary case(s).

(3) Spindle down the CA-800 for any inactive subsidiary case (that is, a case closed for over two years which was accepted for minor conditions, or a case closed "short form" over two years ago). All inactive subsidiary cases should be placed in the A part of the file.

(4) Write the full name of the claimant on the front of the folder with the master number. Underneath the name, list the numbers of all cases contained in the folder, with the master

number first, the lowest case number next, then the next higher, and so forth. The name and numbers should be in the top center part of the folder. For example:

John C. Jones
ACT 00-101498
00-100928
00-100995

(5) Stamp the "Name, Date of Injury, and Filed Under" block on the inside back of the folders of the subsidiary cases; fill in the blanks with a pen; and place all of these folders in the files.

c. Updating Records. The Case Create Clerk must update the records for all subsidiary cases on the database so that any claim number keyed in will prompt the master number. [See the FECS Users Manual (Double/Duplicate, option 05).]

d. Retiring Records. When doubled cases are retired, both the master and all of the subsidiary case files must be retired.

5. Dividing Cases. When the contents of a case file become too thick for the folder, they must be divided. Mail Room staff may decide to divide files on their own, or they may act on request of claims staff. The M&F Clerk should do the following:

a. Prepare a New Folder.

(1) Make up a duplicate folder with the same case number. Beside the number on one folder, write the letter "A"; on the other folder, write the letter "B".

(2) On the front of the folders, write "This case is divided into A and B parts."

b. Divide the Contents.

(1) Place all letters over five years old in the A part if possible. Otherwise, it may be necessary to divide the file again after two or three years.

(2) Place all correspondence received after the cutoff date between the A and B parts in the B part. Also place Form CA-1, CA-2, CA-5, or CA-5b in the B part, as well as the original Form CA-7.

If it becomes necessary to divide the case more than once, the third folder is labeled "AA", the fourth folder "AAA", etc. The B (active) part always contains the most recent documents.

6. Repairing Cases. Case folders and their contents sometimes become worn or unreadable due to wear and tear. When this happens, Mail Room staff should repair the folders and contents (though at DO option, claims personnel may handle this task).

Where papers have torn loose from the spindle, the M&F Clerk should repair or strengthen the page with a gummed or self- adhesive reinforcement, or with transparent tape. If torn or damaged documents cannot be mended, and further damage may occur, the M&F Clerk should photocopy the documents so that the file will contain a readable copy.

7. Location Changes. As cases are moved to different locations in the district office, their locations must be changed in the system as well. The Systems Manager in each district office keeps a list of location codes. Changes are keyed using FECS Case Management subsystem option 19.

a. Notations on Case Jacket. Before keying the change, the M&F Clerk should cross out the current location on the case jacket. When keying is completed, the M&F clerk should check off the "Keyed" space opposite the location code on the case jacket and place the folder in the proper pick-up area for routing to the next location.

b. Replacement Grid Sheets. When the jacket has been completely filled up and all lines have been crossed out, a gummed grid sheet with spaces to enter locations and statuses is to be placed on the cover of the case file.

c. Group Location Change. If many cases are to be sent to the same location at the same time, the keyer should use option 20, Multiple Location Change, to do so. It is useful to sort cases requiring only location changes by new location before keying.

8. Cases Sent Out of the Office. Case files are often mailed to medical specialists for review. Sometimes cases are hand-carried outside the DO for investigations or meetings.

a. Jacket and Summary Sheet. The case jacket and Form CA-800 or CA-105 should always remain in the DO. Doubled cases will contain more than one summary, and all of them should be retained. A copy of the letter to the recipient of the file should be kept in the folder to show where the contents were sent.

b. Mailing the Case. The case may be sent either by the designated express mail service or through the U.S. Postal Service (USPS). If the latter is used, the case should be sent by certified mail. An envelope with a business reply address label and return address should be furnished for the return of the file.

c. Hand-Carrying the Case. If the case is hand-carried, a memorandum should be placed in the folder showing who took the case and where and when it was taken.

d. Computer Location. The automated system should be updated to show that the case is out of the office.

e. Mail. If mail is received for a case with contents out, the folder should be sent with the mail to the proper unit for processing. The case should then be routed back to the "contents out" location.

9. Adjustments to the Database. Changes to the Case Management File are sometimes needed due to errors in data entry or changes to the claimant's address, the employing agency's chargeback code, or the like.

Corrections to those data elements which are used to search the database are especially important. These elements include all name fields, date of injury, date of death, and Social Security Number (SSN).

All such changes should be sent to the Systems Manager (or other designated personnel). In particular, the Systems Manager (or a designee who does not have the authority to enter payments) will make or direct all changes to names and addresses.

Chapter 1-0600, Transfer, Loan and Retirement of Cases

1. Purpose and Scope. This chapter describes how to send case files from one district office (DO) to another, or to the National Office (NO). The chapter also addresses how to retire closed cases to the Federal Records Center (FRC).

These procedures apply to all case files, whether permanently transferred or temporarily loaned. Mail and File staff process all case files to be transferred or loaned among the various offices of the OWCP and the FRC.

2. Transfer of Case Files. Transfers occur mostly between DOs. Only the Assistant District Director (ADD) or higher-level authority may direct or allow transfer of a case from the DO. The criteria for transfers are outlined in FECA PM 2-0400.10a.

a. Initial Request. The requesting DO should complete items 1 through 9 of Form CA-58, Case File Transfer (see [Exhibit 1 \(Link to Image\)](#)).

b. Action by Requesting DO. The requesting DO should send the original Form CA-58 to the sending DO and retain a copy for control purposes. The Form CA-33 or incoming mail which prompted the request for the file should be stapled to the copy of Form CA-58.

(1) On the copy of Form CA-58, the requesting DO should note the employee's or beneficiary's name and the word "mail." The copy is be retained until:

(a) The case file is received;

(b) The requesting DO is advised that the case file cannot be located; or

(c) The sending DO asks the requesting DO to forward the mail. (This is done when the sending DO has jurisdiction of the requested case, and the requesting DO is unaware of it).

(2) If the case file (or a reply to the request) is not received within 30 days, the requesting DO should prepare another Form CA-58. It should be marked "second request."

c. Action by Sending DO. When Form CA-58 is received, it should be placed with the unattached mail to be searched. The Form CA-58 should be handled as routine mail unless there is reason to handle it as priority mail.

(1) When the case file is located, the original Form CA-58 and any unattached mail or other case file material should be associated with it.

(2) The designated manager should review the file and ensure that any pending action (i.e., payment of bills, an adjustment of compensation, a response to a letter, or a decision on the case) is taken immediately. Transfer may then be authorized, and the file should be routed through the Systems Manager so that a printout of CMF information may be prepared and placed in the case folder.

(3) The M&F Clerk should prepare Form CA-1417 (or, at DO option, claims personnel may perform this task). The form should be sent to the employee or the beneficiary, with a copy to the employing agency if the employee is still on the agency's rolls. Copies of the letter must also be sent to other interested parties, such as the employee's representative or physician.

(4) When ADP staff transfer the file, the case location will change to "T--" (DO number). The file should be sent to the requesting DO by designated express mail service or through the U. S. Postal Service, using certified mail.

(5) ADP staff will transfer the CMF and ACPS records to the receiving DO.

(6) The Systems Manager or designee will transmit all case location records at a designated time, thereby advising the receiving office of incoming cases.

(7) If a file cannot be found, the sending DO should so notify the requesting DO on the original Form CA-58.

(8) When a DO sends a case file to another DO without first receiving a request, the sending DO should complete only one copy of Form CA-58 and follow the same steps for transferring the case as stated above.

d. Form CA-67, Case File Transmittal Sheet.

(1) The sending DO should prepare four copies of Form CA-67. This form shows the names of the sending and receiving DOs, and the names and case numbers of transferred files. Form CA-67 is numbered consecutively by calendar year in a series for each DO to which cases are sent. Copies of the form are distributed as follows:

(a) The original and one copy are attached to the case file being transferred; and

(b) One copy is retained for the sending DO's records.

(2) The requesting DO should receive an original and one copy of Form CA-67 with the case files requested. The cases listed on Form CA-67 are checked against the cases received. If correct, item 7 should be initialed and dated. Any changes needed should be noted the form. The form is then returned to the sending DO.

(3) The sending DO should keep the receipted copy of Form CA-67 and discard the previously retained copy.

3. Loans of Case Files. Loans occur mostly between the DOs and the NO, though they may occur between DOs as well. Only the Assistant District Director (ADD) or higher-level authority may direct or allow loan of a case.

a. Reasons for Request by NO. The NO may request cases for action by the Employees' Compensation Appeals Board (ECAB), the Branch of Hearings and Review (H&R), the Director of OWCP, the Director for FEC, or other OWCP staff.

b. Initial Request. The requesting DO or the NO should complete Form CA-58 and proceed as described in paragraph 2b above. (However, cases for the ECAB and H&R are requested by computer report.) If no Form CA-58 has been completed, the sending DO should complete it, using Item 9 to show the destination of the case within the NO.

c. Action by Sending DO. Cases requested by the NO should receive priority handling. The sending DO should proceed as stated in paragraph 2c above, except that:

(1) It is not necessary to notify the claimant of the loan.

(2) Cases loaned to the NO should be mailed to:

Branch of Hearings and Review
200 Constitution Avenue N.W.
Room N-4421
Washington, D. C. 20210.

Use of this address will ensure that the cases are routed through the NO database. The name of the person requesting the file should be shown.

d. Form CA-67. The sending DO should prepare four copies of Form CA-67. In the column titled "Reason for Transfer", the word "loan" should be entered, and the name of the person requesting the file should be shown. Copies of the form are distributed as described in paragraph 2d above.

e. Returning Loaned Cases. To return a loaned case, Mail and File staff should complete items 11a, 11b and 11c of Form CA-58. The Systems Manager should note in Item 12 when the electronic records are returned. The ADD should complete items 13a and 13b, and the file may then be mailed.

4. Retiring Cases to the FRC. Cases that have been closed and have not been reopened are retired to the FRC as necessary to ensure that space is available for active cases. (However, the DO should retain hearing loss and asbestosis cases to minimize FRC storage costs, as these cases will more likely need to be recalled at a later date for further action.)

The OWCP Records Disposal Schedules describe the time periods for which case files must be held and the responsibility for their disposition.

a. Screening Cases. Cases appearing on the Time Lost and No Time Lost Reports should be pulled from the file room and taken to a staging area for review. ADP staff process cases eligible for retirement or destruction and return ineligible cases to Mail and File staff to be reshelfed.

b. Doubled Cases. When doubled cases are retired, both the master and all of the subsidiary case files must be retired.

c. Contacting the FRC. Before retiring cases, the DO should ensure that enough cases are available to meet its records center's minimum requirements for assignment of an accession number. The DO should also verify with the National Archives and Record Administration (NARA) that its records center has enough space available to accept the cases.

d. Electronic Processing. NARA offers electronic processing of reference requests to agencies storing records at a regional records services facility or the Washington National Records Center. This system speeds service by eliminating the delivery of reference requests via the postal service or courier, and negative replies due to wrong center locations. This service may be accessed on the Internet at www.nara.gov/regional/cips.html.

e. Status and Location Codes. Cases to be retired should be given the case status code of "RT", and cases awaiting destruction should be given the case status code of "XX". When keying is complete, DO staff should box the cases leaving one-half inch of dead space to allow for retrieval of individual files. DO staff should also follow the usual procedures for physical destruction of cases. The Systems Manager (or designee) will transmit location/status changes at the designated time of the workday.

f. Recalling Cases From FRC. The DO will contact the FRC with a request to retrieve cases, providing the case number, name, and accession number for each case. Retrieved cases will be recalled electronically from Central. The status will be the one in effect when the case was retired.

FECA Part 2 – Claims: Describes the procedures for adjudicating, paying, and managing claims; includes appeals process and other specialized topics.

Chapter 2-0100, Introduction

1. **Purpose and Scope.** This part of the Federal Employees' Compensation Act Procedure Manual (FECA PM) contains a series of chapters and subchapters which establish policies, guidelines and procedures for adjudicating and managing claims under the FECA.

- a. This chapter describes the structure of FECA PM Part 2.
- b. Subsequent chapters in FECA PM Part 2 describe the laws, regulations, and procedures used to address FECA claims. The procedures are presented in sequential order beginning with routine provisions which apply to all claims and proceeding to provisions which apply to more complex situations requiring specialized action.

2. Organization of Material in FECA PM Part 2.

- a. Chapter 2-200 summarizes the major provisions of the FECA; identifies rules, regulations, FECA Program Memorandums, and other standing instructions that govern the actions and decisions of the Claims Examiner (CE); and provides a list of reference materials, decisions, and other guides which may be useful to the CE.
- b. Chapters 2-400 through 2-500 present the "ground rules" for applying this body of knowledge to claims processing. They describe the rules for organizing and maintaining the documents in a case record; the recording of the status and location of the case record; the procedures for safeguarding case records and arranging for investigations; and the rules for holding informal conferences.
- c. Chapters 2-600 through 2-814 describe the rules for developing and managing claims. Included are discussions of the five basic requirements for accepting claims; occupational illness; continuation of pay; computation of compensation payments; development and evaluation of medical evidence; reemployment; and review of claims where continuing benefits are being paid.
- d. The remaining chapters in FECA PM Part 2 address specialized issues which pertain only to certain claims. These issues include computation of pay, dual benefits, involvement of third parties, representatives' fees, lump sum payments, reopening closed cases, disallowances,

3. **Related Material.** Other instructions affecting claims processing may be found in FECA Bulletins, where new procedures are first published pending inclusion in the PM, and FECA

Circulars, which transmit information but do not require specific action. FECA Program Memorandums contain legal and medical policy determinations applicable to the adjudication and management of claims. These resources are described in detail in FECA PM 2-200.

Other parts of the FECA PM which the CE may consult include part 0, Overview; Part 1, Communications and Records; Part 3, Medical; Part 4, Special Case Procedures; Part 5, Benefit Payments; and Part 6, Debt Management. OWCP PM Chapter 1-400 addresses requests for information under the Privacy Act and the Freedom of Information Act.

Chapter 2-0200, General Provisions of the FECA

1. Purpose and Scope. This chapter is intended to serve as an introduction to the coverage and requirements of the Federal Employees' Compensation Act (FECA) as amended. It summarizes the general provisions of the Act and describes the responsibilities of the Claims Examiner (CE) in administering the FECA. The reference materials listed at the end of the chapter should be available to CEs in each office.

2. General Provisions of the FECA.

a. Definition of Injury. The term "injury" includes all diseases proximately caused by the employment as well as damage to or destruction of medical braces, artificial limbs and other prosthetic appliances. Aggravation of a pre-existing condition by the employment is also compensable.

b. Requirements for Eligibility. Each claim for compensation must be filed within three years of the date of injury, except where the official superior had actual knowledge of the injury within 30 days of its occurrence. The claimant must be a civil employee, and an injury must have resulted from the incident claimed. Finally, the injury or disease must have occurred in performance of the claimant's duties, and it must be causally related to factors of employment. See FECA PM 2-800 through 2-806.

c. Medical Care. An injured employee who meets the statutory conditions of coverage is entitled to all medical care which is required to cure, give relief, or reduce the degree or period of disability. 5 U.S.C. 8103. No dollar maximum or time limitation is placed on medical care, which will be provided as long as the evidence indicates it is needed for the effects of the job-related injury. See FECA PM 2-810 and FECA PM Part 3.

d. Continuation of Pay. An employee who sustains a disabling job-related traumatic injury is entitled to continuation of regular pay (COP) for a period not to exceed 45 calendar days. To qualify for COP, the injured employee must file written notice of injury and claim for COP within 30 days of the injury. COP is not considered compensation and is subject to taxes and

other payroll deductions. The employee must make separate claim for monetary compensation if the disability exceeds 45 days or results in any permanent disability. See FECA PM 2-807.

e. Compensation. Generally, for total disability an employee with no dependents is entitled to compensation equivalent to two-thirds of the weekly salary, while an employee with one or more dependents is entitled to three-fourths of the salary. Certain additional amounts, such as premium pay, night and Sunday differential, dirty work pay, and hazardous duty pay, may be included in salary. Overtime pay, however, cannot be included. A special formula is applied in cases where the employee is a part-time worker, an unpaid volunteer, a temporary employee, or a person working in a similar category. See FECA PM 2-900. Compensation payments are subject to garnishment for past due alimony and child support payments if the office receives the proper documentation from a state agency or a court order that supports such action.

f. Vocational Rehabilitation. If the injured worker suffers a vocational handicap due to the injury and cannot resume usual employment, vocational rehabilitation services may be arranged to assist in training for work that the claimant can perform in the disabled condition. Rehabilitation services are usually provided by private rehabilitation counselors, who are supervised by the OWCP. Where rehabilitation is under way, the OWCP may provide a monthly maintenance allowance not to exceed \$200, in addition to compensation for wage loss. See FECA PM 2-813 and OWCP PM Part 3.

g. Attendant Allowances. 20 C.F.R. 10.312 allows payment for services of an attendant where it is medically documented that the claimant requires assistance to care for personal needs such as bathing, dressing, eating, etc. Such services are paid as a medical expense under 5 U.S.C. 8103 and are paid directly to the provider of the services. See FECA PM 2-812.

h. Duration of Compensation. Compensation payments for total disability may continue as long as the medical evidence supports such payment. As with medical care, no cap is placed on the amount or the length of time for which compensation for total disability may be paid. See FECA PM 2-812.

i. Reemployment and Loss of Wage-Earning Capacity. When an injury results in partial disability, and the employee suffers a wage loss because of the disability, compensation may be paid for such loss of wage-earning capacity. See FECA PM 2-814.

j. Schedule Awards. The FECA also provides for payment of compensation for permanent loss or loss of use (either partial or total) of certain internal organs and members or functions of the body such as arms, legs, hands, feet, fingers, toes, eyes, and loss of hearing or loss of vision. Each extremity or function has been rated at a specific number of weeks of compensation which can be paid even though the employee returns to work at full salary. Where a serious disfigurement of the head, face, or neck results from a job-related injury, an award may also be made for such disfigurement, not to exceed \$3,500. See FECA PM 2-808.

k. Survivor Benefits. In the event of death due to employment, the Act provides for funeral and burial expenses up to \$800, and up to \$200 for the administrative costs of terminating a decedent's status as a Federal employee. The law provides compensation for widows or

widowers with no eligible children at the rate of 50 percent of the deceased employee's monthly salary, and for widows or widowers with eligible children at 45 percent. If a spouse survives, each child receives 15 percent, up to total of 30 percent. Where no spouse survives, the rate for the first child is 40 percent, plus 15 percent for each additional child, shared equally among all children. Monthly payments for all beneficiaries generally cannot exceed 75 percent of the employee's monthly pay rate. Other persons who may also qualify for benefits are dependent parents, brothers, sisters, grandparents, and grandchildren. See FECA PM 2-700.

l. Cost-of-Living Adjustments. In general, if compensation has been paid in either a disability or death case for over a year, Consumer Price Index (CPI) adjustments are made to compensation. See FECA PM 2-900.

m. Third Party Liability. Where an employee's compensable injury or death results from circumstances creating a legal liability on some party other than the United States, the cost of compensation and other benefits paid by the OWCP must be refunded from any settlement obtained. The OWCP will assist in obtaining the settlement; the law guarantees that a certain proportion of the settlement (after any attorney fees and costs are first deducted) may be retained even when the cost of compensation and other benefits exceeds the amount of the settlement. See FECA PM 2-1100.

n. Dual Benefits. The law provides that compensation may not be paid concurrently with certain benefits paid by other Federal agencies. In particular, compensation and a retirement annuity from OPM may not be paid for the same period except where OWCP is paying a schedule award, and veterans' benefits may be subject to offset as well. See FECA PM 2-1000.

o. Review of OWCP Decisions. Under 5 U.S.C. 8116(c) the FECA is a beneficiary's exclusive remedy for injury or death of a Federal civil employee in performance of duty. Although aggrieved parties on occasion do seek remedies outside the FECA through a Federal tort suit or other litigation, the existence of such litigation is not considered in adjudicating claims or taking other case actions. If an employee or the survivors disagree with a final determination of the OWCP, a hearing may be requested, where the claimant may present evidence in further support of the claim. Also, the claimant has the right to appeal to the Employees' Compensation Appeals Board, a separate entity of the U. S. Department of Labor, and OWCP may review a case on its own initiative. See FECA PM 2-1600 through 2-1602.

3. Responsibilities of the Claims Examiner. The main tasks of the CE are to adjudicate claims; authorize benefits and set up compensation payments; manage individual cases, so that timely and proper actions are taken in each claim; and manage a case-load, so that all cases are handled promptly and effectively.

The CE is expected to exercise keen judgment, derived from experience, background, and acquired knowledge, tempered with compassion and common sense, in all claims processing. This exercise involves the ability to identify the issues, determine the additional evidence required, and make a decision once the evidence is assembled. Each case stands on its own merits and the decision in a given case must be based on the facts in evidence in the case file. The decision cannot be based on surmise, speculation, or unwarranted presumption.

The adjudication of a case on the evidence in the file does not preclude the use of precedents in arriving at a decision in a case. Precedents, as distinguished from questions of fact, are legal and medical principles, statements, or decisions rendered in other cases which may serve to define, explain, or justify the legal or medical determinations in like situations. When using precedent material in the adjudication of a case, the CE should place a memorandum in the case file citing the specific reference and principles relied upon, and the manner and extent to which such principle is applicable.

Some of the most useful precedents for FECA cases are the case rulings of the Employees' Compensation Appeals Board (ECAB), the highest appellate source for claims under the FECA. Opinions of the ECAB are first published separately on a case-by-case basis, then in book form. Other precedents are found in court decisions and in such publications as Arthur Larson's Workmen's Compensation Law.

4. Reference Materials for Claims Examiners. Each office should have a library which contains the following items for reference by CEs:

- a. Federal Employees' Compensation Act, 5 U.S.C. 8101 et seq., as amended.
- b. 20 C.F.R. Part 10 (Title 20, Code of Federal Regulations, 1.1 et seq.); US GPO.
- c. FECA Procedure Manual, Part 0, Overview; Part 1, Communications and Records; Part 2, Claims; Part 3, Medical; Part 4, Special Case Procedures; Part 5, Benefit Payments; and Part 6, Debt Management.
- d. FECA Program Memorandums, Bulletins, and Circulars.
- e. Decisions of the Employees' Compensation Appeals Board, available on DOL website.
- f. Workmen's Compensation Law, Arthur Larson, Matthew Bender Publishing Co., Washington, with all updates.
- g. Dorland's Illustrated Medical Dictionary, W.B. Saunders Co., Philadelphia.
- h. Current edition of the AMA Guides to the Evaluation of Permanent Impairment. A copy of prior editions should also be retained.
- i. Current edition of the Dictionary of Occupational Titles, and supplements.

Chapter 2-0300, Communications

1. Purpose and Scope. This chapter discusses preparation and release of letters, including priority and controlled correspondence, and responses to telephone calls. It also addresses how to obtain translations.

2. Policy. Claims staff should respond fully to all written and telephoned inquiries. Responses should be stated clearly and politely, and given in a timely manner. Resources for preparing and releasing letters include the DOL Correspondence Guide (DLMS Handbook 1-200), which contains basic information for those who prepare or review correspondence, and the U.S. Government Printing Office (GPO) Style Manual and Word Division Supplement.

3. Responsibilities. This paragraph describes the guidelines for providing information to employees, employing agency personnel, and other interested parties.

a. Privacy Act and Freedom of Information Act. All persons who prepare letters and provide information by telephone must be familiar with their responsibilities under the Privacy Act and Freedom of Information Act (FOIA). OWCP PM 1-0400 discusses both laws.

b. Format and Grammar. All persons who prepare letters should review them for content, format, punctuation and spelling before releasing them. The signer should also review these items.

c. Time Frames. The District Director (DD) is responsible for ensuring that all letters and telephone calls are answered within established time frames (see FECA PM 2-0400 and paragraph 6 below).

d. Integrity of Form Letters. For legal reasons, the texts of all CA- prefixed letters must be uniform across all offices. Also, OWCP is responsible to the Office of Management and Budget (OMB) for the text of letters cleared by that agency. Such letters must include the OMB clearance number and public burden notice.

Therefore, the DD must ensure that any locally printed or generated letters bearing a CA-number conform exactly to the text authorized by the National Office and that they contain the OMB clearance number and date, if any.

4. Regular Correspondence. This paragraph outlines where form letters can be found, what signature levels and signature formats are needed, and when copies of letters must be sent.

a. Form Letters. Forms can be found in several places:

(1) The Forms Correspondence (FC) option allows the user to generate many form letters, and to obtain sample copies of these letters.

(2) The Letter Generator System (LGS) also contains a variety of form letters. Several indexes list the letters available.

(3) A few forms are available in pre-printed versions only.

b. Signature Level. Claims Examiners (CEs) may release routine correspondence and they may issue some formal decisions (see FECA PM 2-1400). Other formal decisions are issued by Quality Assurance and Mentoring Examiners (QAMs). Controlled correspondence is prepared for the signature of the District Director.

c. Signature Format. Signatures need not be a wet signature. They may be computerized signatures. Signatures and names currently appearing on outgoing correspondence will generally read "Division of Federal Employees' Compensation," and the author of the document will be captured in the case management system. To preserve the Employees' Compensation Appeals Board's (ECAB) ability to identify the adjudicator of certain decisions such as reconsideration decisions, the FECA Program will use a Quick Response (QR) Code to identify decision authors.

Note: A naming convention for the staff is used to provide every employee with a pseudonym for use in telephonic and other oral communications. The naming convention to create the pseudonym will be the employee's first name and last name initial. If more than one individual within an office has the same combination (e.g. two Thomas J.'s) then their middle initials will be added.

Outgoing correspondence (including decisions) will not contain or otherwise reveal the pseudonym when printed. Instead the pseudonym will be embedded into a QR Code on the letter, allowing a QR scanner device to reveal the pseudonym.

d. Copies of Letters to Employing Agencies. The agency should receive copies of all letters addressing substantive developments in the case, even if the claimant no longer works for the agency. This rule applies no matter how much time has passed since the claimant left the agency's employ (except, of course, where the agency no longer exists).

(1) Definition. Substantive actions are those which actually or potentially affect the level of benefits paid. They include formal decisions, overpayment determinations, letters concerning reemployment, changes in work tolerance limitations, responses to requests for surgery or purchase of major medical equipment, referrals for medical examination, and referrals for vocational rehabilitation services. Substantive actions do not, however, include routine inquiries such as Forms CA-1032, CA-1615, and CA-1617 although copies of these forms may be provided to an agency and they may be reviewed through AR imaging.

It is not necessary to send the agency copies of material that does not bear on the overall payment status of the claim. For instance, agencies need not be sent copies of letters returning medical bills for additional information, two-way memos asking for one or two items of information as a follow-up to a previous request, or copies of letters transmitting information contained in the case file.

(2) Addresses. Letters to the U.S. Postal Service should usually be sent to the Management Sectional Center (MSC), and letters to other agencies should be sent to the address shown on Form CA-1 or CA-2 as the reporting office. The employing agency should resolve any internal disagreement as to which party should receive the copy. No more than one copy of each document need be sent to the agency.

e. Copies of Letters to Authorized Legal Representatives. Where the employee has an attorney or other legal representative, the original of any letter to the claimant should be sent to that person, with a copy to the claimant. Similarly, where the claimant is sent a copy of a letter, the attorney or other representative should receive a copy as well. Form CA-900 is used for this purpose.

(1) Supplemental Name File. Upon receipt of a signed statement from a claimant appointing a representative, the CE will add the person's name and address to the supplemental name file in the claims management system.

(2) Generation of Form CA-900. If the name of an attorney or representative appears in the supplemental name file, an original and a file copy of Form CA-900 will automatically print with each FC letter selected. When composing a letter using Word or LGS, the CE must also create a Form CA-900.

(3) Withdrawal of Authorization. Should the claimant withdraw the authorization for the representative, the CE should remove the representative's name and address from the supplemental name file.

5. Priority Correspondence. This paragraph addresses letters received directly by the office from Members of Congress, heads of employee organizations, and other parties as defined in FECA PM Chapter 1-300.2a.

a. Responsibility of Office Staff should prepare replies to all case-specific letters except those involving:

(1) A legislative matter, a substantive program matter, or a question of policy or interpretation of policy for which no guidelines are published, whether or not a specific case is referenced. Such letters should be sent to the National Office (NO) for reply.

(2) A case in another office. The letter should be sent to the Office that owns the case.

b. Preparation of Responses.

(1) Format. All letters should be prepared with one-inch margins on both left and right. The text should appear in block format against the left margin.

(2) Standard Text. Certain themes which sometimes arise in letters from claimants and their advocates should be addressed as follows:

(a) Retirement Program. An explanation that FECA or OWCP is not a retirement program should be included in reply to any letter that suggests otherwise.

(b) Formal Decision. If a formal decision is being issued, the reply should note that if the employee disagrees with the decision, he or she may pursue the courses of appeal described in the decision.

(3) Signature Level. DDs are to sign all Congressional responses. This duty may not be delegated to lower-level employees.

(4) Tracking. Inquiries are monitored using the Priority Correspondence tracking function in iFECS, or on a separate system established for priority letters referred by the NO.

c. Decisions and Other Case Actions.

(1) Other Case Actions. Development of the claim, authorization of medical care, and payment of compensation should not be delayed while replies to correspondence are being prepared.

(2) Release of Decisions. Formal decisions should be released before or concurrently with the reply to the priority correspondence.

(3) Follow-up Replies. The DD should ensure that any further reply promised in the initial response is in fact prepared within the time frame stated. If a further reply has been promised "when the decision is made", the DD should ensure that the case is "flagged".

6. Controlled Correspondence. This paragraph addresses letters referred by the NO to the office for response. Replies and case actions are handled as described in paragraphs 5b and 5c above.

a. Definition. Controlled correspondence includes letters addressed to the Secretary of Labor which require responses according to DOL policy (see DLMS Handbook 1-200). It also includes any letter so designated by the Office of the Director for Workers' Compensation. Most letters from Congressional offices are referred to the office for a direct response, while letters from other parties are sent to the office with a request that a draft reply be sent to the NO.

b. Letters with Direct Responses.

(1) Referral by NO. The NO transmits the inquiry, with attachments, to the owning office along with the control number and the due date.

(2) Copies. When the reply is released:

(a) A signed and dated copy (showing the priority control number) should be sent to the NO. A copy of the incoming letter need not be sent.

(b) Copies of the incoming letter and any attachments should be placed in the case file.

c. Letters with Draft Responses. The NO e-mails the owning Office with a request for the specific information needed and the due date. After receiving the reply, NO staff prepare the response to the inquirer.

7. Telephone Calls. This paragraph addresses how to handle incoming telephone calls.

a. Received in the FECA program by the claims examiner directly or through a centralized phone bank.

(1) Priority Inquiries. These inquiries are defined in paragraph 5 above. A response should be issued within two work days.

(2) Routine Inquiries. A Form CA-110 is used to document all telephone inquiries where substantive information is exchanged.

If the information requested cannot be supplied without a return call, the CA-110 will be referred to the responsible CE for reply.

b. Received in NO.

(1) Priority Inquiries. When time frames for reply are very short, NO staff will request status reports from Office staff by telephone. Such requests are to be answered by telephone or fax within three work days to ensure that the inquiry is answered by the due date.

(2) Routine Inquiries. NO staff refer routine inquiries to the office handling the case.

8. Translations. This paragraph describes how to obtain translations of material in another language.

a. Requesting Translations. It is best to obtain translations locally. If this is not possible, the original and one copy of the correspondence, along with a brief memorandum requesting translation, should be sent to:

Administrative Officer
Office of Workers' Compensation Programs
200 Constitution Avenue, N.W., Room S-3524
Washington, D.C. 20210

Or, the request may be transmitted electronically. The request will be included in the case file when the translation is completed.

b. Contents of Memorandum. The memorandum requesting translation must show the date of the request, the name of the employee, the case file number, and a brief description of the material requiring translation.

c. Copies of Memorandum. The original of the memorandum is attached to the material to be translated. A copy of the memorandum, along with a copy of the material to be translated, should remain in the case file.

Chapter 2-0400, File Maintenance and Management

1. Purpose and Scope. This chapter outlines how to maintain FECA paper case files. It addresses jurisdiction of cases, assembling documents in a file, routing files within the office, doubling files, and transferring files to other offices.

FECA PM Part 1 discusses the responsibilities of Mail and File staff in performing these functions. PM Chapter 2-0401 covers maintenance of data in the FECA Program's automated system, while PM Chapter 2-0402 discusses security of files.

Note: As FECA case files are now created electronically and many cases are completely electronic, these procedures apply to paper files or the paper portion of hybrid case files.

2. Jurisdiction of Paper Files. This paragraph describes case assignment in general.

a. General Jurisdiction Cases. The FECA claims offices adjudicate all cases for compensation unless specialized jurisdiction apply.

b. Special Jurisdiction Cases. Certain types of cases are developed and adjudicated in the National Operations Office and the Special Claims Unit, and most of them remain in those offices for management (see FECA PM Chapter 1-0200.3).

Cases listed in FECA PM Chapter 1-0200.3 are to be sent without processing (other than notices of transfer) to the National Operations Office or Special Claims Unit, and inquiries about these cases should be referred to the appropriate office.

3. Material Loaned from Other Agencies. This paragraph defines the responsibilities of Claims Examiners (CEs) with respect to material loaned by other Federal agencies or other sources to assist in adjudicating and managing claims. (PM Chapter 2-0402 explains the use of investigative reports.)

a. Inclusion in Case File. If the CE plans to base any decision or action on the loaned material, or if it will possibly aid in resolving an issue in the future, the CE must copy the material and place it in the file, then return the original as soon as possible.

b. Refusal of Permission by Agency. An agency which initially refuses permission to copy will often grant it if the CE explains the need for documentation in a letter. If the agency does not

allow its material to be copied, the CE may not use it, since the case file must contain full documentation for any decision.

4. Filing Material in Cases. This paragraph describes the mechanics of maintaining material in case files.

a. Contents of Files. Each case file contains a Form CA-800, Non-Fatal Case Summary, or Form CA-105, Fatal Case Summary, which provides a concise record of case actions; a number of documents filed on a spindle which support those actions; and loose documents on which action is pending.

b. Filing Order. In general, documents are added to the file chronologically as they arrive. Claim forms and notices of injury and death are filed as follows:

(1) In a disability case, Form CA-1 or CA-2 should be placed under the other documents in the case file. If a Form CA-7 is received, it is placed under Form CA-1 or CA-2.

(2) In a death case, Form CA-5b should be placed under the other documents. Form CA-5, the various certificates (birth, marriage, divorce and death), and Form CA-6 are then filed in order from bottom to top.

(3) If a disability case becomes a death case, all material related to the death claim should be filed on a separate spindle, beginning with Forms CA-5b and CA-5, the certificates, and Form CA-6. Forms CA-24 and other documents relating to benefit payment changes may be placed on a separate spindle. The Form CA-800 from the disability case may be added to the old spindle.

c. Filing Down. After reviewing or completing action on loose documents, the CE should initial and date the upper right corner, punch a hole in the center of the document, and place the material on the spindle.

(1) Forms returned by the recipient with information written on the reverse, such as CA-1027, should be placed face down so that the information is uppermost.

(2) Documents which arrive stapled together should be separated before they are placed on the spindle, so that they can be easily reviewed in the future.

(3) Legal-sized pages should be folded at the bottom to letter size.

d. Copies. Mail is filed by date of receipt from bottom to top. If a duplicate copy (for instance, of a medical report or claim form) is received, the CE may discard it. However, if the second copy is sent with a cover letter, the CE should retain it so that the file will show that the writer of the letter included the evidence as stated.

5. Maintaining Files. This paragraph discusses the need to protect files against loss and damage and to keep them in an orderly, readable condition for ease of review.

a. Damaged Documents. Torn documents should be repaired with transparent tape. If it is necessary to photocopy damaged documents to have legible copies in file, the originals should be retained. To prevent claims forms and notices of injury from being detached from the spindle, stiff paper backing may be placed at the bottom of the file.

b. Damaged Case Jackets. If a folder is damaged beyond repair with transparent tape, the entire case file should be sent to the Mail Room for repair or replacement.

c. Dividing Files. If the amount of material in a case starts to exceed the physical capacity of the file, the CE should send the file to the Mail Room with a short memo asking that the file be divided into "A" and "B" parts (see FECA PM 1-500.5).

6. Requesting Files. This paragraph describes how to obtain files not in the CE's location.

a. Within the Office. Individual files within the Office may be requested on Form CA-33, Case File Release or Call Request, according to the instructions on the form. Mail and File staff will search for the case on a priority or regular basis, depending on the reason for the request. (If no reason is given, a regular search will be made).

b. Outside the Office. To request a case file from another office, the CE must complete Section A, Items 1 through 9, of Form CA-58, Case File Transfer, and forward the original to the DD or designee. If the request is to be handled on a priority basis, the reason for doing so must be stated in Item 8. The Mail and File Unit will request the case.

c. Telephone Requests. Where a telephone request is necessary and a case file cannot be located, Mail and File staff will prepare a Form CA-33 on the basis of the telephone request.

d. Lost Files. If a case file cannot be located within a reasonable period of time, it may be necessary to reconstruct it. To do so, the CE must write to the claimant, the employing agency, and all known medical providers and ask them to submit copies of all material in their possession which relates to the claim.

7. Incoming and Outgoing Cases. This paragraph describes the actions which CEs should take on cases and mail newly delivered to their locations and on cases where their work is completed.

a. Incoming Cases. The CE should screen incoming cases to identify those requiring priority action and dispose of any which have either been misrouted or which are quickly and easily handled. Pending cases should also be screened on a daily basis to review newly drop-filed mail.

b. Outgoing Cases.

(1) Cases requiring further action in other parts of the office should be routed to their new location(s), with the CE's location shown last if the CE will need to review the case after the other actions are taken.

(2) Cases not requiring further action should be sent to the file room. All loose mail must be filed down, and any entries to the summary form must be completed.

(a) For open cases, a call-up must be keyed in the automated system.

(b) For closed cases, the proper closure code must be entered into the automated system (see FECA PM 2-0401 for a list of codes).

8. Doubling Case Files. This paragraph describes the process of doubling cases from the claims standpoint. The mechanics of doubling are addressed in FECA PM Chapter 1-500.4.

a. Definition. Doubling is the combination of two or more case files. It occurs when an employee has sustained more than one injury and it is necessary to combine all of the records in one case folder. The case records are kept separately but travel under one claim number, which is known as the "master file". The subsidiary and master files are cross-referenced in the FECS data base.

b. Responsibilities. The responsible CE reviews newly created cases for potential doubling and making doubling recommendations. The District Director or designee(s) approve case doublings and settle any disputes about whether cases should be doubled and which case file number should be the master file number. Unit claims managers may be designated reviewers. Mail Room staff combine the records, and ADP staff update the automated system to show master and subsidiary case file numbers.

c. When to Double Cases. Cases should be doubled when correct adjudication of the issues depends on frequent cross-reference between files. Cases meeting one of the following tests must be doubled:

(1) A new injury case is reported for an employee who previously filed an injury claim for a similar condition or the same part of the body. For instance, a claimant with an existing case for a back strain submits a new claim for a herniated lumbar disc.

(2) Two or more separate injuries (not recurrences) have occurred on the same date.

(3) Adjudication or other processing will require frequent reference to a case which does not involve a similar condition or the same part of the body. For instance, an employee with an existing claim for carpal tunnel syndrome files a new claim for a mental condition which has overlapping periods of disability.

Cases should be doubled as soon as the need to do so becomes apparent.

d. When to Avoid Doubling Cases. If only a few cross- references will be needed, the cases should not be doubled.

(1) Cases of this nature include those where:

(a) Problems arise in distinguishing the cases for bill pay and/or mail purposes, such as when the same physician is treating the claimant for more than one injury;

(b) Periods of disability overlap; and

(c) A single individual should handle the cases to ensure consistency and fairness.

(2) If cases are not doubled and cross-reference is needed, and no CASE632 report appears in the file, the CE should note related cases on Form CA-18. Medical and other evidence from other injuries may be copied, annotated to show the source, and added to the file. This process should mainly be used in cases closed for over two years that were accepted for minor conditions, and short-form closures over two years old.

e. Doubling New Cases. When a new case is created, the CASE632 report, "Claimant New and Prior Injuries Report", is produced. This report identifies cases which already exist for the employee in question. Mail Room staff will forward any new case for which a CASE632 is produced, even if it is closed short-form, to the responsible CE.

(1) The CE will examine the case (and the other cases listed on the report) and decide whether doubling is needed. If so, the CASE632 should be filed just above the CA-1 or CA-2.

(2) The CE should send a request for case doubling to the designated reviewer, along with the cases. This request, which may be made by informal(handwritten) memo, should show the case file numbers, the master case file number, the reason for doubling, the CE's initials, and the date.

(3) If the reviewer approves the doubling, he or she should send the cases to the Mail Room.

f. Doubling Established Cases. If the CE notes, while examining a case file, that other injuries may bear on the case at hand, he or she should request the other case file(s). If the cases meet one of the criteria noted in subparagraph a above, the CE should request that they be doubled as described in subparagraph e(2) above. The reviewer will send approved requests to the Mail Room.

g. File Number. The master case file number is usually the oldest (by file number) case in the office. The CE responsible for the master case file is also responsible for subsidiary files. To avoid changes in CE assignments when a new claim is filed, any related case(s) received at a later date will be doubled into the existing master case file.

h. Subsidiary Cases. These case are not necessarily inactive and may be in an open status. If a subsidiary case is open, it should also have appropriate call-ups in place.

i. Advising the Parties. When case files are doubled, the responsible CE should so advise the claimant, the employer, the treating physician, the authorized representative, and other interested parties in writing. The letters should state which file number to use for inquiries, medical bills, and compensation claims.

j. Payment of Bills. If the accepted conditions in doubled cases are the same, the employing agency is the same, and no third party is involved, bills should be paid using the master file number (if that case is open).

However, where accepted conditions among doubled cases are dissimilar, or employers have changed, or third party liability is involved, bill payments are to be made under the appropriate case file number.

9. Custody and Storage of Files. This paragraph discusses how CEs are to store cases assigned to them. FECA PM Chapter 1-0500 addresses custody and storage of case files in general.

a. Location. CEs should return files to designated shelves in the claims units at the end of each work day. Files are not to be stored in desk drawers, on the floor, or on tables or window sills, etc.

b. Removal of Files. No one may remove a case file from the premises of the office without the prior written approval of the District Director (DD), ADD, or their designee. The approval should take the form of a memorandum to the file, signed by one of these persons, which states the case file number, claimant's name, date of injury, name of the person taking the file, the destination, the date, and the reason for removing the file from the premises.

The memorandum should be prepared in triplicate, with the original to the case file jacket, a copy to the person removing the file, and a copy to the Mail and File Unit. The case jacket, along with the Form CA-800 or Form CA-105 and the memo, should remain in the office in a Contents-Out or similarly-designated file until the contents are returned. The location of the jacket should be noted in the automated system.

10. Case Transfers and Loans. This paragraph describes how case files are transferred and loaned and how mail is forwarded from one office to another.

a. Reasons for Transfer and Loan. Transfers occur most often because the claimant or beneficiary has moved to another jurisdiction. Loans occur most often between the office and the National Office (NO). The NO may request cases for review by the Director of OWCP, the Director for FEC, the Employees' Compensation Appeals Board (ECAB), the Solicitor's Office the Branch of Hearings and Review (H&R), or other OWCP staff.

b. Review by DD or Designee. Individuals with authority to transfer or loan cases should determine whether:

(1) The case has been adjudicated (unless the nature of the claim--e.g., Agent Orange exposure--brings it under the jurisdiction of another Office);

(2) All pending actions have been taken, all correspondence has been answered, and all mail is filed down on the spindle in order of receipt;

(3) The case file jacket is in good condition; and

(4) Regular payment information has been entered into the Automated Compensation Payment System (ACPS) if necessary so the override mode need not be used. If an override cannot be removed, a memorandum should appear in the file explaining the need for it.

If the claimant has moved, the ACPS and Case Management File (CMF) records should be changed. (However, if the claimant is receiving ACPS payments by EFT, the ACPS address should not be changed.)

c. Procedures for Transfer. When the Office receives a Form CA-58 requesting a case, Mail and File staff will locate the file, attach the Form CA-58 and send it to the DD or designee. If the case meets the criteria stated above:

(1) The DD or designee will authorize the transfer by completing items 10b and 10c of Form CA-58;

(2) The Systems Manager or designee will transmit the electronic records, including ACPS records, Bill Processing System records, and any health insurance enrollment or debt records [through the Debt Management System (DMS)].

(3) Mail and File staff will notify the claimant, the employing agency, and other interested parties of the transfer; change the location code to reflect the transfer; and send the file by certified mail to the requesting office.

d. Procedures for Loan. Cases docketed by the ECAB or requested by H&R are requested over the automated system, and the box labeled "ADP" in Item 9 of Form CA-58 should be checked. Other requests may be made verbally, by e-mail, or by Form CA-58.

(1) The reason for the loan and the name of the requestor should be stated in Items 8-9 on Form CA-58.

(2) Cases should be mailed to 200 Constitution Avenue N.W., Room N-4421, Washington, D.C. 20210. Use of this address will ensure that the cases are routed through the NO database.

(3) The electronic records should always be sent for cases requested by the ECAB or H&R. They will not include the health insurance enrollment and/or the DMS record, if any. These records will remain in the office.

e. Receipt of File. When the file arrives in the requesting location, Mail Room staff will log the case into the database and send it, with Form CA-58 attached, to the person who requested it.

(1) Transfer. If the file will remain permanently at the requesting office, the CE must ensure that case file information, such as mailing and check addresses, is correctly recorded in the ACPS and CMF before filing down Form CA-58.

(2) Loan. Cases on loan should be returned as soon as possible. If necessary, material from the borrowed file may be photocopied.

f. Transferring Mail. Mail always follows the case file, even when the file has been loaned temporarily to another office. All such mail will be collected in the Mail Room and sent to the various owning offices on a daily basis.

Chapter 2-0401, Automated System Support for Case Actions

1. Purpose and Scope. This chapter describes the Federal Employees' Case Management System insofar as it records and supports Claims Examiners' (CEs') actions and outlines their responsibilities for maintaining an accurate data base and managing a case load using the automated system. The Disability Tracking System is addressed in FECA PM 2-0601.

2. Responsibilities. The CE has primary responsibility for keeping the automated Case Management File (CMF) accurate, and may use the various capabilities of the system to monitor and assist case processing.

3. System Components. The case management system has multiple subsystems with which the CEs interact. Some of the subsystems are:

a. The Compensation Management System. The CE's responsibilities include providing accurate and detailed payment set-ups for entry into the system.

b. The Correspondence Management System. The CE uses this system to generate letters to claimants, employing agencies, and other interested parties.

c. The Case Management System, including the imaged case record. This program includes a query function, which allows CEs to obtain information about specific cases, and it includes other sub-systems which allow CEs to enter new data.

4. System Capabilities.

a. When an injury report or claim for occupational disease is received in a district office, a record is created in the Case Management System and an acknowledgement to the agency and the claimant is generated automatically. The system controls number assignments and edits entries for duplication of date and other identifiable errors.

b. CEs are required to record their adjudicatory actions in the Case Management System, which should contain current status of each case and the effective date of that status. Other data recorded in the Case Management System include third party status and rehabilitation indicators. Definitions of adjudication and pay status codes appear in paragraphs 6 and 7 below.

- c. Reminders may be set, allowing CEs to diary cases for further review and action.
- d. Responsible Claims Examiner (RCE) is shown in the Case Management System. This shows who is currently managing the case.
- e. Incoming and pending mail may be viewed in the imaged case file. Priority correspondence is tracked in the system and assigned automatically for some correspondence types or upon review as assigned by the CE.
- f. Reports can be produced by managers and CEs using the automated reporting system. These reports are used to query pending cases in need of action and for case management purposes.
- g. Addresses for frequent correspondents other than the claimant or beneficiary are maintained in the Case Management System. Entry of names and addresses of authorized attorneys and other legal representatives is required; entry of other names and addresses is optional. By entry of these addresses into the system, the CE is able to pull them into correspondence as needed.

5. Status Changes. The Case Management System contains a pair of two-character code fields for recording the status of the case file. Adjudication status codes are used to record acceptances and denials of benefits, and case or pay status codes are used to track the level of payments authorized on a case. CEs and claims supervisors have sole responsibility for ensuring that these codes are kept accurate and current. Since office performance is largely measured by the dates these codes are assigned and by the proportion of cases in various statuses to total cases in the office, the integrity of code use is extremely important.

6. Definitions of Adjudication Status Codes. With the exception of noncontroverted no-time-lost cases discussed in paragraph 8, the adjudication status code field may not be filled until the initial acceptance or denial of the case by the responsible CE. Assignment of any of the codes beginning with "D" should reflect a formal decision with appeal rights.

Eighteen (18) two-character adjudication status codes are available in the system. Brief definitions are given below.

Acceptances

AM: Condition accepted as compensable. If open, entitlement to medical benefits only.

AL: Condition accepted and some period of disability supported by medical evidence. Leave elected or used awaiting decision.

AC: Condition accepted as compensable; some period of entitlement to continue pay accepted.

AD: Condition accepted as compensable; some period of entitlement to compensation is or was accepted; not being placed on periodic roll.

AP: Condition accepted as compensable; is or was entitled to compensation on the periodic roll.

AF: Death accepted as work-related; some beneficiary is or was entitled to benefits.

AT: Condition accepted as work-related but claimant entitled only to medical benefits.

AO: Case previously approved; no benefits payable. May be used to identify a case with a third party credit being absorbed in conjunction with MC case status.

Denials-Any denial code prevents entry of payment data in the automated compensation payment system.

DO: Disallowed pending.

D1: Denied as not timely filed, without entitlement to medical benefits (use AT for pre-1974 cases where monetary benefits are denied and medical benefits are payable). Do not use in COP time denials.

D2: Denied; claimant not a civil employee.

D3: Denied; fact of injury not established.

D4: Denied; not in performance of duty.

D5: Denied; causal relationship not established or disability due to injury has ceased.

D7: Remanded by ECAB.

D8: Remanded by H&R.

D9: Request for reconsideration pending.

SU: Consideration for benefits suspended for failure to report for an Office-directed medical exam. This is also used when an initial claim is withdrawn. Use with code CL.

7. Definitions of Pay Status Codes. Every case file acquires a pay status code (or case status code) when it is created and retains such a status throughout its existence. Before the case is adjudicated, the pay status code reflects whether it has been reviewed, and afterwards it reflects whether and what benefits are being paid or are payable. There are nineteen (19) two-character pay status codes in the system. Only certain codes are compatible with payment through the Compensation Management System and allow for bill payment. Brief definitions are indicated below.

UN: Case created, not reviewed. This status is automatically generated at the time of case create, and should not be changed unless the case has been reviewed by a CE.

UD: Under development. Used whenever further development is needed before pay status or closure status can be assigned. Assigned without an adjudication code, after initial review if there is not enough evidence for acceptance or denial. Assigned with DO if a case in D_ status is remanded for development by the Employees' Compensation Appeals Board (ECAB) or Branch of Hearings and Review (H&R), or is under reconsideration.

MC: Entitled for the time being to medical treatment only. Only used in combination with "A_" adjudication code.

DR: Entitled to payment on daily roll; permits payment through the compensation management system. Used for finite period of wage loss or repurchase of leave; not used for schedule award paid in lump sum or for initial or final supplemental payment where the case is or will be on the periodic roll.

PR: Entitled to payment on periodic roll. Used with AP.

PN: Entitled to payment on periodic roll; formally determined to have no wage earning-capacity or re-employment potential for indefinite future. Used with AP.

PW: Entitled to payment on periodic roll at a reduced rate, reflecting a partial wage-earning capacity or actual earnings. Used with AP.

PS: Entitled to payment for schedule award, whether periodic or when a single schedule award payment is made on the daily roll because this single payment represents the initial and final payment of the entire award. This occurs when the date of maximum medical improvement is in the past and the percentage is small enough so the entire award is paid in the past and in full representing one single payment. Assigned with AP to effect payment through the compensation management system.

LS: Entitled to payment of a lump sum schedule award. Assigned only with code AP. Code should not be changed until the schedule award entitlement period has ended.

DE: Monthly payments are being made to at least one beneficiary of a deceased Federal employee. Used with AF. Also required to pay burial, transportation and administrative costs.

ON: Overpayment exists; final decision made on issues of fault and waiver. Claimant not on periodic roll.

OP: Overpayment exists; final decision made on issues of fault and waiver. Claimant on periodic roll.

C1: Closed, accepted, no further payments anticipated; no time lost from work. Assigned only with AM.

C2: Closed, accepted, no further payments anticipated, time lost covered by leave, leave not repurchased. Used with AL adjudication code.

C3: Closed, benefits denied. Assigned with "D_" adjudication code.

C4: Closed, entitlement to continued pay accepted, pay was continued for time lost from work; no further payments anticipated. Assigned with AC.

C5: Closed, previously accepted for benefits, all benefits paid.

CL: Administrative closure.

RT: Retired or awaiting retirement.

8. Assignment of Status Codes. Rules for assigning status codes to cases as they pass through the system will be given at appropriate points in the case development and case management chapters of the Procedure Manual. So that this information is available in summary form, and its relationship to information tracked by reports is clear, a brief account of proper code assignment in developing and adjudicating cases is given here.

a. Primary Adjudication.

(1) Creation. Each case received is placed in status UN at time of case create. No adjudication code is used with UN, and bills cannot be processed while case is in this status. Cases move from UN to UD when reviewed by a CE who makes that disposition.

(2) Development/Review. If the CE is unable to accept a condition without more information, appropriate development letters are prepared and the case should be placed in status UD.

For a primary case under development, no adjudication status code is assigned. Status UD permits payment of bills, but without an adjudication code only bills properly authorized by Form CA-16 or OWCP referral should be paid.

(3) Acceptance. If the CE is able to accept a condition, either on first review or after development, the condition, as well as an appropriate adjudication status and pay status, are entered in the case management system. The adjudication code will depend on whether the CE accepts any period of disability as supported by medical evidence. All approval (A_) codes must reflect true adjudication, which includes acceptance of the five basic requirements and approval of a condition, and the status code date should be the date on which the case was approved.

While the case remains open and no period of compensation is approved, the appropriate pay status code is MC. The case should remain open as long as bills are anticipated and/or there is no reported return to work. Thus, the CE would make the following disposition of an accepted case for which no claim for wage-loss beyond COP has been filed:

AM/MC: Condition accepted as injury-related. No period of disability accepted as injury-related. Further bills expected and probably payable. (This would be the status for an accepted no-time-lost case.)

AL/MC: Condition accepted as injury-related. Leave was elected on Form CA-1, or it is being used to cover disability due to occupational disease. Some period of disability is supported by medical evidence. Case is being held open for medical bill payment.

AC/MC: Condition accepted as injury-related. Leave was elected on Form CA-1, or it is being used to cover disability due to occupational disease. Some period of disability is supported by medical evidence. Case is being held open for medical bill payment.

If COP was elected but must be denied, and the case as a whole is accepted, the appropriate status is AM/MC. This can change to AD/_ if a claim for leave repurchase or wage loss is accepted. If leave is elected, but no period of disability is supported by medical evidence, the appropriate codes are AM/MC.

(4) Closure (in minor cases). With the exception of administrative authorization of limited benefit cases, all cases must be adjudicated, with acceptance of a condition or formal denial, as well as appropriate status codes entered into the case management system.

The appropriate closure codes for adjudicated cases involving no-time-lost, leave, or short term disability situations are:

AM/C1: Condition accepted. Up to \$1500 in medical payments can be made without adjudication by the CE. No time lost.

AL/C2: Condition accepted. Some disability supported and covered by leave. No further claim or bills expected.

Non-controverted no-time-lost cases will be closed without adjudication by the CE as soon as they are created, and will not subsequently require the CE's attention unless any of the following apply:

- (a) The total amount of medical bills exceeds \$1500;
- (b) Evidence is received to show that the injured employee was disabled for work after the date of injury;
- (c) Evidence is received to show that a schedule award may be payable for permanent impairment.

Prior to releasing cases to the claims units, the FECA Office will identify the non-controverted, no-time-lost traumatic injury cases.

COP cases should not be closed until a date of return to work is in file, on Form CA-1, Form CA-3, or other documentation in the file. The appropriate closure code, if no further disability is claimed, is AC/C4.

If COP is elected but disputed in an accepted case, the code should be AM/MC until closure. The issuance of Form CA-1050 should not lead the CE to assign a "D" code. If the case as a whole is denied, Form CA-1050 is not used and a formal notice of decision with appeal rights is issued, with explicit reference to any COP claimed or paid.

b. Compensation Payment.

(1) Daily Roll. The codes for daily roll payments are AD/DR (accepted for daily roll compensation; compensation payable). If continuing CA-7 Forms are expected, the case should remain in that status and should not be placed in a closed or medical pay status, since these will not permit payment through the compensation management system.

Lump sum schedule awards must be in AP/LS status. Therefore, even if a one-time payment of a schedule award is being made, the CE should not use AD/DR. The appropriate status after the payment is made would be AP/C5 or, if medical care continues, AM/MC.

When the claimant returns to work (or ceases to claim compensation) and medical bills are still coming in, the codes should be AM/MC. If the claimant is discharged from treatment, the case is closed AM/C5.

Cases in AL/_ status in which a claim for leave repurchase is filed should remain AL until a leave-buy-back payment is set up, at which time the case status changes to AD/DR.

(2) Periodic Roll. A case in which extended disability is anticipated is paid on the periodic roll and should be in status AP/PR. These codes also apply if the periodic roll payments have ended, and a last payment, not equal to a full four weeks, is paid to fulfill claimant's entitlement.

The case should remain AP/PR while being developed for re-employment potential by the CE, or to determine whether disability continues to be due to the employment. When a determination on future entitlement is reached, the status will change from AP/PR as follows:

AP/PW: Claimant has returned to work with some loss of actual earnings, or claimant's benefits were reduced to reflect a partial earning capacity. Claimant in this status should not be receiving compensation for temporary total disability or a schedule award.

AP/PN: After full development, it has been determined that the claimant has no earning capacity, and a memorandum to that effect has been certified by the Supervisory Claims Examiner (SCE) and placed in the file. These cases must still be reviewed annually to determine whether the status is justified.

(3) Schedule Awards. If a schedule award is being paid, the case should have status AP/PS whether it is being paid on the periodic or the daily roll. If a lump sum schedule award is being paid, the case should have status AP/LS. After expiration of lump sum payment of a schedule award, the case is changed to AP/MC by the system. Further determination by the CE is required to decide whether the status should be changed to AP/C5 or, if medical care continues, AM/MC.

A case should remain in AP/PR status while the CE is determining its ultimate disposition. Cases in PR status for one year or more should be reviewed to determine whether there is a basis for rehabilitation, re-employment, or wage earning capacity determination.

(4) Closure Without Denial. When a claimant who has been receiving compensation on the daily roll returns to work and is discharged from medical care, the case is closed AD/C5. A periodic roll case, when entitlement to medical and compensation ends, becomes AP/C5. However, if expenses for medical treatment are expected to continue after wage loss compensation ends (the claimant is working or elected an OPM annuity), the case may be held in AM/MC status and eventually closed AM/C5.

A0/C5 should not be used routinely on closed cases.

c. Denials.

(1) Use of Denial Codes. A denial adjudication code should reflect a formal decision with full appeal rights, and the adjudication status date should be the date of release of the formal decision by the authorized person. Denied cases are always closed, except on remand from H&R or the ECAB. The codes are shown in paragraph 6 above.

(2) Denial of Monetary Benefits with Continuing Medical Care. If monetary benefits are denied by formal decision, but entitlement to medical benefits continues, the case may be assigned code AT/MC. Examples of AT/MC are:

(a) Claimant has x-ray evidence of asbestos-related disease, but no disability for work and is entitled to yearly medical examinations.

(b) Claimant returned to work without loss of earnings, but will continue to require periodic payment of medical expenses, as for prosthesis repair.

The use of these codes will enable offices to distinguish cases which are inactive but must be kept open and in inventory (AT/MC) from those which are temporarily active but may eventually be closed and removed from inventory via retirement (AM/MC).

(3) Closures. The appropriate closure code when a case is denied for one of the five basic requirements is C3. C5 may be used with D5 when entitlement ceases after initial acceptance.

d. Reconsideration, Hearings, Appeal. Code D7 or D8 is used when a remanded case is not in a payment status and a de novo decision has not been issued. The pay status is UD. D9 is used while an application for reconsideration on a denied case is being processed. Cases in pay status (LWEC, SA) which are remanded or under reconsideration will retain the adjudication and pay status appropriate to their benefit status (e.g. AP/PW).

e. Reopening Closed Cases.

(1) Closed cases should not be reopened merely to pay medical bills.

(2) Denied cases on which a medical bill is payable must be given a payable status temporarily in some instances. Code AM/MC may be used. Efforts should be made to ensure that cases are promptly restored to closed status after the bill has been paid.

(3) Where Form CA-2a or other claim for recurrence is received, case should be reopened using the last adjudication (A_) code and UD.

(4) Remands and reconsideration on denied cases should be assigned the adjudication code D7, D8, or D9, as appropriate, and pay status UD.

(5) Noncontroverted no-time-lost cases which later require adjudication by the CE which cannot be accepted immediately must be reopened. This may be done manually or by the system, and the case status will be UN.

f. Death. Cases on which death benefits are to be paid must be placed in status AF/DE, which allows payment of burial, administrative costs and survivor benefits. AF/UD may be used for a case in which employment-related death is accepted but documents such as birth certificates, marriage certificates, or election forms have not been received. When there is no further entitled beneficiary because of remarriage, completion of college, etc., the case should be closed AF/C5.

9. Inquiries. In addition to its essential use in enabling CEs to take timely and proper action on files, and to enable supervisors to monitor case actions, the case management system provides basic information to contact representatives and others for use in responding to inquiries. It is to the advantage of the CE to maintain correct coding information in the system so that a representative can answer telephone inquiries without having to contact the CE for information.

10. ICD Codes. When conditions are accepted as work-related, the CE should enter the corresponding International Classification of Diseases (ICD) code(s) into the case management system.

a. ICD History. ICD-10 codes should be inputted for all conditions accepted on or after October 1, 2015. ICD-9 codes were utilized for all conditions accepted through and including September 30, 2015.

b. ICD Structure and Code Composition. ICD-10 codes consist of three to seven characters. The first digit is a letter and all letters are used except for U. The second and third digits are numeric and the fourth through seventh digits can be alphabetical or numeric. The decimal is placed after first three characters. All injury types are categorized by body part, whether the injury is a contusion, sprain or fracture. The first three digits of the ICD code identify the category. The second three digits identify the etiology, anatomic site and severity. The last digit is an extension that identifies the episode of care.

c. Severity of Condition. The ICD code should accurately reflect the severity of the condition accepted. Coding should be as specific as possible, coded with as many digits as appropriate. The

CE should also routinely review the record for updated diagnoses, i.e., contusion to sprain, lumbar sprain to herniated disc.

d. Surgery. When a surgical procedure has been accepted as work-related, the CE should ensure that the accepted condition and ICD code have been appropriately updated if applicable to ensure that bills will be paid appropriately.

e. Psychiatric Conditions. When a claimant who has a physical work-related condition requires treatment for a psychiatric condition established as causally related to the work injury (e.g., depressive reaction), the CE should add the psychiatric diagnosis to the case management system. Failure to do so may result in denial of bills for psychiatric care.

f. Laterality and Episode of Care. The CE should pay extra attention to the right, left or bilateral body parts deemed to be work related, and to the episode of care. Laterality is built directly into the ICD-10 coding system.

Where applicable, the seventh digit refers to the encounter, or episode of care, and generally identifies whether the care provided is (1) initial, (2) subsequent or (3) sequelae.

g. Examples: Impact of Transition from ICD-9 to ICD-10.

(1) Claimant diagnosed with medical meniscus tear of the right knee; symptomatic with pain and instability. Functional instability due to anterior cruciate ligament insufficiency. Effusion palpable. Will be treated conservatively at present. Initial encounter.

ICD-9 Diagnosis Codes: 836.0, Tear of Medical Cartilage or Meniscus of Knee, Current; 719.06 Effusion, knee

ICD-10 Diagnosis Codes: S83.206A, Unspecified tear of unspecified meniscus, current injury, right knee, initial encounter; M25.461, Effusion, knee, right

(2) Claimant with 4-view x-ray series of the right shoulder showing calcific deposit. No fracture or dislocation. There is acromioclavicular joint post-traumatic osteoarthritis, post glenoid bone fragment. Documented tendinitis due to calcification.

ICD-9 Diagnosis Codes: 715.31, Osteoarthritis, localized, but unspecified as to primary or secondary, shoulder region; 726.11, Calcifying tendinitis of shoulder; 719.81, Calcification, joint, shoulder.

ICD-10 Diagnosis Codes: M19.111, Post-Traumatic Osteoarthritis, right shoulder; M75.31, Calcific Tendinitis of Right Shoulder

Chapter 2-0402, Security and Prevention of Fraud and Abuse

1. Purpose and Scope. This chapter describes Claims Examiners' (CEs') responsibilities in maintaining the security of payments of compensation. It establishes guidelines and procedures for referring cases to the Office of the Inspector General (OIG) or to investigators of the Wage and Hour Division or the Office of Federal Contract Compliance Programs (OFCCP).

2. Monitoring Files and Documents. It is the CE's responsibility to monitor cases for indications of fraud or abuse. This responsibility includes reviewing forms and documents, checking facts for plausibility and consistency, reviewing payment activity, acting on complaints and witness reports, and generally attending to the accuracy and reliability of documentation in the file.

a. Signatures. The CE must review claim forms and certified documents to ensure that original signatures are present. Original signatures of those persons who certify the accuracy of the information enable the Office to hold them accountable for any misinformation furnished. When claims forms, claimant statements, form medical reports such as CA-20, and witness statements are received without original signatures, they should be copied and returned for proper signature. It is not usually necessary to copy both the face and reverse of a form. The original form should not be returned. Signatures should be reviewed to ensure that they have not been altered. If the signature has been amended or if it appears to be different from other specimens in file, the CE should determine whether the signature is genuine by contacting the person who ostensibly signed the form. If the signature is invalid, the matter should be brought to the attention of the OIG.

b. Alteration of Documents. Alteration of forms is most likely on Forms CA-7 and CA-8 and on medical forms such as CA-20, reporting dates of disability, leave or pay information, etc. It may only be necessary to check with the person who prepared the form to ascertain whether the alteration was made by a third party. If it appears that information submitted by the agency or physician has been altered by a claimant in an attempt to significantly misrepresent the facts, the case should be submitted to the OIG (see paragraph 4).

c. Inconsistent Information. The CE should review Form CA-1032 and other forms to ensure that birth dates of children and earnings information are consistent from one report to the next. If discrepancies are found which do not appear to be accidental, the CE should develop the record to determine the facts. If a discrepancy can be satisfactorily resolved by letter or telephone call, and overpayment has not resulted, the CE should document the file with the correct information, but not alter the erroneous form or document. If preliminary exploration indicates a pattern of deception, and the exact facts cannot be established with certainty, an investigation may be required. For example, if there are inconsistent reports of earnings and employment over a long

period during which compensation has been paid for total disability, investigative help should be requested to establish the earnings record for that period.

d. Other Factors. The CE should be alert to any information which indicates that an improper claim was filed or that a questionable activity, either within or outside the office, has occurred. The best protections against fraud and abuse are careful and attentive case monitoring and intelligent reading of documents. Maintaining current call-ups on all open cases, corresponding with the attending physician, checking the official superior's allegations concerning the claim, and reviewing compensation and medical history against approved payments will prevent fraud in the compensation system.

3. Payments.

a. Unexplained discrepancies between the Office's payments and the actual medical services received should be explored when reported by the claimant. Discrepancies in dates may be due to the claimant's lapse of memory, and unidentified providers may be Office consultants who reviewed the file. If a significant discrepancy is reported, the case file and billing history should be reviewed, and remaining problems referred to the OIG for investigation as explained in paragraph 5.

b. CEs should obtain ACPS and BPS reports periodically to determine if improper payments are being made on cases under their jurisdiction. In addition, payment histories on missing cases should also be reviewed. Any evidence of medical or compensation payments made on a case which are not clearly supported by the evidence of record or otherwise explained should be brought to the attention of the District Director (DD).

4. Information from Outside Sources. Witnesses, whistleblowers, and other complainants occasionally call or send statements reporting that a claimant has undeclared earnings, engages in vigorous yard work while collecting total disability compensation, etc. The CE should document the file with a complete description of any incoming call and compare the information against other evidence in file to determine whether the allegation requires investigation. The lay person, unfamiliar with compensation, may place undue significance on observations of work and activity. If legitimate questions arise from the complaint, the CE should resolve them in one of the ways described above, by development of the record or by referral for investigation. The CE should not continue to correspond or discuss the case with a spouse, neighbor or other external party. If an affidavit or statement is required from such a party, it should be obtained by an investigator.

5. Unreported Earnings. A doctor's report or a letter may contain indications that a claimant has earnings which are not being reported. If an interim medical report mentions the claimant's job, Form CA-1032 may be sent to obtain confirmation of the employment, or a narrative letter may be drafted asking for specific information. If the claimant's response is inconsistent with the record, an investigation may be requested. Further evidence of unreported employment should be referred to the OIG.

Claimants are required to report all employment, whether salaried or not, and self-employment. They are not required to report investment income or ownership of a business in which they take no active part. If the claimant's role in a business or employment activity is ambiguous, the claimant should be asked for precise information about the activities performed, the hours of activity each day or week, and any other information which would enable the CE to determine whether the claimant has demonstrated an earning capacity. If the claimant's responses continue to be unclear, the CE may request an investigation to determine the extent of the claimant's activities, and whether these activities generate any income.

6. Action Where Fraud is Not Involved. Investigation by a Compliance Officer of the Wage and Hour Division, an OWCP investigator, or by claims personnel may be requested as a routine matter in situations which present no clear indication of fraud. For example, such an investigator may check on the activities of a person receiving periodic roll benefits to obtain specific evidence of the kinds of physical movement (lifting, climbing) the claimant is able to engage in, or visit a workplace to determine the factors of employment to which the claimant is exposed.

a. Recommending Cases for Investigation.

(1) If a thorough investigation is needed, the CE should prepare an information worksheet (Exhibit 1) and a typewritten memorandum to the ADD, which includes:

- (a) The particular issues about which additional evidence is required; it is the CE's responsibility to give a clear and concise description of the specific problem so that the need for the investigation will be apparent.
- (b) A resume of the relevant evidence appearing in the record.
- (c) A brief explanation of the reason this evidence is not sufficient to permit a proper determination.
- (d) A brief outline for the kind of evidence which the investigator should seek, including the names of any persons the CE believes should be contacted.

Other material pertinent to the investigation, such as a blank OWCP-20 to collect financial information in an overpayment case, may be attached to the worksheet.

(2) When only a few items are needed to adjudicate a case (i.e., a witness statement or an existing specific medical report which correspondence has filed to produce), the CE may request a limited investigation to secure the evidence. The request should contain the full names and addresses of the custodians of the needed evidence.

Under no circumstances should the CE attempt to instruct the investigator concerning the conduct of the inquiry.

b. Decision to Investigate and Assignment of Claim. After compiling the material listed above, the CE will send it to the ADD through the Supervisory Claims Examiner. If the ADD agrees with the CE's recommendation, he/she will forward it to the District Director (DD), who will decide whether the case should be investigated. If so, the DD will forward it to the appropriate office for assignment. In accordance with 5 U.S.C. 554(d), an individual who will be involved in the final adjudication of a case may not participate in such an investigation.

c. After Assignment for Investigation.

(1) Until the investigation has been completed, it is the responsibility of the CE to inform the investigator of any additional information received or other developments in the case which may be useful in conducting the inquiry. Such new material should be referred to the ADD, who will forward it to the investigator.

(2) The CE may properly continue the development of a case by correspondence while it is under investigation where delay is anticipated in the completion of the investigation. In other cases, development may continue if the CE and the ADD believe that it would be useful.

d. Receipt of Report. When the investigation report is received, the CE will review the report together with the case file and take whatever action is supported by the findings. Any substantial indication of fraud should be referred to the OIG.

If reports show that the claimant's physical activity is inconsistent with medical reports, the claimant should be referred to the attending physician with a statement of facts reflecting the observed activity, and the physician should be asked for a reevaluation of the claimant's fitness for work. Further medical development, including a second opinion, may then be undertaken. The claimant's benefits may not be adjusted unless and until the CE can establish a wage-earning capacity based on actual earnings or suitable and available work.

7. Action Where Fraud is Involved. All OWCP personnel are responsible for reporting actual or suspected abuse or fraud in FECA claims through appropriate channels to the OIG. Form DL-1-156, Incident Report (Exhibit 2 (Page 1 ([Link to Image](#)), Page 2 ([Link to Image](#)))), is used for this purpose. To maintain control over cases reported to the OIG, all Forms DL-1-156 are to be submitted to the OIG under cover of Form CA-503, Referral of Cases Under the Federal Employees' Compensation Act to the Office of the Inspector General (Exhibit 3 ([Link to Image](#)))). This informs the Inspector General of the case status, and whether delays in OIG activity will delay adjudication of the case or payment to the claimant. Known or suspected instances of fraud, abuse, waste or mismanagement, or criminal conduct by or involving OWCP personnel or contractors are covered by Chapter 7 of DLMS (Department of Labor Manual Series) 8. Specifics of the suspected fraud are reported on Form DL-1-156 and processed as described in that section.

8. Action Upon Identifying Possible Fraud.

a. Initial Action. An OWCP employee who becomes aware of an actual or suspected instance of fraud or abuse in a FECA claim.

(1) Immediately prepare a memorandum to the ADD, describing in detail the known or suspected violation and recommending referral to the OIG. The information or documents that led to the discovery or suspicion must be referenced in the memorandum. To recommend referral to the OIG, the information or evidence need not establish actual fraud or abuse, but only raise a reasonable suspicion thereof.

(2) If the suspected fraud involves a report that the claimant is working while receiving compensation, the CE will, at the same time, release Form CA-1032 or equivalent narrative letter to the claimant. No mention will be made of the evidence received about work activities. This is necessary to avoid conflict with any action that may be taken by OIG.

b. Actions by DD. Upon receipt, the DD will review the information or evidence (including the case file) and will arrange for the preparation of Forms DL-1-156 and CA-503 (in triplicate) for the signature of the Branch Chief of Program Integrity, Fraud Prevention and Prescription Management or designee. The DD, will make any pertinent comments on the Form DL-1-156 (Block 14) and will forward the forms and the case file to the Branch Chief of Program Integrity, Fraud Prevention and Prescription Management as quickly as possible. Whether the DD agrees or disagrees with the recommendation for referral to the OIG, the forms and the case file must be forwarded to the Branch Chief of Program Integrity, Fraud Prevention and Prescription Management. In National Office (NO) cases, NO staff will prepare the forms in duplicate for the signature of the Director for FEC, and forward the forms directly to them.

c. Review by the Branch Chief of Program Integrity, Fraud Prevention and Prescription Management. The Branch Chief of Program Integrity, Fraud Prevention and Prescription Management or designee will review the forms and their attachments upon receipt. Any pertinent comments will be made in Block 14 of form DL-1-156. After dating and signing the form, the Branch Chief will ensure that the originals, with attachments, are forwarded to the appropriate regional office of the OIG. A copy of each of the completed forms will be transmitted to the appropriate OIG contact. One copy of each of the forms will be maintained in a locked file in the office of the Branch Chief of Program Integrity, Fraud Prevention and Prescription Management.

d. Placement of Documents. Prior to receipt of a report from the OIG, information, documentation, and evidence concerning the known or suspected instance of fraud or abuse will be placed in the case file and will not be removed unless the OIG specifically requests its temporary removal from the file. The release of OIG reports is covered in OWCP PM 1-400.

e. Reports of Fraud. Whenever an OWCP employee is contacted by someone outside of DOL whether a private citizen or government official, with allegations or information regarding suspected fraud in an FECA claim, the individual will be referred immediately to the ADD or the DD, who will report such contact to the OIG by arranging for the completion and submission of

Form DL-1-156 through the Branch Chief of Program Integrity, Fraud Prevention and Prescription Management.

f. Use and Preparation of Form D-1-156, Incident Report. Form DL-1-156 is to be used for reporting actual or suspected incidents of program abuse, fraud, or other criminal violations involving DOL programs or operations. For reporting actual or suspected fraud or abuse in the FECA program, the form will be completed as follows:

Block 1. Enter the date the form is actually signed by the DD.

Block 2. Enter the FECA case file number.

Block 3. For use by the OIG only.

Block 4. Check as appropriate. "Supplemental" will be used when submitting additional information not available at the time the initial report form was sent to the OIG. Generally, "Final" will not be used.

Block 5. Check as appropriate.

Block 6. Check as appropriate. Usually "Program Participant or Claimant" will be used.

Block 7. Enter office address.

Block 8. Enter the date and time of the incident or discovery. If this is not feasible, enter the date of the document or evidence which led to the allegation or suspicion of the violation.

Block 9. Check as appropriate.

Block 10. Identify the law enforcement agency (such as FBI, U.S. Postal Inspector, Naval Intelligence, etc.) and furnish the agent's full name and address. Results of the contact, including information requested or provided, should be shown in Block 14.

Block 11. Check as appropriate. If necessary, a brief explanation may be included in Block 14.

Block 12. Check "OWCP" and enter the value of funds involved, if available.

Block 13. Furnish the requested information, if available, on the person(s) involved, such as the claimant, physician, etc.

Block 14. Provide a clear and concise statement of the incident. The statement should include the persons and periods of time involved and describe, if possible, how the incident was committed and/or discovered.

Block 15. The responsible official for the purposes of this procedure is the Branch Chief of Program Integrity, Fraud Prevention and Prescription Management or designee.

Block 16. Self-explanatory.

Block 17. Self-explanatory.

Block 18. Copies of all documents (such as forms, letters, reports, etc.) pertinent to the incident, or necessary to clarify the facts, will be forwarded with the original Form DL-1-156 to the regional office of the OIG having jurisdiction, as well as with the copies of the form sent to the OIG, Washington, D.C., and the Director for FEC. The original forms, letters, reports, etc., will be placed in the case file.

g. Pending OIG Actions. The Branch Chief of Program Integrity, Fraud Prevention and Prescription Management shall designate a member of his or her staff to review the file of submissions to the OIG on a periodic basis. In any case where payment or other adjudicative action is being held in abeyance pending OIG disposition, a status inquiry should be sent to the regional office of the OIG to which the material was sent each 30 days. The status of other cases should be checked each 90 days. In the NO these duties will be performed by the designee of the Director for FEC.

Any case where action has been delayed for more than 60 days pending OIG disposition should be reported to the Director for FEC by memorandum, enclosing copies of the Forms CA-503 and DL-1-156. In those cases where action by the OWCP has not been held in abeyance awaiting OIG disposition, a report, enclosing the Forms CA-503, and DL-1-56, should be made to the Director for FEC if no disposition has been made by the end of six months following the submission of the documents. When information is received that the OIG has disposed of a case, the Director for FEC should be advised immediately if a report concerning a delay had previously been made. The FECA program Deputy Director for Program Integrity will advise the Branch Chief of Program Integrity, Fraud Prevention and Prescription Management whether continued monitoring by the office will be necessary in those cases where reports have been submitted to them.

h. Tracking. Any request for information, especially an investigative memorandum, in connection with an investigation of an FECA claimant should be tracked on a local PC system. Initial and follow-up actions should be monitored until a resolution is reached, and the Branch Chief of Program Integrity, Fraud Prevention and Prescription Management or designee should sign any correspondence. The Office should retain tracking reports on the PC or in hard copy form.

9. Physical Security. The physical security of claim files and access to automated payment systems is the responsibility of the DD. Office rules established to protect against loss must be followed carefully by all personnel. The CE should always be aware of the responsibility to safeguard data in the FECS system, case files, and other sensitive materials.

Exhibit 1: Worksheet For Investigation Of FEC Claimant

Name of Claimant or Beneficiary: _____
OWCP Case File No. _____ SSN _____

Address: _____

Telephone Number: _____

Date of Injury: _____

Condition(s) for Which Benefits are Claimed/Paid: _____

Claimant's Occupation: _____

Employment Address: _____

Has case been accepted? Yes ___ No ___ If so, is compensation being paid? Yes ___ No ___ If so, at what rate? \$ _____ each four weeks

Purpose of Investigation:

- ___ Determine facts surrounding injury or exposure
- ___ Periodic roll employment check
- ___ Periodic roll activity surveillance
- ___ Overpayment financial questionnaire
- ___ Other (explain below)

Reasons investigation is requested: _____

Specific actions requested (interview, observation, etc.) _____

Claims Examiner: _____ Date: _____

Telephone Number: _____

Chapter 2-0500, Conferences

1. Purpose and Scope. The purpose of this chapter is to provide specific instructions for holding conferences with claimants, employing agency personnel, or other parties to resolve complex issues and facilitate the claimant's early return to work (RTW).

The issues commonly addressed through conferencing include employing agency controversies and challenges, disputed facts or occurrences, and overpayments. In such situations, the conference is employed as a means of fact-finding, following which a decision is made.

A Disability Management (DM) conference is different from these kinds of conferences in that its goal is usually to facilitate the claimant's return to the work force, and, as such, is a form of principled consensus-building. If the objective of the RTW conference is reached, all parties will experience a positive result.

Although conferences will sometimes be held in person with several parties in attendance, most conferences will be held by telephone and will include the claimant and the employing agency. It is important to note that there are no set rules on who should be part of the conference or how many people should participate. Those who can help resolve the issue(s) at hand should be involved.

2. Responsibilities. Quality Assurance and Mentoring Examiners (QAME) and journey level Claims Examiners (CE) are responsible for conferencing cases. Non-journey level CEs may also participate in some types of conferences.

The Supervisory Claims Examiner (SCE) may refer a case to a QAM/GS-12 CE if he or she determines that such a case would benefit from a conference; however, in most instances, the GS-12 CE is responsible for identifying cases for conferencing.

3. Types of Conferences. All conferences are to be non-adversarial in nature. There are two specific types of conferences - formal conferences and informal conferences. This chapter focuses primarily on formal conferences. Informal conferences as part of the Disability Management process are discussed in greater detail in PM Chapter 2-0600-12.

a. Formal Conferences. A formal conference may be conducted in the following types of situations.

(1) When entitlement (due process) is involved, e.g., during the adjudication of a claim or reaching a final determination in an overpayment case.

(2) When an issue is in dispute or where detailed technical evidence is required to decide an issue in a case.

In most other instances, an informal conference may be sufficient.

b. Informal Conferences. Ongoing and steady communication between all parties involved in the DM process is vital to a successful resolution, and informal conferences are a particularly effective means of addressing issues that arise that may impede the return-to-work process. Conferences are also helpful when miscommunication between one or more parties has occurred.

Participants involved in an informal conference will vary greatly depending on the issue. During nurse intervention, the Field Nurse (FN) will often be involved as well as the employing agency and the claimant. During vocational rehabilitation, often times the Rehabilitation Specialist (RS) and the Rehabilitation Counselor (RC) will participate along with the claimant and CE.

(1) An informal conference during DM should have the goal of addressing the concerns of all involved parties and arriving at a solution that addresses participant concerns whenever feasible within the confines and parameters of the FECA program.

(2) Some reasons for conferencing during the DM process include: disputed medical evidence being used for a return-to-work effort; questions regarding the duties in a job offer; personnel issues pertaining to a job offer; and expectations during the various phases of vocational rehabilitation, including placement.

(3) A detailed Form CA-110 (record of call) or a memorandum to the file which documents the conference discussion should be placed in the case file.

(4) A formal follow-up or comment period is not required after an informal conference. In most instances, the issue at hand will likely be resolved by taking some other type of action, such as referring the case for a second opinion, requesting a new job offer, or sending a narrative letter which will reference the conference discussion.

4. Cases Suitable for Formal Conferences. Formal conferences should be considered in the following situations:

a. The employing agency has controverted Continuation of Pay (COP) or has challenged the claim. This may be due to Fact of Injury, Performance of Duty (e.g., recreational injuries, assault cases), or for some other reason.

b. An overpayment has been identified and an issue remains unresolved.

(1) The financial data in the file is not adequate for a decision on waiver or repayment, or

(2) The issue of fault is in question, or

(3) No possible offset for recovery exists and compromise is possible.

c. Vehicle or housing purchase and/or modification. If the nature and complexity of the issue in these circumstances is relatively minor, an informal conference may be acceptable.

d. The evidence of record indicates that the claimant is not able to express himself/herself well in writing.

5. Preparation. Before addressing the issues of the conference, the QAM/GS-12 CE should advise the participant of the nature, seriousness, and possible results of the conference. The QAM/GS-12 CE should also ensure that it is convenient for the participant to proceed with the conference and that the participant has any necessary records at hand. If either of these conditions is not met, the QAM/GS-12 CE and the participant should schedule the conference at a mutually agreeable time in the near future.

Especially for conferences involving more than one party, a pre-conference call may be needed to schedule the call, provide the phone number, and explain the use of the conference line. If a pre-conference call is held, a CA-110 should be prepared for the file to document the call.

Upon calling the conference party, the QAM/GS-12 CE should:

- a. Give the participant a clear picture of the purpose of the conference call.
- b. Explain the issues to be discussed.
- c. Describe any evidence the participant needs to have for the conference call.

A pre-conference call is not a requirement. If the conference party is willing to proceed at the time of the initial call, the QAM/GS-12 CE can proceed with the conference.

6. Elements of a Conference. All conferences, regardless of whether there is a pre-conference call, should include the following:

- a. Identification of caller.
- b. Statement of the purpose of the call.
- c. Statement that notes will be taken and, for this reason, periodic pauses will occur.
- d. If the claimant is the only participant, advise him or her that information gained during the call will be shared with the employing agency.
- e. An acknowledgement from the participant(s) that he or she understands the nature of the issues and the purpose of the conference.

7. Quality Assurance and Mentoring Examiner/GS-12 CE Actions. During the discussion, the QAM/GS-12 CE should:

- a. Address the issues in ascending order of difficulty and listen carefully to what is being said.
- b. Take notes complete enough to capture necessary information.
- c. Probe responses which are too general or not credible, or which conflict with other statements given or other evidence in the file.
- d. Confirm the accuracy of the statements recorded by reading them back to the participant(s) for confirmation.

8. Memorandum of Conference. After a formal conference is completed, the QAM/GS-12 CE should complete a neutral Memorandum of Conference (that is, one which does

not contain findings). It should describe what each party said in the conference in clear, non-technical language. The Memorandum of Conference should:

- a. Include the name of the claimant, file number, and date of the conference.
- b. Identify the QAM/GS-12 CE who conducted the conference and the participants in the conference.
- c. Provide a background.
- d. Identify and describe the issues which were discussed.
- e. Describe each party's position before the conference.
- f. Describe the explanations provided in the conference to properly document the record. The QAM/GS-12 CE should explain, in clear language, the criteria being used to make the various decisions and the implications of those decisions.

For instance, if the GS-12 CE provides explanation to a claimant in an overpayment case concerning the criteria for deciding "fault" and "waiver" and the implication of these decisions, this should be fully documented. The meaning of "fault" should be explained, as well as the criteria upon which it is determined. For example, the GS-12 CE should state that a preliminary finding of fault was made and explain how it was reached; state the implications of this finding; and invite the claimant to provide any information that could affect the finding.

- g. Describe what each party said in the conference that is relevant to the issue.
- h. Describe the method used to confirm the accuracy of the information collected during the conference and recorded in the Memorandum of Conference.
- i. Describe any agreements reached in the conference. For example, an agreement with a claimant in an overpayment case to repay with deductions from schedule award payments.

9. Obtaining Comments. In most cases, the QAM/GS-12 CE should offer each participant an opportunity to comment on the Memorandum of Conference.

a. Comments Required. A comment period is required for most formal conferences, with the exception of the circumstances describe below, especially if a conference with the claimant results in new allegations that need to be shared with the employing agency for confirmation or rebuttal.

(1) Each participant should be sent a copy of the Memorandum of Conference and be requested to provide any comments within 15 days. The requests may be sent to all parties simultaneously rather than serially. However, if comments from one or more parties result in a material change to the Memorandum of Conference, the QAM/GS-12 CE will need to request comments from the other party(ies) again.

(2) At the end of the 15-day period, the QAM/GS-12 CE should make findings on the issue(s) for resolution. These findings need not be the subject of a separate memorandum, but they will need to be documented in any resulting formal decision. Where a controversy is not upheld, rationale for OWCP's action should be provided in accordance with 20 C.F.R. Section 10.119.

b. Comments Not Required. When it is clear that the decision will benefit the claimant and that the basis of any objection from the employing agency will be addressed in the ensuing decision or other correspondence, a comment period is not required. For instance, a controverted case which will be resolved in the claimant's favor as a result of a conference, and the employing agency's controversy will be addressed via correspondence which will advise the agency of the basis for continuing pay.

Chapter 2-0600, Disability Management

1. Purpose and Scope. This chapter discusses the management of disability claims. It provides an overview of various intervention techniques, including nurse and rehabilitation interventions, which are addressed in more detail in PM Chapter 2-0811 and PM Chapter 2-0813. This chapter also discusses medical management as it relates to the disability management process, though medical management is discussed in detail in PM Chapter 2-0810.

2. Introduction. The Office of Workers' Compensation Programs (OWCP) is responsible for seeing that benefits are promptly paid and helping claimants return to duty as soon as possible in order to minimize the period of disability. The OWCP is also obligated to see that benefits do not continue after the effects of the work-related condition have ceased.

Management of disability claims begins as soon as a new claim is received indicating that the claimant has lost time from work as a result of the injury or is disabled from his or her date of injury position. The Claims Examiner (CE) assists the claimant in returning to work as soon as possible and continues to manage the case until a resolution is reached. Disability management, however, is a team approach and consists of more than just CE intervention. The best outcomes stem from an active team approach where the OWCP, the Employing Agency (EA), the claimant, and the medical providers use all available tools to ensure medical recovery and a sustainable return to work.

The CE uses the Disability Management (DM) Tracking system in iFECS to record actions taken during disability management. A disability management record should be created as soon as work-related lost time is verified in an accepted case. In some instances a record will be automatically created, and in other instances a record must be manually created. A record may also be created for use when managing cases in which the claimant has not lost time from work but is only working limited duty. PM Chapter 2-0601 discusses the DM Tracking system in detail.

3. Intervention Actions and Case Management. Each disability case presents a different set of circumstances that must be addressed. Effective disability management requires the CE to correctly analyze the evidence in a case and determine a course of action which will be effective in helping the claimant recover and return to work. The process of reviewing the evidence, identifying obstacles and challenges to recovery and return to work, and taking timely, appropriate action to resolve these hurdles should be repeated as necessary until the claimant returns to work. The CE should then continue to monitor the return-to-work effort until a decision can be made regarding the claimant's wage-earning capacity.

Disability management consists of multiple case management components and various types of intervention actions which should take place simultaneously in order to produce the best possible outcome for the claimant. These actions are outlined here briefly and discussed in greater detail later in this chapter.

a. Case Management. Routine case management actions during the period of disability management are critical to a successful outcome. Types of case management actions necessary during disability management include, but are not limited to:

(1) Case Adjudication. Prompt and accurate adjudication of the initial injury claim is an important first step towards a successful disability management outcome. Proactive steps by the CE at the adjudication stage result in more timely intervention actions, such as assignment of a Field Nurse.

(2) Payment of Compensation Claims. Prompt payment of claims for compensation sets the foundation for a positive return-to-work outcome, since the claimant will not suffer undue financial hardship during the period of disability.

(3) Customer Service.

Returning phone calls promptly and providing information so that outstanding issues can be addressed allows the case to move forward.

Responding to written inquiries in a timely and responsive manner so that pending issues can be addressed allows the return-to-work effort to continue without delay.

b. Intervention Actions. The CE is responsible for taking a series of intervention actions to assist the claimant in recovery and return to work. Intervention actions should be timely and appropriate based on the evidence in the case. Types of intervention actions include, but are not limited to:

(1) Medical intervention includes the following:

Authorizing medical treatment. Authorizing treatment expeditiously allows medical recovery to progress.

Questions to the attending physician. The CE may write case-specific questions to the attending physician to obtain information about the claimant's condition, the anticipated period of disability, work capacity, and the physician's treatment plan.

Second opinion referrals. The CE may request a second opinion examination at any time to clarify the claimant's condition, the extent of disability, work capacity, or other issues.

District Medical Advisor (DMA) referrals. The CE may refer the case to the DMA if surgery or treatment is requested and input prior to authorization is needed. Also, if the CE needs advice on unfamiliar or technical medical issues, the CE may seek clarification from the DMA.

Referee medical examinations. A referral for a referee examination should be undertaken when a conflict of medical opinion between the attending physician and an OWCP-appointed physician, such as a second opinion physician or the District Medical Advisor, has been identified and the medical opinions are of equal weight.

(2) Nurse intervention includes the following:

COP Nurse (CN) Assignment. Cases are assigned to a CN for action if the claimant sustained a traumatic injury and has not returned to work. After gathering information from the claimant, EA and physician, the CN provides a report to the CE so that appropriate action can be taken.

Field Nurse (FN) Assignment. If the claimant has not returned to full duty and the case has been accepted, a FN can be assigned. The FN works as a liaison between the claimant, EA and physician to address medical and return-to-work issues.

(3) Vocational Rehabilitation intervention includes the following:

Re-employment. When work limitations have been obtained, the CE may refer the case for assignment of a Vocational Rehabilitation Counselor (RC) to assist the claimant with returning to work with either the EA or a new employer.

Medical Rehabilitation. If permanent work restrictions are not yet on file, the case may still be referred for Medical Rehabilitation for work hardening programs and functional capacity evaluations aimed at producing work tolerance limitations. A referral may also be appropriate for speech therapy, orthotics, or prosthetics which would make the injured worker more employable; or psychiatric counseling, drug addiction counseling, or pain management clinics which would likely improve the claimant's condition with a view towards return to work.

(4) Employing Agency intervention centers on maintaining open lines of communication with the EA and providing the EA with the information needed so that a job offer can be made as soon as possible. Since the EA and OWCP have the same goal of the claimant returning to work as quickly as possible, it is important to maintain ongoing communication with the EA throughout all stages of disability management. This will occur both telephonically and via written correspondence, which should be documented in the claimant's file.

(5) Claimant intervention centers on keeping the claimant actively involved in the disability management process and focused on returning to work as the ultimate goal. When the CE becomes aware of concerns raised by the claimant in the management of a claim, the CE should explain the purpose of disability management and fully address any concerns raised by the claimant. Open lines of communication with the claimant are equally as important as the communication with any other party involved in the disability management process.

(6) Conferencing. The CE may arrange for a telephone conference with the claimant, EA, FN or RC to address and resolve return-to-work issues. Conferencing can be an effective tool to move the return-to-work effort forward. These should be fully documented in the file.

The case management and intervention actions mentioned in this paragraph are outlined in detail in the remaining paragraphs of this chapter. Though listed separately, they do overlap, as these actions take place concurrently, not linearly. Possible outcomes and resolutions for cases are outlined in paragraph 14 of this chapter. It is important to remember that the best possible outcome for the claimant can frequently be obtained by timely and appropriate proactive intervention and case management.

4. Case Adjudication. Timely receipt of new injury claims from the EA with subsequent prompt adjudication by the CE is crucial to effective disability management. While neither of these may at first appear to be actual components of disability management, they are actually important building blocks for a successful outcome. In any claim where the claimant has not returned to work, a sense of urgency is needed to gather the necessary information to make a decision so that the focus can quickly change to maximizing medical recovery and assisting the claimant with return to work.

The quicker the EA transmits the new injury claim and supporting evidence to the OWCP, the sooner the OWCP can take action on the claim. If the case can be accepted upon initial review, the CE can move straight into disability management if the claimant is not working or has not returned to the date of injury position. This is true whether the claim is for a traumatic injury or an occupational disease. If the claimant's return to work status is unclear at the time of adjudication, the CE should make appropriate contacts to verify this information, which should then be documented in the file.

If the case cannot be accepted on initial review, tailored development outlining the deficiencies in the case should be undertaken immediately. While 60 days should be provided for the submission of evidence, the case can and should be accepted as soon as sufficient evidence is received. Before a case is denied, the full 60-day period for submission of evidence is required; however, the OWCP should make every effort to issue acceptance decisions on these claims as soon as possible so that medical treatment and disability management can commence. Further, approximately halfway through the 60-day development period in traumatic injury, administrative authorization of limited benefit cases and basic occupational disease cases, if the evidence remains insufficient to accept the case, the CE should conduct a second review of the evidence and explain to the claimant why such evidence does not meet their burden of proof, reminding them that a final decision will be issued at the end of the 60-day period.

5. Payment of Compensation Claims. Like new injury claims, prompt processing of wage-loss claims is critical to a successful disability management outcome. Every effort should be made to pay wage-loss claims as soon as possible so that the claimant does not suffer undue financial hardship during the period of medical recovery. If a wage-loss claim is received, and the information submitted with the claim in conjunction with the evidence on file is insufficient to make payment, the CE should be proactive in obtaining the necessary information.

If information is needed from the EA, the CE should usually first attempt to gather it via phone, rather than written correspondence, since sending requests through the mail and awaiting a mailed response can create significant delays that may affect the claimant financially. If a written request must be sent, the CE should determine whether some kind of payment can be made in the interim, e.g. a payment using the base pay rate while awaiting verification of premium pay. If a payment is made based on a temporary pay rate, the claimant should be notified and follow-up action should be taken to resolve the outstanding issue.

If the medical evidence on file is insufficient to support payment, a written request should be sent; however, other alternatives can be considered simultaneously. Other alternatives include communication with the claimant and/or physician via phone to explain the type of evidence required. If a FN is active with the case, he or she could assist in eliciting the necessary information.

When compensation payments are initiated, the CE should review the medical evidence regarding the anticipated period of disability to determine whether compensation should be paid on the daily roll or the periodic roll. Payment of compensation is addressed in detail in PM Chapter 2-0901.

a. Daily Roll. When the initial anticipated period of disability is unclear, or disability is expected to continue for fewer than 60-90 days, compensation should usually be paid on the daily roll. In cases where compensation is paid on the daily roll, the CE should monitor the medical evidence when subsequent compensation claims are received to determine whether the medical evidence continues to support disability. If the attending physician extends disability without clear supporting medical rationale and objective examination findings, appropriate medical intervention should be initiated.

b. Periodic Roll. When the medical evidence indicates that disability is expected to continue for more than 60-90 days, compensation should usually be paid on the periodic roll.

6. Customer Service and Communication. Effective and efficient communication throughout the life of a case is very important, but during the disability management phase it is crucial. In the course of managing a disability claim, the CE is responsible for communicating case management goals to the claimant, EA, attending physician, and others involved in a case so that each is aware of his or her responsibilities. The CE should also work with them to address and resolve issues hindering return to work. Intervention strategies with the Nurses, Rehabilitation Specialist and Rehabilitation Counselor, EA, and claimant are outlined in detail later in this chapter.

Routine customer service is equally as important as targeted intervention.

a. Phone Calls. Returning calls to all parties promptly is necessary so that outstanding issues can be addressed. The CE should attempt to return calls as quickly as possible in these cases because good communication is integral to effective early disability management. All calls should be documented in the case file.

b. Response Mail. Responding to written inquiries in a timely and efficient manner allows pending issues to be addressed so that the return-to-work effort can continue. Sometimes, especially if the claimant or EA seem uncertain of the status of the case or a recent action, a phone call in response to a written inquiry may be more helpful than a written response. A phone call allows the parties involved to discuss any areas of concern. Depending on the issue, a conference may also be beneficial. (Conferences are discussed later in this chapter.)

7. Medical Intervention. The goal of medical intervention in disability cases is to address and resolve medical issues to assist the claimant with recovery and return to work. The CE is responsible for authorizing appropriate treatment for the accepted conditions, clarifying medical issues, obtaining information about work capacity, and taking other intervention actions as needed to address medical issues impeding recovery and return to work. Developing and evaluating medical evidence is discussed in detail in PM Chapter 2-0810.

a. Initial Contact with the Attending Physician. When the initial period of compensation entitlement is established, the CE should review the medical evidence to determine the expected period of disability. Initial intervention action should be taken consistent with the information provided by the attending physician (AP). A letter to the AP could be one of the CE's first steps in the disability management of a case. Not only will this letter to the AP be used to gather information, it will also set the tone for working with this medical provider moving forward.

If the relationship between the mechanism of injury and resulting accepted condition(s) is very clear and the AP has been treating the claimant since the date of injury, it is not always necessary to provide a Statement of Accepted Facts (SOAF) to the AP with the initial inquiry. However, if either of these criteria is not met in a particular case, or the case is complex factually or medically, the CE may provide a SOAF for the physician to use as the framework for responding to questions posed.

The initial letter to the AP should outline the accepted conditions in the case and seek responses to relevant issues, such as:

- The status of the claimant's recovery from the injury.
- An update on the claimant's post-operative condition, if applicable.
- The specifics of the treatment plan.
- Projected date of return to work with and without restrictions.
- Prognosis for full recovery.

The CE should be careful not to ask questions that are not germane to the case. For instance, if the claimant just had a spinal fusion one week ago, it would be inappropriate to ask whether the

claimant's condition has now resolved. On the other hand, if the claimant only suffered a minor sprain eight weeks ago, asking whether the condition has completely resolved would be appropriate.

b. Clarifying medical issues. Not only at the onset of disability, but also throughout the course of a disability case, it will be necessary for the CE to request clarification of medical issues such as the anticipated length of disability, new diagnoses, the treatment plan, recommendations for work restrictions or other medical issues. In addition, the claimant may encounter delays in recovery or obstacles to obtaining a release for work.

(1) Common examples of issues that would require clarification through medical intervention include:

- The physician estimates a length of disability longer than usual for the injury or condition, without medical justification.
- Disability extends beyond the date the physician originally projected, and no explanation is provided.
- The medical evidence no longer supports continued total disability, but the claimant has not been released to any type of light duty or full employment.
- Temporary restrictions have continued beyond the usual duration for the accepted condition.
- The restrictions provided are of a greater severity than would normally be expected for the accepted condition.
- The claimant develops a non-work related condition which may affect the time needed to recover from the work-related condition.

(2) When a delay or obstacle is encountered, or a medical issue needs to be clarified, the CE should initiate medical intervention. Depending on the circumstances in the case, the intervention may include the following:

- Questions to the AP. The CE could write to the AP and ask specific questions to obtain the information needed to resolve medical issues. The CE may pose questions about the treatment plan, the reasons for the length of disability, whether a return to regular duty will be likely, and recommendations for work restrictions. Just like the initial contact with the AP, the CE should tailor the questions to the specific circumstances of the case and not ask questions that are not relevant to the case.
- Review by the District Medical Advisor (DMA). When the CE needs assistance with interpretation of medical reports, information about general medical issues related to a case, or review of the appropriateness of medical authorizations, the DMA can be asked to review the case and provide an opinion to assist the CE with the medical management of a case.
- Second opinion referrals. Medical evaluations from a second opinion physician may be requested at any time. If the attempt to obtain information from the AP is unsuccessful, the CE should refer the case for a second opinion. Second opinions are also useful throughout the course of a case for obtaining additional information about the claimant's condition and work capacity.

- Referee examinations. When a conflict of medical opinion arises between the AP and an OWCP-appointed physician such as a second opinion referral specialist or the DMA, and the opinions are of equal weight, the CE must arrange for a referee medical examination to resolve the conflict of opinion. The authority for referee medical examinations is also found at 5 U.S.C. 8123(a).

c. Recurring Medical Intervention. When an action is taken, the CE should review the outcome of the intervention to determine whether the issue has been resolved and whether medical recovery and return-to-work efforts are progressing appropriately. If the medical intervention does not clarify or resolve the issue, the CE should undertake further intervention.

Timely, specific, and ongoing intervention to address and resolve medical issues is essential to helping the claimant recover and return to work as quickly as possible. The CE may need to use all of the medical intervention techniques described above at various times during the disability management of one case.

In order to facilitate the best outcome, the CE should advise the FN or RS of the weight of medical evidence regarding work capacity, should the outcome of medical intervention actions change this determination. The claimant and EA should be kept abreast of the CE's ongoing actions in this regard.

d. Authorization for medical treatment. Beyond specifically targeted medical intervention, the CE should also review and respond promptly when requests for authorization of medical treatment are received to ensure treatment is not delayed. Authorizing medical treatment quickly allows medical recovery to progress. The CE may receive formal requests for authorization but may also learn of pending medical requests via updates from the FN or while reviewing new mail.

(1) When clarification is needed regarding an authorization request, the CE should request clarification from the AP, consult the DMA, or refer the case for a second opinion examination. Appropriate medical development should be undertaken in a timely manner so that the treatment authorization issue can be resolved and the case can move forward.

(2) Requests for surgery. If the AP requests authorization for surgery, the CE should ensure that medical rationale has been provided to establish that the proposed surgery is appropriate for the accepted condition(s). If appropriate, the case should be sent to the DMA for review prior to authorization. See PM Chapter 2-0810.

If the surgery is authorized, the CE should ensure that ICD codes for the accepted conditions are updated if necessary. The CE should also request the surgery date and expected period of disability from the AP, as this information is necessary to medically manage the case.

8. Nurse Intervention. The Nurse Intervention program was implemented to assist CEs with medical management of disability claims and to provide claimants with assistance in coordinating medical care. The goal of Nurse Intervention is medical recovery for the claimant and early return to work.

The Nurse Intervention program is comprised of a Staff Nurse, COP Nurses and Field Nurses, who work on a contractual basis. The CE, however, is responsible for the management and overall direction of the case. Nurse Intervention is discussed in more detail in PM Chapter 2-0811.

a. The Role of Nurses.

(1) Staff Nurse (SN). The SN plays an important role in the Nurse Intervention process. The SN's responsibilities include, but are not limited, to the following:

- Ensuring there is a sufficient number of CNs and FNs to service the program's needs.
- Monitoring of the nurse's performance in correlation to both the contract specifications and the quality of services provided.
- Assigning CNs and FNs in particular cases.
- Reviewing nurse reports for completeness and timeliness prior to authorizing payment of bills.
- Communicating with the CEs regarding the cases assigned to FNs.
- Relaying important or time-sensitive information to the CEs so that action can be taken if needed, e.g. if expedited adjudication is needed.

(2) COP Nurse (CN). The CN is a registered nurse who is assigned early in the life of a traumatic injury case and works each case telephonically rather than in person. The information obtained is then used to make decisions about the best path for that particular case. The CN's responsibilities include, but are not limited to, the following:

- Contacting the claimant to obtain a history of injury, history of treatment, and current work status, as well as physician contact information.
- Confirming the work status with the EA and ascertaining whether accommodations are available if needed.
- Contacting the physician's office to obtain a verbal history of treatment and expected treatment plan. He or she can also provide the OWCP address for submission of reports and contact information for requesting medical authorizations should the claim be approved.

(3) Field Nurse (FN). The FN is a registered nurse who assists in the management of disability claims in a number of ways. Unlike the CN, the FN's contact is frequently in person with the claimant, EA, and medical providers. The FN's responsibilities include, but are not limited to, the following:

- Developing a rapport with the claimant and answering questions about what to expect from OWCP, while at the same time establishing the return-to-work goal clearly for the claimant from the outset.
- Making determinations about the initial extent of the injury, treatment necessary for recovery, and return-to-work expectations (using the CN's report, if available, as part of this process).

- Attending the claimant's medical appointments to facilitate communication about return to work and ease any authorization difficulties the claimant may be encountering.
- Obtaining functional capacities, restrictions and limitations from the physician as early as possible, and then providing these to the EA.
- Identifying possible barriers to the claimant's return to work and then developing a plan of action with the CE to resolve the identified barriers.
- Continual evaluation of the likelihood of return to work with the EA and physician, with the goal of following the plan through to successful full duty return to work and closure.
- Communicating regularly with the medical providers, claimant, EA, SN and CE to keep all parties informed of the status of the case to facilitate a timely, sustainable return to work.
- Making recommendations for vocational rehabilitation when necessary.

Usually a FN's contact with the claimant, EA and physician is in person. Sometimes though, contact may be only telephonic in nature. This may occur, for instance, if there is no available FN in the claimant's locale. This may also occur in non-complex cases where telephonic intervention is determined to be sufficient. Regardless of whether the communication is in person or telephonic, the nurses in these cases are referred to as FNs, since the goal of the intervention is the same.

b. COP Nurse Assignments. Although nurse intervention will not be extensive during the COP period, the medical knowledge and experience of a CN will permit identification of cases that require more extensive intervention due to the severity of the injuries, contemplated surgical intervention, or lost time from work.

Based on the data entered when a traumatic injury case is created (particularly date stopped work), a case will become automatically eligible for a CN assignment if the claimant does not return to work. This happens even if the case has not yet been formally accepted.

(1) Cases are electronically assigned, if eligible, to a particular CN. Upon receipt of the case, the CN should make a three-point contact in order to effectively "triage" the case, and then report these findings via a COP Nurse Report to the SN and CE.

(a) Claimant - The CN should make initial contact with the claimant. Often this contact is the claimant's first experience with OWCP; therefore, it should be positive. It sets the tone for moving forward toward a positive outcome for the claimant. The CN should obtain details concerning the injury and determine whether the claimant has a treating physician. If so, contact information should be obtained. The CN can also answer general questions about OWCP.

(b) Employing Agency - The CN should contact the agency to confirm the claimant's work status and determine whether work accommodations are going to be available during recovery. The CN can also discuss with the EA whether he or she feels that a FN assignment would be beneficial in the particular case.

(c) Attending Physician - The CN should contact the physician's office to obtain information concerning treatment and the date of the claimant's next appointment. The CN can provide

general information about dealing with OWCP, such as the address for submission of reports and how to submit authorization requests and medical bills should the claim be approved. The CN can also advise whether accommodations can be made at the EA.

(2) Once the information has been gathered, the CN enters it on the COP Nurse Report, along with other relevant information pertaining to possible issues or foreseeable barriers. The CN should also make a specific recommendation pertaining to whether a FN assignment would be beneficial.

(3) Once the COP Nurse Closure report is received, the SN reviews it and submits the bill for payment. At that point, the COP Nurse Report will be viewable by the CE, who can use the information provided to determine whether a referral for FN intervention is needed. The closure type and date will also be visible to the EA in the Agency Query System (AQS) at that time.

If the CN closes the case and the claimant has not returned to work in a full-time capacity, the case should be reviewed for adjudication action. See the Case Adjudication paragraph above for an explanation on the importance of expediting adjudicatory actions in these types of cases.

c. Field Nurse Assignments. FN services are a valuable tool for assisting claimants in returning to work and assisting CEs in moving a case towards resolution. Early referral for FN intervention services is critical to ensuring successful disability management, and FN assignment should occur as soon as possible after the injury occurs if the claimant has not returned to work. Referral for FN services may also be made if the claimant has returned to work but is disabled from performing his or her date of injury position.

(1) The need for a FN referral can be established with any of the following criteria:

- The claimant is disabled as a result of the accepted condition and has not returned to work. This is true even if a projected return-to-work date is on file but has not yet occurred. In this case, the FN will work with all parties involved to obtain a release to work or facilitate the return-to-work effort on the projected date.
- Surgery is authorized. In these cases, it is important to assign a FN prior to the actual surgery date if at all possible (unless the claimant is working full duty prior to the surgery) so that the FN can attend the pre-operative appointment with the claimant and assist with arranging any post-operative care that may be needed.
- Work tolerance limitations are on file but outstanding medical issues hinder or preclude a return to work. The FN can assist with the outstanding medical issue (e.g., physical therapy, medication, treatment plan, etc.).
- Work tolerance limitations are on file, but they are considered temporary pending further medical recovery. The FN can work with the claimant, EA and physician to obtain a return to work with temporary accommodations, stable and well-defined work restrictions, or a release to full duty.
- The anticipated return-to-work date does not coincide with the severity of the original injury, or the return-to-work date is extended without clear medical reasons. The FN can work with the claimant and physician to clarify the reason for the severity or delay and

perhaps assist with obtaining authorization for medical treatment that would remove the barrier.

- The claimant is only working limited duty but may be able to return to full duty.

(2) The Nurse Referral. A FN can be assigned in an accepted case as soon as there is an indication that the claimant is out of work due to the work injury or disabled from performing the full duties of the date of injury position, as well as any of the reasons outlined in the prior paragraph. This referral can be made even if the claimant is still in the COP period following the injury and even if the OWCP has not yet made a wage-loss payment. A FN may also be assigned upon request by the EA for other reasons if the CE concurs that a FN would be helpful in resolving the case and the claimant is not already working full duty. How to make a nurse referral is discussed in more detail in PM Chapter 2-0811.

(3) Upon receipt of the referral, the FN is expected to meet with the claimant, attend medical appointments, monitor the claimant's return to work, visit the work site, and communicate with the CE, SN, AP and EA. The FN obtains and relays information through a combination of phone calls, written communication, and face-to-face interaction. The FN can assist in the following ways:

- Coordinate medical care if various medical providers are involved, e.g. an attending physician, a specialist, physical therapists, etc.
- Relay authorization information for diagnostic tests, equipment, surgery, etc.
- Obtain treatment plans from the attending physician and determine whether more active treatment or more active participation by the claimant in the recovery process may be needed. Also, the CE may want the FN to address any prolonged treatments such as physical therapy without clear goals or direction.
- Provide guidance to the CE where the claimant has sustained a catastrophic injury or has undergone surgery.
- Assist the CE in resolving medical issues.
- Assist in arranging for a Functional Capacity Evaluation (FCE) and/or work hardening program.
- Clarify work status and obtain work tolerance limitations, and then relay this information to the EA.
- Assist in work site evaluation following a return to work and monitor the claimant post return to work to ensure it is sustained.
- Address any problems the claimant may have in adjusting to the work setting.
- Obtain the date of maximum medical improvement.
- Recommend a second opinion examination.
- Recommend vocational rehabilitation services.

After receiving the referral, the FN should make the initial contacts with the EA, claimant and AP. The FN should then contact the CE to discuss the strategy for moving forward with the case. At that time, the CE can direct the FN to take specific actions as needed.

(4) CE and FN Interaction. During the period of FN intervention, the CE and the FN will confer, either by telephone or written communication, to determine the next action. Timely response to

FN inquiries is crucial to successful case management. The CE determines the best approach to achieve progress in the case and directs the FN in obtaining necessary information or completing specific tasks needed to achieve those goals, as detailed in the prior section.

The FN may note such information as the physician's opinion concerning length of disability, work limitations, etc. The CE may use this information as the basis for questions to the physician but should not base adjudicatory actions on nurse reports.

The FN will report to the OWCP, either by telephone, in writing, or both. The FN's monthly report should outline accomplishments and action plans necessary to resolve barriers to sustainable return to work. Written reports are usually required every 30 days, but effective disability management hinges on more frequent communication in most cases.

(5) Length of Assignment. The length of a FN's involvement will depend on the specific circumstances in a case. An initial assignment period will be determined at the outset of the case, usually 120 days. This may be adjusted, however, depending upon the progress in that case. Return to work monitoring by the FN is automatic for 60 days after a light duty return to work, and for 30 days following a full duty return to work. These extensions are automatic, even if the extension takes the case beyond the initial 120-day assignment period.

If the CE determines that the FN could still be of assistance after that initial period, the CE should document the file extending the FN intervention for 30-60 additional days. A follow-up review should then be undertaken after that extension period has ended. As long as the CE documents the case file accordingly and the rationale for continued intervention is clear, the CE can extend the FN intervention period for up to 180 days. During this period, return-to-work 30/60 day extensions are automatic as well.

Rationale for extending the FN intervention period includes, but is not limited to, the following:

- Work tolerance limitations are expected shortly and the EA has indicated a willingness to accommodate the claimant.
- The claimant has undergone surgery during the initial intervention period, and the FN needs more time to work with the claimant and physician post-operatively to obtain a release to work.
- The claimant has returned to a temporary modified assignment, but the work restrictions are expected to lessen in the near future, and the FN could assist the EA with the formulation of a permanent position.
- A full-duty release is expected in the near future, and the FN would be able to assist with that transition back to full duty.
- The claimant has returned to a modified position, and the FN could monitor the claimant post return to work to ensure that it is sustained.
- A second opinion or referee examination was obtained during the initial intervention period which delayed the CE's determination of the work tolerance limitations that should be used for the return-to-work effort; therefore, the FN needs extra time to work with the EA on an appropriate job offer.

- The claimant has encountered medical setbacks or the recovery has been unusually delayed, and the FN's services would be beneficial to the claimant's medical recovery and/or return-to-work effort.

FN intervention past 180 days must be approved by a Supervisory Claims Examiner (SCE), upon recommendation of the CE, unless the extension is due to a 30/60 return-to-work monitoring period. Any extension beyond 180 days should also be discussed with the SN. Even with Supervisory approval, nurse intervention should usually be closed after 10 months of assignment, unless the case is catastrophic in nature.

The key for extending FN services in any circumstance is that the CE makes a purposeful decision for the extension with clear goals for the FN to accomplish during the next approved period. Extending the FN intervention period without clear direction and communication from the CE to the FN is not permissible. The process for extending FN services is discussed in more detail in PM Chapter 2-0811.

(6) Dual Tracking. Based on the circumstances in the case, OWCP may determine that the assignment of a Vocational Rehabilitation Counselor (RC) simultaneously with FN intervention could be useful.

(a) Although not always necessary, dual assignment should be considered in the following kinds of circumstances:

- The claimant has a condition that will likely lead to permanent work related restrictions, which would prohibit a return to the date of injury position, and the EA has indicated that it will not have any work available for an individual within the expected restrictions. In this instance, the file should reflect expectations for when the restrictions will likely be permanent and the kinds of restrictions that are expected.
- If the EA needs vocational information and assistance with formulating a job offer, the RC and FN may work concurrently with the EA. In these instances, the RC may be able to provide vocational testing, transferable skills analysis, ergonomic assessments, and even arrange for short-term training that would enable the EA to make a job offer.

(b) If the CE determines that dual tracking would be useful, a rehabilitation referral will be sent to the RS for consideration. If the case is opened for both rehabilitation and nursing services simultaneously, the CE should send a letter to the claimant (with copies to the FN, RC, and EA) outlining the circumstances, roles of each party, and the claimant's expected cooperation with the return-to-work effort.

(c) If dual tracking occurs, the FN and RC have different roles, but each compliments the other. The FN should focus on the following:

- The claimant's medical condition in order to obtain permanent and/or stable, well-defined work tolerance limitations.

- Maintaining open communication with the physician while providing information as necessary to the CE and RC. Any needed communication by the RC with the physician should flow through or be coordinated with the FN (while still assigned to the case).
- Communicating with the SN, CE and RC as needed - documenting any communication in the monthly reports.

Once the FN obtains stable and well-defined work restrictions, FN intervention should be usually be closed, unless work with the EA is necessary to complete a job offer, and the RC should commence with developing a return-to-work plan.

9. Vocational Rehabilitation Services. Returning the claimant to suitable work is the primary goal of vocational rehabilitation. It is a valuable resource for the return-to-work effort. In most cases, the earlier the claimant begins vocational rehabilitation, the greater the likelihood of a successful return to suitable, gainful employment.

Vocational Rehabilitation (VR) services are addressed in section 8104 of the FECA. Like medical treatment and wage-loss compensation, these services are a benefit to which the claimant may be entitled. While vocational rehabilitation is provided at the discretion of OWCP, participation on the part of the claimant is mandatory under the FECA.

The VR program serves a dual purpose: providing return-to-work services to the claimant while also providing a basis where appropriate for OWCP to make a determination on the claimant's capacity to earn wages. This paragraph will specifically address how vocational rehabilitation should be used in the disability management process to achieve a return to work. PM Chapter 2-0813 provides a comprehensive description of VR services.

The VR program is comprised of a Rehabilitation Specialist (RS), and the RC, who works on a contractual basis. The CE, with recommendations from the RS, is responsible for the management and overall direction of the case, even during the VR period.

a. Vocational Rehabilitation Roles.

(1) The RS plays an important role in the VR process. The RS's responsibilities include, but are not limited to, the following:

- Ensuring there is a sufficient number of counselors to service the program's needs.
- Monitoring the RC's performance in correlation to both the contract specifications and the quality of service provided.
- Assigning RCs to particular cases.
- Reviewing RC reports for completeness and timeliness prior to authorizing payment of bills.
- Communicating with the CEs regarding the cases assigned for VR services.
- Relaying important or time-sensitive information to the CEs so that action can be taken if needed, e.g. a new issue with the claimant's medical condition that is hampering the VR effort.

- Providing training and guidance to CEs in regard to how to recognize when vocational services are necessary to assist the claimant with returning to work, and serving as a vocational resource to the CEs.
- Providing solutions for return-to-work barriers in cases.

(2) The RC is a certified counselor who assists with the VR effort in a number of ways. The RC's contact is usually in person with the claimant since he or she is assigned by area when available. The RC's responsibilities include, but are not limited to the following:

- Evaluating the claimant's vocational abilities and transferrable skills.
- Arranging for vocational testing and training.
- Overseeing Occupational Rehabilitation Plans.
- Conducting labor market surveys.
- Formulating a vocational re-employment plan.
- Assisting the claimant with job-seeking skills such as resume building and interview techniques.
- Arranging for specialized ergonomic job and home modification services.
- Making recommendations to the RS and CE if a particular barrier is hindering the return-to-work effort.
- Working with the FN during a dual tracking period.

b. Referral for rehabilitation services should be made in the following circumstances:

(1) If the claimant has been released to work and the FN intervention period has ended, the claimant should be able to work at least four hours per day if the goal is return to work with the date of injury employer. If return-to-work services with the EA have been exhausted and the goal of rehabilitation is placement with a new employer, the claimant should be able to work on a full-time basis and should be capable of at least sedentary work. A referral for a work release of only 4 hours can be considered in some circumstances, and the CE and the RS should discuss this option, especially if part-time work may be available.

(2) If the physician recommends work hardening and work restrictions are expected after completion of the program, the claimant can be referred to vocational rehabilitation for an Occupational Rehabilitation Program (ORP). Once restrictions are established, the rehabilitation services will then focus on return-to-work efforts.

(3) A Dual Tracking period with FN services and VR services may be helpful, as outlined in the prior paragraph, 8(c)(6).

c. Return to work with the EA (not involving Dual Tracking) is only to be undertaken by the RC if the CE and FN nurse have not previously exhausted all attempts to get a suitable job offer.

(1) The time frame for placement with the previous employer is a maximum of 90 days, although if the EA chooses not to make an offer early during this phase, the phase should be much shorter.

(2) During this phase, the claimant, RC, EA and CE all participate in the return-to-work effort. A conference call is often helpful to address any issues that arise which may impede this process. Conferences are discussed later in this chapter.

(3) If the outcome of this phase is positive and the claimant returns to suitable employment with the agency, the RC should remain on the case for 60 days after the return to work. At that time, OWCP should be in a position to issue a formal loss of wage-earning capacity decision, if applicable. If the claimant is working full time in a light duty position, but the position is not one for which a formal loss of wage-earning capacity decision can be issued, the RC should ascertain whether that position will continue indefinitely or whether further VR services would be helpful in formulating a permanent job offer. If further services will not be helpful, VR will close at that time.

(4) If the claimant does not return to work during this phase, there are two possible outcomes. If the claimant refused to accept a suitable offer of employment, the CE should follow sanction procedures under Section 8106 of the FECA, as discussed in FECA PM Chapter 2-0814. If the agency failed to offer employment, the VR effort should move on to the next phase, the development of a plan for placement with a new employer.

d. Plan development is the next phase of vocational rehabilitation. During this phase, the RC should gather information about the claimant's work history, education, and transferable skills. This information is then compared to the jobs available in the local labor market where the claimant resides.

(1) If the claimant has sufficient transferable skills to obtain employment that is reasonably available in the local labor market, a placement plan is put into place. The claimant will be provided with placement assistance (resume and interviewing skills, job leads, etc.) for 90 days. If the claimant secures a job, the counselor will follow up for 60 days to ensure a successful return to work. If the claimant does not obtain a job or fails to take advantage of the placement assistance provided, a constructed loss of wage-earning capacity decision can be considered based on the job(s) identified in the placement plan.

(2) If the employing agency cannot offer a job and the claimant is unemployable in the local labor market with his or her current skills, a training plan can be pursued if vocational testing establishes that the claimant has the necessary aptitude. The claimant can be provided training to prepare him or her for a job that is reasonably available in the local labor market. Once the training period has ended, the claimant is offered placement services as described above. If training is needed, short-term or pre-vocational training that would serve to upgrade basic skills are the preferred options. Long-term training plans should be pursued as a last resort, since returning the claimant to work in the shortest time possible is a primary focus of vocational rehabilitation.

e. Dual Tracking. OWCP may determine that the assignment of a RC simultaneously with FN intervention in certain circumstances could be useful, as noted earlier in this chapter. The referral for the RC in these cases will be for Medical Rehabilitation, and the period will usually be limited to 3 months for concurrent services.

If the EA needs vocational information and assistance with formulating a job offer, the RC and FN may work concurrently with the EA. In these instances, the RC may be able to provide vocational testing, transferable skills analysis, ergonomic assessments, and even arrange for short-term training that would enable the EA to make a job offer.

In other cases, where the EA has determined there will be no job opportunities for the claimant, the claimant's work restrictions may not yet be stable and well defined. As a result, full plan development cannot begin immediately with these claimants, but, in the interest of expediting the return to work, the RC may assist with work hardening and functional capacity evaluation scheduling and begin the groundwork for the development of a return-to-work plan by obtaining the claimant's work history, performing preliminary labor market surveys, and conducting transferrable skills analysis.

The FN should focus on the medical aspects of the case, and the RC should focus on the vocational aspects of the case. Once the claimant has stable and well-defined restrictions, nurse intervention should usually cease (unless continuing assistance to the EA would be helpful in formulating a job offer), and the RS will direct the RC to begin actual plan development.

10. Employing Agency Intervention. The EA has a vested interest in returning the claimant to work as soon as possible, so partnering with the EA throughout the return-to-work process is important to a successful outcome.

The first step in the disability management process is solely within the EA's purview - the transmission of new injury claims and subsequent wage-loss claims. The quicker the EA transmits the new injury claim and supporting evidence to the OWCP, the sooner the OWCP can take action on the claim. If the case can be accepted upon initial review, the CE can move straight into disability management if the claimant is losing time from work or disabled from performing his or her date of injury position.

It is also the EA who first speaks to the claimant about the OWCP and what to expect after a claim is filed. For that reason, the OWCP should partner with the EA throughout the process so that the EA can effectively communicate the purpose of the FECA program to the claimant and convey from the outset that medical recovery and return to work are the ultimate goals.

a. Communication between the OWCP and the EA. Since the EA and the OWCP have the same goal of the claimant returning to work as quickly as possible, it is important to maintain open and ongoing communication with the EA throughout all stages of disability management.

During the disability management process, the OWCP should be able to expect the EA to:

Notify the OWCP promptly when the claimant either returns to work or does not return to work after being released by the AP and notified of the availability of modified work.

Allow the FN and/or RC access to the claimant's work site.

Maintain contact with the claimant and address the claimant's concerns about personnel issues such as retirement and health insurance benefits that may be affected by a return to work.

Communicate any medical updates to the OWCP.

The EA should expect the following from the OWCP during the disability management process:

Information relevant to the return-to-work effort, especially work tolerance limitations.

Pertinent information obtained by the FN and RC that would enable the EA to formulate a job offer.

Prompt determinations on medical issues and the suitability of job offers when needed.

Communication as described above will occur both telephonically and via written correspondence, but use of the phone (with documented CA-110s for the file) for many issues is the best way to resolve outstanding issues.

b. Job Offers. The most important action of the EA can be the formulation of a job offer within the claimant's work restrictions. The CE can solicit a job offer once work restrictions are obtained. The EA may also obtain the work restrictions through the FN, physician, or even the claimant. Once obtained, it is up to the EA to provide work accommodations and create a suitable job.

The EA will determine whether work accommodations can be made when medical restrictions are presented. The FN can assist with this process during nurse intervention, and the RC can assist with this process during vocational rehabilitation. If work accommodations are available for a partially disabled claimant, the EA will advise the claimant in writing of the specific duties and physical demands of the modified position. Offers of employment are addressed in detail in PM Chapter 2-0814.

If a FN is assigned to the case, but the EA, the FN, or the OWCP believes that vocational rehabilitation services may also be beneficial for the return-to-work effort (perhaps to arrange for specific job training or address ergonomic issues unable to be addressed by the FN), then a RC can be assigned concurrently to assist with the return-to-work effort.

11. Claimant Intervention. The most important party in the return-to-work process is the claimant. All interventions and CE actions are done with one goal in mind, ensuring that the claimant recovers and is able to return to work in a sustained capacity following a work injury. Claimants must therefore understand from the very beginning that the OWCP is in fact a return-to-work program - not a retirement program. The EA plays a large part in encouraging return to work, but it is the OWCP's responsibility as well to convey the advantages of a speedy return to the workplace.

a. Retention Rights. A primary goal of disability management is to return the claimant to work as soon as possible, but particularly within one year of the onset of disability. This one-year

deadline is significant because section 8151(b) of the FECA requires the EA to offer the claimant his or her former position or its equivalent if the injury or disability has been overcome within one year. If the disability is overcome after one year, the EA must make "all reasonable efforts" to rehire the claimant. In practice, this means that in some cases there may be only a one-year window of opportunity for return to work with the EA. It is therefore essential that a return-to-work agenda be emphasized early in the life of an accepted disability claim to take advantage of this limited opportunity so that the claimant does not lose his or her opportunity to continue in the Federal employment system and does not sustain a negative impact on retirement benefits.

If the claimant has not returned to work and that one-year time frame is approaching, the claimant should be reminded of his or her retention rights. Approximately two months prior to the one year mark, or at the end of efforts to place the claimant in a job with the previous employer (whichever occurs sooner), the claimant should be advised in writing that the previous employer has not identified a job meeting the claimant's work limitations and that contacts with the previous employer do not indicate that any such offer will be forthcoming. It is also appropriate to alert the claimant at this time that the OWCP will begin vocational rehabilitation plan development if the claimant can work in some capacity, and that the rehabilitation effort will prepare the claimant for other work, possibly with another government agency but probably with a private employer. The "Ten Month" letter is used for this purpose.

b. Communication between the OWCP and the Claimant. Early in the disability management process, the FN plays a key role in communicating on behalf of the OWCP. The CE may also need to communicate with the claimant as well to clarify any questions the claimant may have. Timely responses to the claimant's inquiries will foster a good relationship with the claimant and alleviate any concerns he or she might have about the status of his or her case moving forward. As outlined earlier in this chapter, timely customer service and prompt payment of compensation claims build trust with the claimant and enable the claimant to concentrate on recovery and return to work.

Beyond routine customer service items, the CE or other designated staff will also communicate with the claimant when:

- A FN and/or RC are assigned to the case.
- Medical information is requested from the AP.
- The claimant is scheduled to report for a second opinion or referee examination.
- A job has been determined to be suitable and the claimant is expected to return to work.
- The various stages of vocational rehabilitation begin.

12. Conferences. As noted throughout this chapter, ongoing and steady communication between all parties involved in the disability management process is vital to a successful resolution. Conferences are a particularly effective means of addressing any issues that arise that may impede the return-to-work process. Conferences are also helpful when miscommunication between one or more parties has occurred.

There are two types of conferences - formal conferences and informal conferences. Formal conferences are discussed in PM Chapter 2-0500. Formal conferences require a memorandum of

conference, as well as a follow-up comment period. When due process is involved, e.g. during the adjudication of a claim or reaching a final determination in an overpayment case, a formal conference is needed. At other times, though, an informal conference may be sufficient.

a. An informal conference during disability management is a form of mediation, and the goal is to address the concerns of all involved parties and arrive at a solution that is agreeable to everyone. Some reasons for conferencing during the return-to-work effort include, but are not limited to, the following:

(1) Medical evidence used for a return to work may be disputed by the claimant or the EA. An explanation of how medical evidence is afforded the weight for return-to-work purposes can alleviate these concerns.

(2) The duties of a limited duty position offered by the EA may not be described sufficiently so that a determination on suitability can be made. Additionally, a claimant may have a different idea about the requirements of a described job duty than the employer. Discussing these concerns and arriving at an understanding of the actual duties of an offered position can serve to inform the EA of how the job offer should be written and to alleviate the claimant's concerns that a particular job requirement exceeds his or her work abilities.

(3) Wage disparity can be a major deterrent to a claimant seeking to return to work. During the conference, the CE can explain the loss of wage earning capacity procedures and assure the claimant that income will not decrease even if the wages of the limited duty position are lower than those of the date of injury position.

(4) Personnel issues may not affect the suitability of a job offer as reviewed by the OWCP, but they can present obstacles to a successful return to work. For example, the claimant may object to a new work schedule. The conference allows an opportunity for all parties to express concerns and for a compromise to be reached whenever possible.

(5) Placement with a new employer may not be the claimant's desire. He or she may want to retain Federal status instead. If the EA is unable to make a job offer, the placement period during vocational rehabilitation is critical to a successful outcome for the claimant. If the claimant is aware from the beginning what will happen at the end of the placement period, e.g. a likely reduction of benefits with or without placement, he or she is more likely to cooperate fully during the placement period.

b. Participants in the Conference. A conference is usually held with the CE plus two or more parties. During nurse intervention, the FN will often be involved as well as the EA and the claimant. During vocational rehabilitation, often times the RS and the RC will participate along with the claimant and CE. There are no set rules on who should be part of the conference or how many people should participate. Whichever parties can help resolve the issue at hand should be involved.

c. Elements of an Informal Conference. Unlike a formal conference where an actual conference memorandum is necessary and the memorandum is mailed to the participants, informal

conferences can usually be documented with a complete and thorough CA-110 or memo in the case file. Regardless of the format used, the conference should be fully documented in the file. Whether using a CA-110 or memo, it should contain the following information:

- (1) A heading at the top annotating the call as a Conference.
- (2) A list of who was involved in the conference and his or her role in the process, e.g. Jane Smith - EA Injury Compensation Specialist.
- (3) Descriptive but thorough bullet points may be used in lieu of a full narrative, but the CE should be careful to attribute specific comments to specific individuals.
- (4) If any action was promised as a result of the conference, the bottom portion of the CA-110 should clearly outline the pending actions.
- (5) While a narrative memorandum is not needed, the CE must still ensure that the CA-110 or memo contains an accurate depiction of the content of the conference.

d. Follow Up Actions. Because these conferences are used to address various return-to-work issues and resolve any miscommunication, as opposed to formal adjudication actions, a formal follow up is not required. Often times the conference itself will have resolved the issue at hand. Other times, the CE's follow-up actions (letters, second opinion referrals, requests for a new job offer, etc.) will reflect information discussed during the conference.

13. Intervention Strategies and Timing. Each interaction between the CE and the claimant, EA or AP should be used to ensure the claimant's recovery is progressing and to emphasize the goal of return to work. Brief but timely inquiries and open communication with all involved parties are effective tools in conveying case management goals and encouraging a successful return to work. Interventions may involve any of the types described in this chapter, and, as previously noted, these intervention actions can and should overlap for effective disability management. Taking actions sequentially is not usually the most effective method. Intervention actions are most effective when used simultaneously.

a. Key Strategies for Disability Management.

- (1) Consider the evidence in the specific case file. The appropriate intervention to take on a specific case is based on a number of factors, including the accepted condition, extent of injury, treatment provided, availability of work accommodations, and other variables.
- (2) Identify any pending obstacles or barriers to medical recovery and return to work.
- (3) Anticipate the outcome of the possible intervention actions. Prior to taking an action, the CE should anticipate the possible outcome of such an action to determine whether the action will enable the disability management effort to progress.

(4) Decide on the best intervention action to resolve any pending issues in the case and then move forward.

(5) Assess the outcome of the intervention action taken. Did the intervention action yield the necessary outcome to move forward in the case?

(6) React to the new evidence in the file and repeat the five steps outlined above again until the case has been resolved.

b. Choosing an initial Disability Management strategy. Decisions made early in the disability management process are crucial to minimizing the effects of a work related injury in the long-term. The CE should review the specific circumstances of the case and utilize judgment in deciding which strategies to employ in order to minimize disability and the effects of the work injury. Initial actions will not be the same for every case. For instance, if the claimant is off work because of a pending surgery, this would require different intervention than a case where the claimant has undergone treatment and the physician anticipates a return to work in the very near future.

Choices made upon initial review of the claim can affect the return-to-work effort. For example, if a claimant files a claim for carpal tunnel syndrome and submits a medical slip stating "off work pending carpal tunnel release," the CE knows even before the case is adjudicated that the claimant is out of work. The CE therefore needs to make a decision about the best way to obtain the evidence necessary to adjudicate the claim so that disability management actions can be initiated and compensation can be paid if the case is ultimately accepted. Tailoring the development letter to request information about the possibility of surgery, while simultaneously requesting the evidence needed to adjudicate the case, is one way to begin the disability management process before the case is even accepted.

c. Adjusting Disability Management strategies as the case progresses. As the claim progresses through the disability management process, the CE should regularly assess the claimant's medical condition and return-to-work status and decide what type of intervention is appropriate. Tailoring the kind of interventions taken to the specific circumstances of the case and anticipating the outcome of each intervention is key to successful disability management. For instance, a conference call might be appropriate to address a claimant who is not fully cooperating with the vocational rehabilitation process, but it will not be useful in a case where disability has recurred and medical management is needed. A few examples of the decision making process are outlined below.

(1) If the claimant has not returned to work, the CE should usually write directly to the AP first or seek the assistance of the FN in addressing necessary issues with the AP. However, a second opinion should be scheduled if the AP fails to submit rationalized medical evidence that clearly establishes the claimant's work tolerance limitations. Alternatively, there may be a benefit to taking both actions at the same time. If the AP does not respond to the letter or provides an inadequate response, a second opinion will already be in process to obtain the requested information. If the AP does respond, the opinions of the two physicians can be compared and

weighed to determine the next disability management action. Should a conflict of medical opinion exist, a referee examination can be scheduled to clarify and resolve the issue.

(2) If the EA fails to make a suitable job offer, the CE should direct the FN to work with the EA on the formulation of such an offer. If the EA cannot or will not make a job offer, a conference should be considered. If a job offer is still not forthcoming, the case should be referred for vocational rehabilitation.

(3) If the claimant has been released to work, but a FN is no longer assigned to the case, the CE can request a job offer from the EA and refer the case for VR. Taking these actions simultaneously is usually the best strategy so that a RC can assist with the creation of a job and provide adjustment counseling to the claimant, which should result in a smoother transition back into the work environment for the claimant.

(4) If the claimant develops a disabling medical condition after VR efforts have been initiated, the CE should assess the medical evidence to determine whether the condition is work related. After contemplating the outcome of the various options, the CE needs to decide whether to approach the AP, refer the claimant for a second opinion, or pursue both courses of action simultaneously. During this medical intervention, the CE and RC should continue to communicate with the claimant so that return to work remains the ultimate goal even during this period of development.

d. Intervention Timing. Though intervention actions vary, timely and appropriate interventions do help to minimize the length of disability by maintaining focus on the goal of assisting claimants in returning to work.

As stated previously, a primary goal of disability management is to return the claimant to work as soon as possible, but particularly within one year of the onset of disability. It is critical that the CE be attentive to the specific issues of each case in order to actively manage the case and take timely action on any situation to achieve this goal. CEs should use all available tools, including reminders and reports, in order to take substantive actions on disability management in a timely fashion. While in active disability management, the case should usually be reviewed often and as frequently as necessary to ensure intervention actions and the disability management strategy are on course. This consistent focus will allow CEs to address issues hindering recovery, facilitate return-to-work efforts, and move cases towards resolution.

14. Resolution of Disability Management Cases. The CE should actively manage the case until the claimant reaches maximum medical improvement and a resolution is reached regarding the claimant's work capacity. There are several possible outcomes; the purpose of this paragraph is to describe these possible outcomes.

Following are the most likely outcomes, along with any associated decision and the steps needed to pursue that course of action.

a. Complete recovery from injury-related conditions.

(1) In cases where the claimant has completely recovered from the employment injury and returns to the job he or she held when injured, no formal decision is necessary and the case may be closed if the claimant has been released from care.

(2) In some instances, the claimant has fully recovered but does not return to the date of injury position. The claimant has no ongoing entitlement to compensation for wage loss and medical benefits once the injury-related condition has resolved. In these cases, a formal decision following a notice of proposed termination is necessary to notify the claimant of this change in entitlement. (Formal decisions are discussed in PM Chapter 2-1400.) As the claimant's response may change the preliminary determination to terminate compensation, the OWCP should continue any nurse and/or rehabilitation services during the notice period until a formal decision with appeal rights is issued, unless the claimant is already in receipt of OPM benefits.

b. Complete recovery from injury-related disability.

(1) In cases where the claimant has recovered from the employment-related disability and returns to the job he or she held when injured, no formal decision is necessary. If the claimant has returned to the date of injury position but still requires ongoing medical treatment, the case can be left open for medical benefits.

(2) In some instances, the claimant recovers from the injury to the point that he or she is capable of performing the date of injury position but does not actually return to that job. The claimant has no ongoing entitlement to compensation for wage loss once the medical evidence establishes the claimant's ability to perform the date of injury position. In these cases, a formal decision following a notice of proposed termination is necessary to notify the claimant of this change in entitlement. (Formal decisions are discussed in PM Chapter 2-1400.) As the claimant's response might change the preliminary determination to terminate compensation, the OWCP should continue any nurse and/or rehabilitation services during the notice period until a formal decision with appeal rights is issued, unless the claimant is already in receipt of OPM benefits.

c. Return to modified work, with or without wage loss.

(1) Re-employment with no Loss of Wage Earning Capacity (LWEC).

(a) If the claimant returns to a new position or a modified version of the date of injury position with the previous employer at a pay rate commensurate with the current pay for the job held when injured, the claimant has no loss in wage earning capacity as a result of the injury. Once the claimant has satisfactorily performed the position for a period of at least 60 days, the CE should review the case to determine whether the medical evidence establishes permanent restrictions and whether the position fairly and reasonably represents the claimant's wage earning capacity. If so, the CE should prepare a formal decision making this finding. This type of decision is necessary even though there technically is no loss of wage earning capacity. See PM Chapter 2-0814. If the position does not fairly and reasonably represent the claimant's wage earning capacity, no decision can be issued. Different resolution codes are used for each of these scenarios.

(b) If the claimant returns to work with a new employer at pay rate commensurate with the current pay for the job held when injured, the claimant has no loss in wage earning capacity as a result of the injury. Once the claimant has satisfactorily performed the position for a period of at least 60 days and the medical evidence establishes permanent restrictions, the CE should prepare a formal decision addressing whether the earnings fairly and reasonably represent the claimant's wage earning capacity.

(2) Re-employment with LWEC.

(a) If the claimant returns to a new position or a modified version of the date of injury position with the previous employer and is earning less than the current pay rate of the job held when injured, the claimant has sustained a loss in wage earning capacity as a result of the injury. Once the claimant has satisfactorily performed the position for a period of at least 60 days, the CE should review the case to determine whether the medical evidence establishes permanent restrictions and whether the position fairly and reasonably represents the claimant's wage earning capacity. If so, the CE should prepare a formal decision making this finding. See PM Chapter 2-0814. If the position does not fairly and reasonably represent the claimant's wage earning capacity, no decision can be issued.

(b) If the claimant returns to work with a new employer and is earning less than the current pay rate of the job held when injured, the claimant has sustained a loss in wage earning capacity as a result of the injury. Once the claimant has satisfactorily performed the position for a period of at least 60 days and the medical evidence establishes permanent restrictions, the CE should prepare a formal decision addressing whether the earnings fairly and reasonably represent the claimant's wage earning capacity.

d. Determination of LWEC without actual job placement. This type of decision can be issued after the OWCP has made reasonable efforts to return the claimant to work and has advised the claimant of his or her rights and responsibilities. See PM Chapters 2-0813, 2-0814, and 2-1400.

In these cases, the claimant has been notified that the OWCP will provide vocational rehabilitation assistance leading to re-employment. The claimant is able to return to work and the file contains documentation that establishes appropriate work is reasonably available in the local labor market; therefore, benefits are adjusted to reflect any loss in wage earning capacity. The OWCP issues a decision based on the selected jobs, regardless of actual employment status.

In this instance, the CE will prepare a pre-reduction notice, addressing the claimant's loss of wage earning capacity based on a suitable position for which the claimant received training and/or placement efforts. After the notice period ends, a formal decision establishing the claimant's wage earning capacity will be issued, taking into account any evidence or arguments submitted during the notice period and compensation reduced or terminated as of the date of the final decision.

e. Application of sanctions. A claimant's failure to cooperate with the OWCP's rehabilitation and/or reemployment efforts may result in the suspension, reduction, or termination of benefits.

In these cases, the claimant has been notified of the obligation to participate in vocational rehabilitation efforts and has been provided vocational rehabilitation assistance leading to re-employment, either in the private sector or with another Federal agency. If the claimant continues not to cooperate, even after being warned of the consequences of non-cooperation, the CE should issue a formal decision and reduce or suspend compensation as of the date of the final decision. Alternatively, the CE may issue a formal decision for failure to accept suitable employment and terminate compensation as of the date of the final decision. See PM Chapters 2-0813, 2-0814, and 2-1400.

f. A finding that the claimant has no wage earning capacity or re-employment potential for the indefinite future can be made on the basis of a medical or vocational determination. If no rehabilitation plan can be developed due to the severity of the claimant's medical condition and/or the limited job market in the claimant's commuting area, the CE may determine that the claimant has no wage earning capacity. If there is no expectation of further recovery or a change in the vocational determination or medical condition, the case can be placed in PN status with the concurrence of the Supervisory Claims Examiner. See PM Chapter 2-0812. This determination, however, should not be made during the early period of disability, especially during the first 30 months, except in rare circumstances.

Chapter 2-0601, Disability Management Tracking

1. Purpose and Scope. This chapter describes the Disability Management (DM) Tracking System in the Integrated Federal Employees' Compensation System (iFECS), through which periods of disability and intervention actions associated with Case Management, Nurse Intervention and Vocational Rehabilitation are monitored. It addresses why and how a disability management record is created, managed, updated and resolved. It also addresses coding and data entry for this system and describes the relationship between the DM Tracking System and the tracking system for nurse and vocational rehabilitation activity.

Information related to the various DM components can be found in other chapters of the Federal Employees' Compensation Act (FECA) Procedure Manual (PM), as well as the Continuation of Pay (COP) Nurse Handbook, the Field Nurse Handbook and the Vocational Rehabilitation Counselor Handbook.

- a. The DM process is outlined fully in FECA PM 2-0600, Disability Management.
- b. Medical management is discussed in FECA PM 2-0810, Developing and Evaluating Medical Evidence. See also Part 3 Medical.
- c. The Nurse Program is outlined in FECA PM 2-0811, Nurse Case Management, FECA PM 3-0201, Staff Nurse Services, and Part 7 Nurse Intervention. Additional information can be found in the COP Nurse Handbook and the Field Nurse Handbook.

d. Monitoring disability claims paid on the periodic roll is discussed in FECA PM 2-0812, Periodic Review of Disability Claims.

e. The Vocational Rehabilitation Program is outlined in FECA PM 2-0813, Vocational Rehabilitation Services, Part 8 Rehabilitation, and in the Office of Workers' Compensation Programs (OWCP) PM Part 3, Rehabilitation. Additional information can be found in the Vocational Rehabilitation Counselor Handbook.

2. Introduction. OWCP is responsible for assisting injured workers with medical recovery from a work injury and facilitating a return to work as soon as practicable so that the length of disability is minimized. The processes relating to these functions are collectively known as Disability Management (see FECA PM 2-0600).

Disability Management is comprised of both the Quality Case Management (QCM) phase of a disability case, which encompasses the first 30 months of disability, as well as the Periodic Roll Management (PRM) phase, when disability continues beyond the initial 30 months. The DM Tracking System is used during both the QCM and PRM phase of a case.

The DM Tracking application is used to track the actions taken during the DM process, as well as critical return-to-work and case closure data used by the FECA Program. This system measures the duration of disability, the effectiveness of case management actions, the success of returning injured workers to employment, and case resolutions following disability which resulted from a work injury or illness.

Consistent and accurate coding in the DM Tracking System is essential for proper analysis and measurement of actions taken during the DM process.

3. DM Objectives. To measure performance, OWCP tracks disability cases and focuses on medical recovery, return to gainful employment and case resolution. These objectives are tracked and measured in several different ways, with much of the data taken directly from DM Tracking. In order to achieve the objectives of DM, it is important that timely and substantive actions/interventions are taken throughout the life of a claim. The best outcome for achieving successful DM objectives and case resolution is obtained by taking the case management actions (and entering the mandatory DM intervention codes) as described in Paragraph 6 of this Chapter.

a. Medical Recovery. Assisting the claimant in obtaining appropriate medical care and pursuing a successful treatment plan via medical management interventions is of utmost importance. There are multiple medical management interventions that can be undertaken to achieve the objective of obtaining maximum, if not complete, medical recovery. The specific strategies and interventions are discussed in more detail in PM Chapters 2-0600, 2-0810, 2-0811, 2-0812 and 2-0813.

b. Return to Work. Returning the claimant to work as soon as possible, but especially within one year of the onset of disability, is also an important objective of disability management. This one-year deadline is significant because section 8151(b) of the FECA (involving civil service restoration/retention rights which is in the jurisdiction of the Office of Personnel Management

(OPM)) requires the employing agency to offer the claimant his or her former position or its equivalent if the injury or disability has been fully overcome within one year. See PM Chapter 2-0600-11(a), which discusses retention rights in greater detail. This one-year time frame is utilized in the tracking of lost production days.

(1) QCM Lost Production Days (LPD). QCM LPDs begin to count on the date disability begins and continue to count either until the employee has returned to full-time work or until certain closure codes are entered into DM Tracking.

(a) The formula used to compute the average LPDs assumes that each employee will remain off work for the entire first year; therefore, for each employee who has not returned to work during year one, the total number of lost production days defaults to 365. When the employee returns to work, the number of LPDs for that employee is adjusted to reflect the actual number of days of disability.

(b) LPDs are calculated differently in cases where the return to work is less than full-time. If a claimant returns to part-time employment, the LPDs continue to count, but each day defaults to a partial day, as opposed to a full day.

(c) When a claimant returns to work, or some other action is taken to resolve a case within the first year of disability, the overall LPD average should drop. The sooner the return to work or case resolution, the greater the reduction in average LPDs.

c. Resolutions. The term resolution has slightly different meanings depending on the phase of the case - QCM or PRM. Paragraph 13 of this chapter discusses the various types of resolutions in more detail.

(1) QCM Resolution. The QCM resolution objective is a measurement set at 30 months from the date disability begins. Regardless of whether or not the claimant returns to work, a case will remain in the QCM universe until a resolution is reached, or the case reaches 30 months from the date disability began. In general, a QCM resolution means the claimant has returned to the full duties of his/her date of injury job or that a final decision has been reached on a case if the claimant has not returned to his/her date of injury job. Resolution examples include a termination for no continuing disability when a claimant has been released to return to his/her date of injury job and neglects to do so, a formal loss of wage-earning capacity (LWEC) decision, etc.

If the claimant remains totally disabled and/or no resolution code has been entered into the DM Tracking System by the 30-month mark, the case moves into the PRM universe if there is continued wage loss.

(2) PRM Resolution. Unlike the QCM 30 month resolution objective, there is no specific timeframe for achieving a PRM resolution in a specific case. A case will remain in the PRM universe indefinitely until a resolution is reached. The types of resolutions discussed above for QCM cases, however, also count as resolutions in PRM cases, e.g. a return to the full duties of their date of injury job, return to light duty work with a formal LWEC decision, a termination for no continuing disability, etc. There is one addition, though, for PRM cases that does not apply to

QCM. Because of the nature of PRM cases (longer term disability), a determination that there has been no change in the claimant's entitlement may also count as a resolution as long as the medical and factual evidence in the file reflect this finding; the case, however, remains in the PRM universe.

4. DM Records. A DM record should be created for each period of disability. Some cases may have more than one period of disability and, therefore, multiple records may exist throughout the life of a case, but only one DM record should be active in a particular case at one time.

In some instances, a record will be automatically created, and in other instances a record must be manually created. It is important that the Claims Examiner (CE) recognize the need to create a DM record manually so that periods of disability can be appropriately tracked and managed.

a. When to create a DM record. Tracking and management of a DM case begins early in the life of a case. Early tracking aids the CE in managing the case by providing the CE with a mechanism to record case management actions and return to work (RTW) data until a resolution is reached.

(1) Case Acceptance. A DM record should be created as soon as a case is accepted and the evidence indicates that the claimant has not returned to work as a result of the injury. A DM record can also be created at the time of acceptance if the claimant is working but is still disabled from his or her date of injury position.

(2) COP Nurse Closure. In traumatic injury cases where a COP nurse has been assigned, a COP Nurse Closure report is on file, and there is no evidence in the file reflecting a full-time RTW date, the CE should review the case for appropriate DM actions. If the claimant has not returned to work, and there is no clear imminent RTW date, a DM record should be created in an accepted case, even if the COP period has not yet expired. A DM record can also be created at the time of COP Nurse case closure and case acceptance if the claimant is working but is still disabled from his or her date of injury position.

(3) Lost Time from Work. A DM record should be created any time after acceptance of the case when the claimant is disabled from work due to the work-related condition(s).

(a) When the CE first becomes aware that the claimant is disabled from work (even if the COP period has not expired or a wage-loss claim has not yet been received).

(b) The first CA-7, Claim for Compensation, is approved for a non-intermittent period of leave without pay, and medical evidence supports continued disability from work.

(c) A recurrence of disability is accepted.

(d) If surgery is approved, the CE can ascertain the date of surgery (which would equate to disability from work). The DM record can then be created at the time of surgery, even if a CA-7 has not yet been received.

b. DM Start Dates and Track Dates. When a DM record is created, these two dates are of particular importance. The goals outlined in the preceding section track from one of these two dates; therefore, it is of the utmost importance that they be accurate.

(1) The Start Date is the date that the DM record was created. This date cannot be modified.

(2) The Track Date usually reflects the date wage loss or the period of disability began. The Track Date can be entered by the CE when a DM record is manually created. This date can be modified by those who are authorized to do so, generally at a level higher than a CE.

(a) If the claimant returns to full-time light duty work before the DM record is created, the Track Date is the same as the Start Date. LPD will not be measured in these cases, but DM performance with regard to resolution tracking will be based on the Track Date.

(b) If the claimant returns to part-time light duty work before the DM record is created, the Track Date should be the date of the part-time RTW and partial LPDs will be counted. See paragraph 2-601-3a(1) for more discussion on how LPDs are calculated.

(c) For total disability cases, LPDs begin with the Track Date and are counted as explained in paragraph 2-0601-3a(1).

(d) For a Traumatic Injury case which did not meet the eligibility requirements to become a Triage COP Case, and the claimant has not returned to full-time employment during the COP period, the DM record can still be manually created upon case acceptance. When manually creating this DM record during the COP period, the Track Date should be set to equal the Start Date. LPDs begin with the Track Date and are counted as explained in paragraph 2-0601-3a(1). Reference 2-0601-8a for explanation of eligible Triage COP Case DM records.

(e) For a Traumatic Injury case which did not meet the eligibility requirements to become a Triage COP Case, and the claimant has not returned to full-time employment during and after the expiration of the COP period, the DM record can be manually created upon case acceptance. When manually creating this DM record after the expiration of the COP period, the Track Date should be set to equal the first date of disability after the expiration of COP (day 46). LPDs begin with the Track Date and are counted as explained in paragraph 2-0601-3a(1), Reference 2-0601-8a for explanation of eligible Triage COP Case DM records.

c. Maintaining the DM Record. Once the record is created, DM Tracking allows the CE to enter information regarding disability, intervention actions, work status, and medical work restrictions. The CE is responsible for maintaining the DM record so that it accurately reflects the intervention actions taken to assist the claimant in recovery and return to work.

Each DM code and date should correspond to an intervention action or change in case status. These codes should be entered promptly when actions are taken so that the DM record reflects a history of the actions taken as the case progresses towards resolution.

Intervention codes -- including intervention actions, optional process codes, and closure codes -- should be entered on the Disability Tracking tab in the DM record in iFECS. Information about work status, job offers and suitability, and corresponding dates is entered on the Work Status Tracking tab in the DM record. When RTW information is saved, the data populates the first screen and LPDs are automatically updated, if applicable. Information about work restrictions can be entered on the third screen of the DM record to assist the CE in effectively documenting the record.

Some codes are mandatory and some codes are optional. The remaining paragraphs in this chapter discuss the coding structure in detail.

5. DM Categories. When DM codes are entered, they automatically trigger updates to the DM categories. These categories reflect the progress of a DM record from the beginning stages until resolution is reached.

If a return to work without wage loss or other resolution is not achieved during the initial 30 months of QCM disability tracking, the DM record continues to be tracked and managed in the PRM universe until a resolution can be reached. If the resolution of a QCM case involving ongoing partial disability does not trigger a closed DM record, the ongoing disability is also managed and tracked under PRM.

The DM category codes and descriptions are as follows:

QCM - Triage	A DM record is open and a COP Nurse has been assigned.
QCM - Resolved Triage	The claimant has returned to work full time within the 45-day COP period.
QCM - Open	A DM record is open and does not have a return to work date. A QCM-Triage category may be of record prior to this category, but not always.
QCM - Working Light Duty	The claimant has returned to work at less than full duty, but a loss of wage-earning capacity (LWEC) decision has not been issued.
QCM - Complete	The claimant has returned to work at full duty, or at modified duty with no loss of wage-earning capacity, a formal decision has been issued regarding the claimant's future entitlement (e.g. no injury-related disability, refusal of suitable work), or some other resolution code has been entered indicating no further entitlement to compensation (e.g. the claimant has elected retirement benefits). No further disability tracking action is necessary.
QCM - Suspended	A sanction decision (such as for failure to attend a medical examination) has been issued which suspends

	disability management actions. If the SRO code is entered, DM tracking resumes and the record reverts to the previous category code.
QCM - Removed from QCM	The DM record has been manually removed from tracking (e.g. it was created in error).
QCM - Expired	If no resolution has occurred within 30 months from the DM Track Date, the QCM record will expire.
PRM - Open	The DM record has been open 30 months or more past the DM Track Date and the claimant remains off work or is working with wage loss. The case will continue to be managed under PRM.
PRM - Working LD	The claimant has returned to work at less than full duty, but an LWEC decision has not been issued.
PRM - PN	A finding has been made that the claimant is entitled to payment on the periodic roll with no wage-earning capacity for the indefinite future (case status code PN).
PRM - LWEC	A formal loss of wage-earning capacity (LWEC) decision has been issued and the claimant is receiving payments on the periodic roll.
PRM - Suspended	A sanction decision (such as for failure to attend a medical examination) has been issued which suspends disability management actions. If the SRO code is entered, DM tracking resumes and the record reverts to the previous category code.
PRM - Remove from PRM	The DM record has been manually removed from tracking within the PRM universe of cases (e.g. it was created in error).
PRM - Complete	The claimant has returned to work full duty, returned to work with no loss in wage-earning capacity, a formal decision has been issued regarding the claimant's future entitlement (e.g. no injury-related disability, refusal of suitable work), or some other resolution code has been entered indicating no further entitlement to compensation (e.g. the claimant has elected retirement benefits). No further disability tracking action is necessary.

6. DM Codes. The DM record should be updated to reflect the actions taken to bring a DM case to resolution. Some DM codes are mandatory, while others are optional. The codes are described in more detail later in this chapter.

a. Mandatory Codes. There are six types of mandatory codes.

(1) CE Intervention Codes. These codes must be updated in the DM record whenever a CE actively intervenes, taking substantive action(s) in an effort to bring a case towards resolution. See 2-0601-7 for a detailed discussion on CE intervention codes. The following are just some situations when a mandatory CE intervention code is required:

- (a) a narrative report is requested from a physician;
- (b) a second opinion examination or referee examination has been scheduled;
- (c) a second opinion report or referee report has been received;
- (d) a second opinion or referee follow-up action has been taken;
- (e) a job offer has been requested from the employing agency;
- (f) a suitable job offer letter has been issued;
- (g) a pre-reduction or pre-termination notice has been sent;
- (h) a second opinion examination has been determined to be unnecessary at the current time;
- (i) a ten-month letter has been issued;
- (j) a conference has been completed;
- (k) valid work tolerance limitations are in file, but the claimant has not returned to work; or
- (l) valid work tolerance limitations are not in file.

(2) Codes Reflecting a Nurse or Vocational Rehabilitation Status Change. When a Field Nurse (FN) or Rehabilitation Counselor (RC) is assigned to the case, a nurse or vocational rehabilitation case has been closed, or the status of a nurse or vocational rehabilitation case has changed, the appropriate codes must be updated by the Staff Nurse (SN) or Rehabilitation Specialist (RS) via the Nurse/Rehabilitation Tracking System (NRTS). When the codes are entered into NRTS, the DM record will auto-populate with the appropriate DM code. See paragraph 2-0601-8 below for a detailed discussion of nurse intervention codes; see 2-0601-10 for a detailed discussion of vocational rehabilitation program codes.

(3) Dual Tracking Codes. During the Nurse Intervention period, the CE has the option to dual track certain cases. Dual tracking is when both a FN and a RC are assigned to a case at the same time. See paragraph 2-0601-9 for a detailed discussion of Dual Tracking codes.

(4) Return to Work (RTW) Codes. When a claimant returns to work, the appropriate RTW information should be entered via the Work Status Tracking tab in the DM record. The RTW information should document the claimant's work schedule, his or her work capacity, and the

effective date of the claimant's RTW. See paragraph 2-0601-11 for a detailed discussion of RTW codes.

(5) Closure Codes and Resolutions. Whenever a case is resolved other than through the claimant's return to the full duties of his/her date of injury job, the DM record should be updated using the appropriate closure or resolution code. See paragraph 2-0601-13 for a detailed discussion of QCM/PRM closures and resolutions.

(6) Suspension Codes. If compensation is suspended for any reason, the DM record should be updated with the appropriate suspension code. However, when the claimant satisfies his or her burden and entitlement resumes, the DM record should be reopened with the appropriate code. See paragraph 2-0601-13.

b. Optional Codes. Optional codes are not required; however, entering these codes provides a detailed explanation of the progression of a DM case and can assist the CE with management of the case. Optional codes are useful not only to clarify the past management of a case, but also to indicate what further actions may be necessary. See paragraph 2-0601-12 for a detailed discussion of optional codes.

c. RMV Code. When a DM record is created erroneously, the case must be removed from DM using code RMV. This code should only be entered by a Supervisory Claims Examiner (SCE), or higher, after concurring that the case should be removed from DM tracking. Sufficient explanation should be given in the record to explain the reason for the removal. This explanation may be documented by updating the notes section in DM Tracking. Valid DM cases should not be removed from DM via the RMV code.

Note - In some situations, the RMV code is automatically populated based on other codes that are entered.

7. CE Intervention Codes. Codes should be updated in the DM record whenever a CE actively intervenes in an effort to bring a case towards resolution. The following mandatory codes should be entered into DM Tracking by the CE:

a. CON (Conference Completed). This code should be used for both formal and informal conferences, but it should only be used when the conference pertains to the DM aspects of the case, e.g. this code should not be added to DM Tracking if a conference was held with regard to an overpayment. The effective date of the status is the date of the conference.

b. JOL (Suitable Job Offer Letter Issued). JOL can be entered when the Office sends the job offer suitability determination to the claimant. The code can be used for both the 30-day letter and the 15-day letter. This code is useful for alerting the CE that a follow-up action is necessary so that a final decision can be reached.

c. JOR (Job Offer Request / Work Restrictions to EA). JOR can be entered when the CE solicits a job offer from the EA. This code is useful for alerting the CE that a follow-up action may be

necessary. The effective date of code JOR should be the date that the job offer is actually requested.

d. MSC (Second Opinion Report Received). MSC can be entered when the CE receives a second opinion examination report. It is useful to alert the CE that a follow-up action may be necessary. The effective date of the MSC code should be the date the report is received.

e. MSI (Second Opinion Scheduled). The effective date of the status is defined as the date of the second opinion examination (a date in the future is allowed). This code should not be entered when a case is referred for a second opinion evaluation; rather, it should be entered once the appointment date has been set.

f. MSF (Second Opinion Follow-up Taken). MSF can be entered when the CE follows up with the second opinion examiner after receiving a second opinion examination report. This code is useful for alerting the CE to follow up if the information requested is not received in a timely fashion. The effective date of code MSF should be the date the follow-up action is taken.

g. MSN (Second Opinion not Necessary per SCE). MSN should be entered when the Supervisory Claims Examiner (SCE) concurs that a second opinion medical examination in a total disability case is not necessary at that time. The code should only be used in cases where a second opinion examination would not assist with the medical management or resolution of the case, such as when severe/catastrophic injuries are still being actively and appropriately treated or a recent surgery has been performed and the claimant is still in the initial recovery period.

The fact that a claimant is released to limited duty and/or is participating in Vocational Rehabilitation is not in itself a valid reason to use the MSN code. To use the code in such cases, the file should reflect that there are no pending issues related to (1) continuing causal relationship of the condition(s) to the work injury/illness, or (2) whether the claimant could return to full duty.

The code may not be entered until at least ten months have elapsed since the Track Date, and a memorandum to file signed by the SCE is required to explain the use of code MSN. The effective date of this code is the date of the signed memorandum.

h. MRI (Referee Exam Scheduled). The effective date of the status is defined as the date of the referee examination (a date in the future is allowed). This code should not be entered when a case is referred for a referee evaluation; rather, it should be entered once the appointment date has been set.

i. MRC (Referee Report Received). MRC can be entered when the CE receives a referee examination report. It may be useful to alert the CE that a follow-up action may be necessary. The effective date of the MRC code should be the date the report is received.

j. MRF (Referee Follow-up Taken). MRF can be entered when the CE follows up with the referee examiner after receiving a referee examination report. This code can be used to alert the

CE to follow up if the information requested is not received in a timely fashion. The effective date of code MRF should be the date the follow-up action is taken.

k. OIC (Other Intervention by CE). Used when the CE contacts the claimant or Employing Agency (EA) to discuss a RTW date and/or the availability of limited duty once work limitations and a release to work have been obtained. This code may be used more than once in a given DM record, but it may not be used when the conversation concerns bill payment, compensation payment, or other case issues not specific to disability management. The OIC intervention should be focused on RTW. The effective date of the status is the date of the letter or telephone conversation. It may be used in the following instances:

(1) The CE contacts the claimant to specifically discuss return to work issues. Topics would include the anticipated return to work date (for either regular or light duty); the current work limitations and, if applicable, why they preclude any work at all, or preclude a return to the claimant's regular job; and whether the claimant has contacted the employer about the availability of light duty. This type of contact will usually occur by telephone and should be documented in the file via a CA-110 (or equivalent). The conversation should be substantive and serve to remind the claimant of his or her responsibility to return to work.

(2) The CE contacts the EA to discuss the most recent work limitations/release to work and the availability of light duty, or to solicit a job offer. Once the claimant has been released to work, the description of work limitations should be available on the date of the contact. If the use of OIC is based on a telephone call, the CE should fully document the conversation in a CA-110 (or equivalent).

l. PRL (Pre-reduction notice sent). PRL can be entered when a proposed notice of reduction is sent to the claimant. This code is useful for alerting the CE that a follow-up action is necessary so that a final decision can be reached.

m. PTL (Pre-termination notice sent). PTL can be entered when a proposed notice of termination is sent to the claimant. This code is useful for alerting the CE that a follow-up action is necessary so that a final decision can be reached.

n. QAP (Narrative Report Requested from Physician). Used when the CE poses written questions to the attending physician about the extent and duration of disability, work tolerance limitations or the claimant's ability to work, current treatment plan to facilitate medical recovery, etc. The effective date of the status is the date of the letter.

o. SRO (Suspension Reopened). If the claimant's compensation has been suspended for obstruction of the rehabilitation effort (SUC), obstruction of a medical examination (SUM), or failure to return Form CA-1032 (SUE), and compensation is later reinstated, code SRO is required. The effective date of the status is the date that compensation was reinstated.

p. TTD (Continuing Total Disability per Secop/Referee). TTD should generally be entered only after a second opinion or referee examination report substantiates that the claimant is temporarily totally disabled due to his or her accepted work injury and the condition is not expected to

improve within the foreseeable future. However, in rare instances, it may be used following an extremely thorough and well-rationalized medical report from an attending physician or when a case is considered catastrophic in nature. This code should be documented with a memorandum to file countersigned by a Supervisory Claims Examiner or higher authority. The effective date of this code is the date of the signed memorandum.

q. WTL (Valid WTLs in File-No RTW). An employee that is unable to return to his/her date of injury job because of disability may instead return to alternative employment once current and well-defined work tolerance limitations, or work restrictions, have been obtained. Note, however, that these work restrictions do not have to be considered permanent in nature (i.e. they may be considered temporary in nature and necessary only during the claimant's period of medical recovery and rehabilitation). This code is required when valid work restrictions for all conditions have been obtained but the claimant has not yet returned to work. "All conditions" include those which have been accepted in the current claim as well as any other accepted conditions in other case files, conditions which pre-existed the injury, and conditions which arose after the injury.

There are two options for entry of the WTL code in the DM record:

(1) Manual Entry by the CE. The effective date of the status is the date of the most recent medical work release outlining the necessary work restrictions.

(2) Auto-Population from the response provided in the Periodic Entitlement Review (PER) record. If the CE answers "Yes" to the PER question "Valid work restrictions in file for all conditions?", the PER will then require entry of the date of the most recent medical work release outlining the necessary work restrictions. After entry of this information in the PER record, the DM record will auto-populate the WTL code in the DM record. The effective date of the status will auto-populate with the date entered in the PER record (i.e. the date of the most recent medical work release outlining the necessary work restrictions). The pertinent question in the PER will only activate for cases in a PR or PN status since cases in a PW status already have a determined wage-earning capacity.

NOTE: Entry of either the WTL or WTX code (see below) can be made and updated at any time during the life of a DM case/record, but it is mandatory upon Field Nurse closure when a claimant has not returned to work (via CE manually entry) and when completing a PER record for any case with a status of PR or PN (via auto-population). However, for optimal case management, the CE should also update the DM record with a WTL or WTX code whenever the claimant's ability to work changes, not just at the time of nurse closure and during the annual PER review.

r. WTX (Valid WTLs not in File). If the claimant has not been released to work and remains totally disabled from reemployment, code WTX is required. This code is also required when a claimant who previously had been given a work release, but had not returned to work, is no longer released to work due to an increased disability or when the work tolerance limitations have changed such that they are no longer considered valid (in these situations, the WTX code can be entered in the DM record subsequent to the previously entered WTL code – the previously entered WTL code should not be deleted from the DM record).

There are two options for entry of the WTX code in the DM record:

(1) Manual Entry by the CE. The effective date of the status is the date the CE determines that valid work restrictions are not in file for all conditions. As noted above, for optimal case management, the CE should also update the DM record with a WTL or WTX code whenever the claimant's ability to work changes, not just at the time of nurse closure and during the annual PER review. However, if a WTX code has already been entered into the DM record, there is no need for a subsequent manual WTX code entry unless there was a release to work (and entry of the WTL code) in the interim.

(2) Auto-Population from the response provided in the PER record. If the CE answers "No" to the PER question "Valid work restrictions in file for all conditions?", the PER will auto-populate the WTX code in the DM record. The effective date of the status will auto-populate with the date of the PER record closure.

8. Nurse Intervention Codes. Nurse intervention codes are used to document actions throughout the Nurse Intervention phase of DM. These codes document actions with regard to both the COP Nurse and the Field Nurse. The following are the mandatory codes pertaining to Nurse Intervention. Some are automatic and others must be entered manually.

a. COP Nurce (CN) Codes.

(1) NCP (Referred to COP nurse). This code is auto-populated from the date of assignment of the COP Nurse in NRTS.

(2) TCC (Triage COP Case). New traumatic injury claims are eligible for assignment to a COP Nurse seven (7) days after the claimant stops work (based on the data contained on the CA-1). If a return to work date has been entered into iFECS prior to assignment of a CN, the case will not be eligible for assignment. For eligible cases though, the TCC code is auto-populated using the "current" date to create an open DM record in the system. No LPD count during this period.

(3) TCQ (QCM - Triage to QCM - Open). Once 45 days from the date of injury have elapsed, if no return to work full-time code has been entered in DM Tracking, the status code TCQ is auto-populated via a nightly run and the category changes to QCM - Open. The Start date and Track date are populated with the date the record is changed to QCM Open, and LPDs start to count. If the claimant has returned to part-time work, the category changes to QCM-Working LD and LPDs count partial days.

(4) TRC (Closed - Triage case with Full Time RTW during COP). If a full-time return to work date is entered in the DM record within 45 days of the date of injury, code TRC is auto-populated and the category is changed to QCM - Resolved Triage. Additional codes are not allowed after entry of TRC; therefore, if the CE wishes to track a full-time light duty return to work and assign a FN, a new DM record will need to be manually created. No LPD count in these cases and they are not considered as resolutions for QCM. Return to work activity and success during the COP Nurse phase of a case is assessed based primarily on the coding in NRTS.

b. Field Nurse (FN) Codes.

(1) NSN (Referred to Staff Nurse). The date the CE completes the referral to the Staff Nurse (SN). This code auto-populates to the DM record when the referral is completed in the Case Referral application in iFECS.

(2) NFN (Referred to Field Nurse). The date the SN makes the assignment to the FN. This code is auto-populated from the SN's assignment action made in NRTS.

(3) NF3 (30-Day Nurse Extension Granted). If the claimant has not returned to work in a full-duty capacity and there is something specific the FN can do within 30 days to further the return to work effort, the CE can extend nurse services for 30 days. There must be a clear indication that FN services would be useful for a specific purpose, and the case record must clearly document that purpose and that direction has been provided to the FN. After 30 days, if an additional extension is needed, the same justification and documentation are necessary to approve an additional 30-day extension.

No justification for a 30-day extension is needed if the claimant has returned to work and the extension is for monitoring that effort (60 days for light duty and 30 days for full duty); however, the extension coding should still be entered in the DM record. Refer to FECA PM 2-0811-10 for additional details about granting extensions during the FN assignment period.

(4) NF6 (60 Day Extension Granted). Just as with the 30-day extension, if the claimant has not returned to work in a full-duty capacity and there is something specific the FN can do within the next 60 days to further the return to work efforts, the CE can extend nursing services for 60 days. There must be a clear indication that FN services would be useful for a specific purpose, and the case record must clearly document that that purpose and that direction has been provided to the FN.

No justification for a 60-day extension is needed if the claimant has returned to work and the extension is for monitoring that effort (60 days for light duty); however, the extension coding should still be entered in the DM record. Refer to FECA PM 2-0811-10 for additional details about granting extensions during the FN assignment period.

(5) NCO (Nurse Case Closed). The initial nurse assignment is 120 days, regardless of whether the claimant has returned to light-duty work or not. A shorter assignment may be considered if the claimant has already returned to light-duty work. The initial assignment period can be extended consistent with the guidance provided in FECA PM 2-0811-10. Supervisory approval is necessary for extensions past 180 days unless the claimant returns to work during an initial extension period and the return to work monitoring period (60 days for light duty and 30 days for full duty) will exceed the 180 days. When FN intervention has ended, though, the NCO code is required. This code is auto-populated from the SN's closure action in NRTS.

9. Dual Tracking Codes. During the Nurse Intervention period, the CE has the option to dual track certain cases. Dual tracking is when both a FN and RC are assigned to a case at the

same time. Refer to FECA PM Chapter 2-0600-8, 2-0600-9, 2-0811-11 and 2-0813-5. Both dual tracking codes are mandatory, and both must be entered manually by the CE.

a. DTO (Dual Track Opened). This code is entered when it is determined that a case would benefit from dual tracking with a FN and a RC on the case at the same time. Since a FN will already be assigned to the case when dual tracking is initiated, code DTO should be entered when the RC is also assigned to the case.

b. DTC (Dual Track Closed). This code is entered when dual tracking is no longer needed. If the case is closed for Nurse Intervention, but the RC remains on the case, the DTC code should be entered when the FN is closed. If the RC is closed, but the FN remains on the case, the DTC code should be entered when the RC is closed.

Note - If the claimant returns to work as a result of dual track intervention, the RTW code (discussed later in this chapter) must be entered prior to the DTC.

10. Vocational Rehabilitation Intervention Codes. A few codes are manually entered by the CE in DM to reflect vocational rehabilitation actions. However, most codes relating to vocational rehabilitation efforts are auto-populated into DM by coding entered by the RS in the NRTS application. The following are the mandatory codes pertaining to Vocational Rehabilitation.

a. Rehabilitation Referral Codes.

(1) RHR (Referred to Rehabilitation Specialist). This code is auto-populated into DM the date the CE completes the Vocational Rehabilitation referral in the Case Referral application in iFECS.

(2) RRC (Referred to Rehabilitation Counselor). This code is triggered by the date the RS makes the assignment to the RC. This code is auto-populated from the RS's assignment action in NRTS.

b. Plan Development Codes.

(1) RHD (Plan Development). When code D is entered into NRTS, status code RHD is populated into DM.

(2) RHI (Rehabilitation Plan in Place). When code I is entered into NRTS, status code RHI is populated into DM. In addition, an iFECS reminder is sent to the CE to send a letter advising the claimant of the eventual reduction of compensation as the result of rehabilitation efforts.

(3) RLT (Eventual Reduction via Rehabilitation - letter sent by CE). This code is manually entered into DM by the CE when the appropriate letter is issued to the claimant.

c. Placement Previous Employer Codes.

(1) RHN (Placement Previous Employer - Without Other Services). When code N is entered into NRTS, status code RHN is populated into DM.

(2) RHW (Placement Previous Employer - With Other Services). When code W is entered into NRTS, status code RHW is populated into DM.

d. Training and Placement New Employer Codes.

(1) RHT (In Approved OWCP Vocational Training). When code T is entered into NRTS, status code RHT is populated into DM. This code does count as a QCM resolution.

(2) RHP (Placement New Employer). When code P is entered into NRTS, status code RHP is populated into DM.

(3) RHS (Self-Employment). When code S is entered into NRTS, status code RHS is populated into DM.

e. Assisted Re-employment Codes.

(1) RHG (Assisted Re-employment Program). When code G is entered into NRTS, status code RHG is populated into DM.

(2) RHV (Employed, Assisted Re-employment Program; RC Follow-Up). When code V is entered into NRTS, status code RHV is populated into DM.

f. Employment Codes.

(1) RHE (Employed). When code E is entered into NRTS, status code RHE is populated into DM. (The CE will still need to enter the RTW information in the Work Status tracking tab in the DM record.)

(2) RHZ (Post-Employment Services). When code Z is entered into NRTS, status code RHZ is populated into DM.

g. Codes related to Medical Issues and Interruption of Services.

(1) RHM (Medical Rehabilitation). When code M is entered into NRTS, status code RHM is populated into DM.

(2) RHX (Vocational Rehabilitation Services Interrupted). When code X is entered into NRTS, status code RHX is populated into DM.

h. Closure and Suspension Codes.

(1) RCL (Rehabilitation case closed with no RTW). When the rehabilitation case is closed with code 5 in NRTS, status code RCL is populated into DM.

(2) RHC (Returned to Claims Examiner). When code C is entered into NRTS, status code RHC is populated into DM.

(3) RWL (Rehabilitation non-cooperation 30-day warning letter). This code is manually entered into DM by the CE effective the date the letter is issued.

i. Schedule A Initiative Codes. The Program's initiative to utilize the Schedule A non-competitive hiring authority to help rehire injured federal workers back into the federal government occurs during vocational rehabilitation. Codes related to the Schedule A Initiative must be entered into NRTS by the RS and then, upon notification, the CE manually enters the appropriate code in DM, as described below.

(1) SCI (Schedule A Identified). When the RS identifies a claimant who may be a suitable candidate for Schedule A placement, he or she will make a referral to the Schedule A RS for review. The RS will then code the case in RTS as AI (Schedule A Identified) and notify the CE so that SCI can be added to DM.

(2) SCC (Schedule A Certified). When a claimant wishes to participate in Schedule A placement services, in addition to the usual rehabilitation placement services for a job in the private sector, the Schedule A RS prepares a disability certification letter and enters code AC into NRTS and notifies the CE so that SCC can be added to DM.

(3) SCR (Schedule A Rejected). When a claimant is not a good candidate for Schedule A placement services the Schedule A RS enters code AR into NRTS and notifies the CE so that SCR can be added to DM.

(4) SCD (Schedule A Services Declined). When a claimant indicates that he or she does not want to proceed with Schedule A placement services, the RS enters code AD into NRTS and notifies the CE so that SCD can be added to DM.

(5) SCW (Schedule A RTW). When the claimant returns to work via the Schedule A hiring authority and the case record is documented with the specifics of the RTW, the RS enters code AW into NRTS and alerts the CE so that SCW can be added to DM. Note - Along with the Schedule A disposition code, the RS enters the usual NRTS codes to document the RTW. The CE then enters the usual RTW codes in DM to appropriately reflect the RTW via rehabilitation and to change the DM category. See paragraph 2-0601-11 for a discussion of updating RTW codes.

(6) SCO (Schedule A RTW Other). When the claimant returns to work without the use of the Schedule A hiring authority (after having been Schedule A Certified - SCC) and the case record is documented with the specifics of the RTW, the RS enters code AO into NRTS and alerts the CE so that SCO can be added to DM. Along with the Schedule A disposition code, the RS enters the usual NRTS codes to document the RTW. The CE enters the usual RTW codes in DM to appropriately reflect the RTW via rehabilitation and to change the DM category. See paragraph 2-0601-11 for a discussion of updating RTW codes.

(7) SCN (Schedule A Closed - No RTW). When the vocational rehabilitation placement period ends for a case in which the claimant was Schedule A certified (SCC) and there was no RTW, the RS enters code AN into NRTS and notifies the CE so that SCN can be added to DM.

11. Return to Work (RTW) Codes. RTW codes are used to indicate a return to work during DM. All RTW codes are mandatory. In order to use RTW codes, the claimant must actually return to work; a release to return to work without an actual return to work is not sufficient for use of RTW codes.

These codes should be entered in the DM Work Status Tracking tab. Although RTW codes may be manually entered in DM Tracking by adding the specific status, this method of entering the code may not result in the proper tracking of LPD and should not be used. The specific hours and days worked should be entered on the Work Status Tracking tab, and the source should be identified as the CE, the FN, or the RC.

Any additional information regarding the job offer can also be entered on the Work Status Tracking tab. Information regarding the job offer, salary, the claimant's response, the suitability determination, the claimant's response to the suitability decision, and the CE's decision should be entered as appropriate.

The following are brief descriptions of each RTW code and the process for entering the codes in the DM record. Refer to FECA PM 2-0600 for additional details regarding case management actions surrounding a RTW.

a. Pre-DM RTW Codes.

(1) PFP (Pre-DM RTW Full Duty/Part-Time). Used when the claimant returns to full-duty work on a part-time basis before the DM record is created. This code begins counting LPDs at a fraction.

(2) PLF (Pre-DM RTW Light Duty/Full Time without wage loss). Used when the claimant returns to full-time light duty work before the DM record is created. This code prevents LPDs from counting.

(3) PLP (Pre-DM RTW Light Duty/Part Time). Used when the claimant returns to light duty part-time work before the DM record is created. This code begins counting LPDs at a fraction.

(4) PL\$ (Pre-DM RTW Light Duty/Full Time with wage loss). Used when the claimant returns to full-time, light-duty work with wage loss before the DM record is created. This code prevents LPDs from counting.

b. Nurse RTW Codes.

(1) NFF (RTW via Nurse DOI or pre-established LWEC Job). Used when the claimant returns to work at the date of injury or pre-established LWEC position via nurse services. This RTW code

stops counting LPDs. This type of RTW is also considered a closure code and a QCM/PRM resolution. No further codes can be entered after this RTW code.

(2) NFP (RTW via Nurse Full Duty/Part Time). Used when the claimant returns to part-time, full-duty work via nurse intervention. This code starts counting LPDs at a fraction.

(3) NLF (RTW via Nurse Light Duty/Full Time without wage loss). Used when the claimant returns to full-time, light-duty work via nurse services. This code stops counting LPDs.

(4) NLP (RTW via Nurse Light Duty /Part Time). Used when the claimant returns to part-time, light-duty work via nurse intervention. This code may also be used in cases that already have a PLP code, but only if the work hours actually increase due to intervention by the nurse. This code causes LPDs to be counted at a fraction.

(5) NL\$ (RTW via Nurse Light Duty/Full-Time with Wage loss). Used when the claimant returns to full-time, light-duty work with wage loss via nurse services. This code stops counting LPDs.

c. Vocational Rehabilitation RTW Codes.

(1) RFF (RTW via Rehab DOI or pre-established LWEC Job). Used when the claimant returns to work at the date of injury or pre-established LWEC position via rehabilitation services. This RTW code stops counting LPDs. This type of RTW is also considered a closure code and a QCM/PRM resolution. No further codes can be entered after this RTW code.

(2) RFP (RTW via Rehab Full Duty/Part Time). Used when the claimant returns to part-time, full-duty work via rehabilitation services. This code starts counting LPDs at a fraction.

(3) RLF (RTW via Rehab Light Duty/Full Time without wage loss). Used when the claimant returns to full-time, light-duty work via rehabilitation services. This code stops counting LPDs.

(4) RLP (RTW via Rehab Light Duty/Part Time). Used when the claimant returns to part-time, light-duty work via rehabilitation services. This code may also be used in cases that already have a PLP code, but only if the work hours actually increase due to intervention by the RC. This code starts counting LPDs at a fraction.

(5) RL\$ (RTW via Rehab Light Duty/Full Time with Wage Loss). Used when the claimant returns to full-time, light-duty work with wage loss via rehabilitation services. This code stops counting LPDs.

d. DM RTW Codes without Nurse Intervention or Vocational Rehabilitation. To use these codes, the CE's intervention should be readily identifiable, and these codes should only be used if a FN or RC is not assigned at the time of the RTW.

(1) CFF (RTW via CE DOI or Pre-established LWEC Job). Used when the claimant returns to work at the date of injury or pre-established LWEC position with CE intervention. This RTW

code stops counting LPDs. This type of RTW is also considered a closure code and a QCM/PRM resolution if there are prior DM intervention codes. No further codes can be entered after this return to work code.

(2) CFP (RTW via CE Full Duty/ Part Time). Used when the claimant returns to full-duty work on a part-time basis with CE intervention. This code starts counting LPDs at a fraction.

(3) CLF (RTW via CE Light Duty/Full Time without wage loss). Used when the claimant returns to light-duty work on a full-time basis with CE intervention. This code stops counting LPDs.

(4) CLP (RTW via CE Light Duty/Part Time). Used when the claimant returns to part-time work with CE intervention. This code may also be used in cases where a PLP code is already used, but only if the work hours actually increase through the CE's intervention. This code begins counting LPDs at a fraction.

(5) CL\$ (RTW via CE Light Duty/Full Time with Wage Loss). Used when the claimant returns to light duty on a full-time basis with wage loss with CE intervention. This code stops counting LPDs.

(6) CPS (RTW via CE in the Private Sector). Used when a claimant returns to work in the private sector with CE intervention. This code stops counting LPDs.

12. Optional Codes. Optional codes provide a detailed explanation of the progression of a DM case. Optional codes are useful not only to clarify the past management of a case, but to help decide what further actions may be necessary to bring a case to resolution. These codes cannot be entered as a substitute for mandatory intervention codes. Optional codes should be used in conjunction with the mandatory codes to fully document the management of a case. Below is a list of optional codes and an explanation of their use. All of these codes must be manually entered into the DM tracking system.

a. ADO (Agency Declined to Offer Modified Job). ADO can be entered if the claimant has been released to return to modified work duties, but the EA has declined to offer a modified job or work accommodations. The effective date of code ADO should be the date that confirmation was obtained from the EA (via CA-110 or other form of correspondence) that work was not available to accommodate the claimant's work restrictions.

b. DMA (DMA referral complete). DMA can be entered once the referral documents have been completed and forwarded to the District Medical Advisor. However, since this code is to be used for the purpose of managing Disability Management cases, the DMA code should only be entered for those referrals directly related to disability management activities such as surgery requests, case expansion considerations or other issues having direct impact on medical recovery and return to work issues. The DMA code should not be entered for Schedule Award referrals. The effective date of code DMA should coincide with the date of the DMA referral document(s).

c. IAE (Interim Actual Earnings). IAE can be entered if the claimant is being paid for an LWEC based upon actual earnings, but a formal decision has not been issued. This code is useful for

alerting the CE to review the case for a possible formal decision regarding an LWEC. The effective date of code IAE should be the date the first LWEC payment is certified.

d. JOB (Job Offer Made). JOB can be entered when a job offer is made to the claimant. This code is useful for alerting the CE that a follow-up action may be necessary, such as determining the suitability of the job offer. The effective date of code JOB should be the date that the job is actually offered to the claimant.

e. JON (Job Offer not Suitable). JON can be entered after a formal job offer has been determined to be unsuitable (reference PM 2-0814 for more information concerning the requirements of job offers). The effective date of code JON should be the date of the written correspondence to the claimant and EA advising them of the determination and the reason(s) for such determination.

f. JOW (Job Offer Withdrawn). JOW can be entered when a job offer is withdrawn from the claimant. This code is useful for alerting the CE that further intervention is necessary. The effective date of code JOW should be the date the job offer was actually withdrawn.

g. MDN (Medical Development Needed). MDN can be entered if the CE determines that additional development of a particular medical issue may be warranted. This code is not appropriate for QCM cases, but it may be useful for managing PRM cases identified during Periodic Entitlement Reviews as needing further action.

h. MIN (Medical Interruption of DM Activity). MIN can be entered if there is a non-work-related medical condition that is delaying the disability management of a case. This code is useful to document when there are non-work-related medical issues that prevent active intervention in a case, and to alert the CE to frequently review the medical evidence in the case. The effective date of code MIN should be the date the CE determines that disability management must be delayed.

i. MNR (Narrative Report Received). MNR can be entered if a narrative medical report is received from the claimant's attending physician that provides substantial information regarding the claim. This code may only be used when a narrative report is submitted in response to a request from OWCP (after the entry of the QAP code) and the CE has reviewed this medical evidence. The narrative report should answer the questions posed by the CE in the QAP letter. MNR may not be used to notate the coincidental receipt of a periodic medical report, routine treatment notes, etc. The effective date of code MNR should be the date the specific narrative report is received.

j. MRR (Referred to Scheduler for Referee). MRR can be entered when referee medical examination referral documents have been forwarded to the scheduler. The effective date of the MRR code should be the date of the referral document(s).

k. MSR (Referred to Scheduler for Second Opinion). MSR can be entered when second opinion medical examination referral documents have been forwarded to the scheduler. The effective date of the MSR code should be the date of the referral document(s).

l. NIC (Nurse Intervention via CE). NIC can be entered when the CE contacts the Field Nurse (FN) and directs the FN on further case actions. The code may be used when the CE initiates the contact and provides specific case management instructions. A general discussion of the case and/or an update from the FN is not sufficient for use of this code. This CE action must be documented in the file. The effective date of the NIC code should be the date of the documentation.

m. OPM (Elected OPM benefits). OPM can be entered if the claimant has elected Office of Personnel Management (OPM) benefits. The effective date of code OPM should be the effective date of the OPM election. Note - Code CSB will be needed to actually close out the DM record once appropriate case management actions have been completed.

n. PRX (Pre-reduction cannot be finalized). PRX can be entered after a proposed notice of reduction has been sent to the claimant (see PRL code above) and subsequent evidence or argument is received which hinders the CE from proceeding with a final notice of reduction. The effective date of code PRX should be the date of the notification sent to the claimant advising him/her of the determination to discontinue with the proposed reduction.

o. PTX (Pre-termination cannot be finalized). PTX can be entered after a proposed notice of termination has been sent to the claimant (see PTL code above) and subsequent evidence or argument is received which hinders the CE from proceeding with a final notice of termination. The effective date of code PTX should be the date of the notification sent to the claimant advising him/her of the determination to discontinue with the proposed termination.

p. RIC (Rehabilitation Intervention via CE). RIC can be entered when the CE contacts the Rehabilitation Counselor (RC) and directs the RC on further case actions. This code may be used when the CE initiates the contact and provides specific case management instructions. A general discussion of the case and/or an update from the RC is not sufficient for use of this code. This CE action must be documented in the file. The effective date of code RIC should be the date of the documentation.

q. SUR (Surgery Authorized). SUR can be entered when the claimant has approved surgery. This code is useful for alerting the CE to re-evaluate the disability management options for this case. The effective date of code SUR should be the date the surgery is performed. If the surgery is scheduled for a date in the future, entry of this future date is allowed.

r. TRL (Transfer of case). TRL can be entered to denote a transfer of a case file from one Office to another. The TRL code can be entered by the receiving Office effective the date it received the transferred case.

13. Closure Codes and Resolutions. Certain DM status codes when entered into DM Tracking serve to close the period of disability being tracked. These closure codes may reflect the claimant's return to full-duty work, a return to modified work with a formal LWEC decision, a termination for no continuing disability or failure to accept suitable employment, a recurrence, or election of other benefits. There should always be documentation in the file to support the closure code used and its effective date.

Some codes are considered successful resolutions for both QCM and PRM, while some outcomes are only considered a resolution for QCM cases and others only a resolution for PRM. Note below where those distinctions have been made, showing whether a particular code is considered a resolution for QCM only, PRM only, or both QCM and PRM. Resolution of DM cases is discussed further in FECA PM 2-0600. Further discussion of PRM resolutions can be found in FECA PM 2-0812.

a. RTW to Date of Injury or Pre-Established LWEC Job. The effective date of the code is the actual RTW date. In order to use these codes, the claimant must actually return to work; a release to return to work without an actual return to work is not sufficient for use of these codes. These closure codes will count as a QCM or PRM resolution, though NFF would be rarely seen in a PRM case.

(1) CFF (RTW via CE DOI or pre-established LWEC Job). Used when the claimant returns to work at the date of injury or pre-established LWEC position without nurse intervention or vocational rehabilitation (services closed when the return to work occurs). Prior CE DM intervention coding is required.

(2) NFF (RTW via Nurse DOI or pre-established LWEC Job). Used when the claimant returns to work at the date of injury or pre-established LWEC position via nurse services.

(3) RFF (RTW via Rehab DOI or pre-established LWEC Job). Used when the claimant returns to work at the date of injury or pre-established LWEC position via rehabilitation services.

b. RTW to a modified or new job with LWEC decision. If the claimant returns to work in less than a full-duty capacity, entry of the RTW code will stop the LPDs from counting (or counting fully in part-time RTW cases) if the return to work occurs within the first year of disability. The record will remain open, however, until an appropriate resolution code is entered. This typically requires issuing a formal LWEC decision. The effective date of these LWEC-related closure and/or resolution codes will be the date of the LWEC decision issued. These closure codes will count as a QCM or PRM resolution.

(1) CAE (RTW, actual Earnings LWEC). This code should be used when the claimant has permanent or stable and well defined work restrictions stemming from the work injury, has returned to a new position or modified version of the date of injury position, and OWCP has issued a formal LWEC decision based on the claimant's actual earnings, with wage loss. While this code is considered a resolution for both QCM and PRM cases, if entered in the QCM period the DM category changes to PRM – LWEC and the case remains active in the PRM universe, since the claimant is still receiving monetary compensation.

(2) CNL (RTW, not DOI job with 0% LWEC Decision). This code should be used when the claimant has permanent or stable and well-defined work restrictions stemming from the work injury, has returned to a new position or modified version of the date of injury position, and OWCP has issued a formal LWEC decision based on no wage loss.

(3) CCL (LWEC Modification-Cost Savings). This code should be used when a previous formal LWEC decision was modified resulting in the issuance of a new formal LWEC decision with a greater wage-earning capacity and less wage loss. While this code is considered a resolution for PRM cases, it is not a closure code and the PRM case will remain in the DM category of PRM-LWEC since the claimant is still receiving monetary compensation.

c. RTW in a temporary assignment where a formal LWEC decision cannot be issued. There may be occasions when the EA is only able to provide a temporary light duty assignment to the claimant even though the claimant held a permanent job at the time of injury.

(1) CNC (RTW in non-classified position). This code is used if the claimant's work restrictions have reached a stable and well-defined state, the claimant has returned to a full-time light duty work assignment with no wage loss, and a formal LWEC decision cannot be issued due to the work assignment being a non-classified and/or temporary position.

As the effort to obtain a permanent job offer should not be abandoned prematurely, the CNC code should usually not be entered earlier than 2 years from the Track Date unless extenuating circumstances exist or the Employing Agency provides a written statement that it will be unable to provide a permanent and/or classified position. A memorandum to file is required to explain the use of the CNC code for the specific case.

The effective date of the CNC code is the date of the memorandum, and this code is considered a resolution in both QCM and PRM cases. Since entry of this code closes the QCM or PRM record, it should not be entered if the claimant has continued wage loss and is receiving benefits on the periodic roll. See code TNW below for further explanation.

(2) TNW (RTW temp LD w/wage loss-10.500). This code is used if a formal LWEC decision cannot be issued, but the claimant is receiving wage loss compensation on the periodic roll based upon his/her actual earnings. Similar to a CNC case, the claimant's work restrictions have reached a stable and well-defined state and the EA is providing a consistent light duty work assignment in a non-classified position and/or a position that is temporary in nature. However, unlike a CNC case, the claimant's employment is either less than full-time or full-time with lower wages than what the claimant earned in his/her date of injury job.

As the effort to obtain a ratable job offer should not be abandoned prematurely, the TNW code should usually not be entered earlier than 2 years from the Track Date unless extenuating circumstances exist or the Employing Agency provides a written statement that it will be unable to provide a permanent and/or classified position. A memorandum to file is required to explain the use of the TNW code for the specific case.

The effective date of this code is the date of the memorandum, and it counts as a QCM resolution once 30 months have elapsed. At that point, the DM Category changes from QCM-Working Light Duty to PRM-Working LD and the case remains active in the PRM universe (since the claimant is still receiving wage loss compensation on the periodic roll).

d. No actual RTW, but medically able to RTW. Compensation entitlement is reduced.

(1) TNX (Comp reduced/declined temp LD-10.500). This code should be used when the claimant's entitlement to wage loss compensation is reduced as a result of declining a temporary light duty assignment. For example, there may be occasions when the EA is only able to provide a temporary light duty assignment that is either less than full-time or full-time with lower wages than what the claimant earned in his/her date of injury job. This can occur even though the claimant held a permanent job at the time of injury. If the claimant declines the temporary assignment, the penalty language of Section 8106(c) cannot be applied. However, the claimant is expected to return to appropriate work when it is provided and declining an appropriate temporary light duty assignment may result in a reduction of wage loss compensation (if the assignment is either less than full-time or full-time with lower wages than what the claimant earned in his/her date of injury job). (Reference PM 2-0814-9 for details regarding temporary assignments as they relate to 20 CFR §10.500.)

The TNX code should be used when a claimant is provided a temporary light duty assignment that is either less than full-time or full-time with lower wages than what the claimant earned in his/her date of injury job; the temporary assignment appropriately accommodates the claimant's medically-imposed work restrictions; and the claimant declines the assignment. A formal decision is issued reducing the claimant's entitlement to wage loss compensation. The effective date of the TNX code is the date of the final decision, and it counts as a QCM resolution once 30 months have elapsed. At that point, the DM Category changes from QCM-Open to PRM-Open and the case remains active in the PRM universe (since the claimant is still receiving wage loss compensation on the periodic roll).

(2) CLW (Constructed LWEC Decision). This code should be used when the claimant has permanent or stable and well-defined work restrictions stemming from the work injury and has participated in vocational rehabilitation with an unsuccessful placement effort. The claimant is rated based on a position identified by the RC as one that is suitable, readily available, and within the claimant's capabilities. A final reduction decision is issued, reducing the claimant's entitlement with a formal constructed LWEC decision, based on the wages of the selected position identified. This code is considered a resolution in both QCM and PRM cases, but if entered during the QCM period, the DM category changes to PRM – LWEC and the case remains in the PRM universe if the claimant continues to receive wage-loss compensation. The effective date of this code is the date of the final decision.

e. No compensable disability from work. Claimant's entitlement to wage loss and/or medical benefits due to the work injury has been terminated. These closure codes count as a QCM or PRM resolution.

(1) CCO (Benefits Terminated, no continuing injury-related disability). This code should be used when the claimant's work-related condition no longer prevents him or her from returning to the job held on the date of injury. In some cases, the work-related condition has resolved completely, while in other cases there are still residuals of the work-related condition but those residuals do not prevent the claimant from being able to return to the date of injury job. The claimant has no ongoing entitlement to compensation for wage loss once the medical evidence establishes the ability to perform the duties of the date of injury position. A formal decision denying ongoing

disability wage-loss compensation, medical benefits, or both is issued. The effective date will be the date of the final decision.

(2) CCT (Comp terminated/declined temp LD-10.500). This code should be used when the claimant's wage loss compensation is terminated as a result of declining a temporary light duty assignment that would have resulted in no wage loss. For example, there may be occasions when the EA is only able to provide a temporary light duty assignment even though the claimant held a permanent job at the time of injury. If the claimant declines the temporary assignment, the penalty language of Section 8106(c) cannot be applied. However, the claimant is expected to return to appropriate work when it is provided and declining an appropriate temporary light duty assignment may result in a termination of wage loss compensation (if the assignment would have resulted in no wage loss). (Reference PM 2-0814-9 for details regarding temporary assignments as they relate to 20 CFR §10.500.)

The CCT code should be used when a claimant is provided a temporary light duty assignment that would result in no wage loss; the temporary assignment appropriately accommodates the claimant's medically-imposed work restrictions; and the claimant declines the assignment. A formal decision is issued terminating the claimant's entitlement to wage loss compensation. The effective date of the CCT code is the date of the final decision.

f. Sanctions. Most sanctions can close a DM record under QCM or PRM and count as a resolution, but the SUE code does not count as resolution in either QCM or PRM.

(1) CFC (Fraud Termination, against OWCP/US Government). This code is used when a formal decision is issued terminating entitlement to compensation because of a fraud conviction. The effective date for this code will be the date of the Section 8148 decision.

(2) CRC (Reduction – Incarcerated due to Felony). This code should be used when a claimant is incarcerated due to a felony conviction that is not related to fraud against OWCP/US Government. Benefits are not payable to the claimant but a reduced benefit may be payable under 5 U.S.C. 8148 (b) to the claimant's dependents. The effective date for this code will be the date compensation is reduced.

(3) CSA (Sanctions for refusing suitable work, Section 8106). This code should be used when a claimant is offered suitable employment within his or her medically-imposed restrictions and refuses the job offer. The claimant has no ongoing entitlement to compensation for continuing disability, since he or she refused a suitable offer of employment commensurate with his or her work capacity. A formal decision is issued and the claimant's entitlement to wage loss and a schedule award is terminated. The effective date will be the date of the final decision.

(4) SUC (Suspension of Compensation for Rehab Non-Cooperation). The effective date for this code will be the date of the decision. The DM record may be reopened later with code SRO.

(5) SUE (Suspension of Compensation for No Report of Earnings/ Dependency - CA-1032). The effective date for this code will be the date of the decision. The DM record may be reopened later with code SRO.

(6) SUM (Suspension of Compensation for Obstruction of Medical Examination). The effective date for this code will be the date of the decision. The DM record may be reopened later with code SRO.

g. Claimant in an approved vocational rehabilitation training program.

(1) RHT (In Approved OWCP Vocational Training). This code populates in DM Tracking when the RS enters code T into NRTS. Because a vocational rehabilitation training program can last for several months, but is intended to result in a return to work, this code does count as a QCM resolution if present at the 30-month mark. It does not, however, count as a PRM resolution.

h. Claimant Unable to Work or No Change in Benefit Level. There are instances when it is determined that the claimant is unable to work due to the severity of the injury.

(1) CPN (Permanent Total Disability Determination). This code should be used when the claimant is found to have no wage-earning capacity or re-employment potential for the indefinite future and the case is placed in a PN status. A memorandum to the file is required to document the reason(s) for this determination, and the memorandum must document concurrence from a Supervisory Claims Examiner. See FECA PM 2-0812. Since this is not a successful QCM resolution, this should only be used for the most serious injuries while the disability case is still within the first 30 months. The effective date for this code will be the date of the PN memo. Entry of CPN in a QCM record changes the category to PRM-PN. This code does not count as a resolution for either QCM or PRM.

(2) PCR (No entitlement change following PR review). This code should be used when the factual and medical evidence in the file clearly reflect that the current benefit level is appropriate. The file must be documented with a memorandum to the file. See FECA PM 2-0812 for a sample of this memorandum. If a PN recommendation occurs simultaneously with the use of the PCR code, the same memorandum can be used for both purposes. This code is only applicable for cases in the PRM universe and can only be used once every five years.

i. Recurrence of Disability. If the claimant sustains a recurrence of total disability, new injury, or increase in disability following a return to light duty, this new work stoppage should be reflected in the DM record. If the recurrent disability is due to the same injury, a new DM record should be created in that case after the current record is closed. If the recurrent disability is due to a new injury, then the current DM record should be closed and a new DM record should be opened under the new injury case file.

(1) CRN (Recurrence/New Injury Following RTW Light Duty). This code should be used when the claimant sustains a recurrence or a new injury during the QCM period. In addition to new work stoppages due to the injury, any increase in disability from work may lead to a CRN code, such as when the claimant decreases his or her working hours from eight to four. CRN should not be used in a PRM case; CRL is the recurrence code for PRM cases (see below).

Note - Timely identification of a work stoppage or an increase in disability is essential. DM Tracking does not allow this information to be entered at a later date, especially if the claimant

has already returned to work since the increase in disability. When coding DM with a code CRN, it is also important to properly notify the SN and FN if nurse intervention is still active. The new work stoppage and DM record will re-set the clock and allow the FN a new intervention time frame.

Cases closed with this code will be considered resolved successfully only if an earlier RTW occurred due to QCM intervention (as shown by status codes CLP, CL\$, CLF, NLP, NL\$, NLF, RLP, RL\$, or RLF). If the prior RTW was a PLP, PL\$, or PLF, the DM Tracking System will code the DM record RMV and remove the case from the QCM universe when the CRN code is entered.

(2) CRL (Recurrence, LWEC Modification – TTD). This code should be used when a recurrence occurs or a formal LWEC decision is modified to accept temporary total disability. PRM disability management is considered complete, but the system will initiate a request to create a new DM record to track the new period of total disability as a QCM case. This code is used only in PRM cases, but it does not count as a resolution.

j. Election of Benefits or Compensation No Longer Claimed. The DM record may also be closed when the claimant elects to receive benefits from OPM in lieu of FECA benefits, elects increased disability benefits from the Department of Veterans' Affairs (DVA) in lieu of FECA benefits, or when the claimant has not claimed compensation.

(1) CSB (Compensation Not Claimed). This code is used in conjunction with the OPM code when a claimant elects OPM benefits. This code is also appropriate when a claimant has elected to receive increased VA disability benefits in lieu of FECA benefits. In situations other than an OPM or VA election, there should be a memorandum to the file to explain the use of this code. This code should not, however, be used as a substitute for a formal decision. For example, if a claimant has been released to return to his/her date of injury job but neglects to do so, it is more appropriate to issue the formal decision advising that there is no continuing disability. The CSB code will count as a resolution for both QCM and PRM.

k. Death of the Claimant.

(1) DEA (Death of Claimant). This code is used whenever a claimant who has an active DM record dies. The effective date of the code is the date of death. This code will close a QCM or PRM case, but it does not count as a resolution in either instance.

14. Obsolete Codes. Some DM codes have become obsolete and are no longer used; therefore, when reviewing previous coding in a DM record, some codes (and descriptions) may appear that are no longer available for use.

Chapter 2-0700, Death Claims

1. Purpose and Scope. This chapter describes procedures for developing and adjudicating death claims under the FECA. It discusses entitlement to monthly compensation benefits, funeral and burial expenses, and 24-month lump-sum payments.

2. Policy. Death claims generally take precedence over other types of claims, and inquiries about them should be answered with speed and sensitivity. Great care must be taken in adjudicating these cases to ensure that dependents of a deceased employee do not suffer undue hardship because of delay in adjudication. Death benefits are subject to garnishment for overdue child support or alimony payments upon submission of proper documentation from a state agency or a court order (20 CFR 10.423).

3. Authority. Death benefits to dependents of employees who die from job-related illness or injury are outlined in 5 U.S.C. 8101 (6-11 and 17), 8102, 8119-8122, and 8133 (which also addresses administrative costs related to terminating the decedent's status as a Federal employee). Section 8134 discusses funeral and burial costs and expenses for transportation of the body, and Section 8135 covers lump-sum payments.

4. Responsibilities. The Office of Workers' Compensation Programs (OWCP) and the parties to the claim have the following obligations in death claims:

a. OWCP. Upon receipt of a new death claim or notice that such a claim is about to be filed, the Claims Examiner (CE) or Supervisory Claims Examiner (SCE) should telephone the surviving spouse or other close family member. The caller should briefly and politely convey knowledge of the death, express sympathy over the event, and state the desire to assist as much as possible in processing the claim. The caller should advise the family member to expect to receive a postcard bearing the case file number and office's address, as well as a separate letter requesting routine information needed to process the claim. The caller should give a telephone number and assurance that he or she will be available to discuss the claim as needed.

The CE is responsible for advising claimants and employing agencies how to process a death claim. This includes furnishing claim forms and instructions for obtaining evidence. Because evidence in the custody of a Federal establishment is more readily available to OWCP than to a claimant, it is the CE's obligation to secure such evidence. Also, the CE should render a decision on each case as soon as possible to avoid delay in payment of benefits or exercise of appeal rights.

b. Claimant. The claimant is responsible for giving notice of death (5 U.S.C. 8119) and has the burden of proving a relationship between an employee's death and factors of Federal employment. Except where the relationship between the death and the employment is obvious, the claimant must present medical evidence relating the death to the injury. See Bernice W. Curtis, surviving wife of Oscar Lee Curtis (1ECAB 95), and Rose Martin, claiming as widow of Bruce Martin (24 ECAB 243).

c. Employing Agency. Section 5 U.S.C. 8128 requires the employing agency to report to OWCP any injury resulting in death, and to provide such supplementary reports as OWCP may require. The agency should be asked to assist in compiling and submitting evidence required from the claimant and witnesses except where adjudication occurs long after the decedent has been removed from the agency's rolls, and the agency no longer retains records of the decedent's employment. The claimant or OWCP must obtain statements from witnesses no longer on the agency's rolls.

5. Initial Processing.

a. Reports of Death and Claim for Compensation. When an employee dies in the performance of duty, the employing agency must report the death immediately to OWCP by telephone or telefax so that an autopsy may be considered. As soon as possible, the agency must complete and submit Form CA-6, Official Superior's Report of Employee's Death. In accordance with 5 U.S.C. 8119, an eligible beneficiary specified in 5 U.S.C. 8133 or someone acting in his or her behalf must give notice of death on Form CA-5 or CA-5b. A death case will be created upon receipt of any such message or forms.

b. Timeliness. Survivors must give written notice within 30 days of the date of death, but the timely filing of a disability claim will satisfy the time requirements for a death claim based on the same injury as long as the claim is filed during the dependent's lifetime. This provision does not apply to the dependent's heirs or estate (see Ned C. Lofton (John C. Lofton), 33 ECAB 1497).

(1) For an injury occurring on or after September 7, 1974, the time requirements are also satisfied if the immediate supervisor had actual knowledge of the death within 30 days, provided the knowledge was such as to put him or her reasonably on notice of an employment-related death.

(2) If written notice was not given, or the immediate supervisor did not have actual knowledge of the death within 30 days, or a timely disability claim was not filed for the injury on which the death claim is based, compensation benefits may not be allowed unless an original claim for death benefits was filed within three years after the death, or within three years of the date the claimant was aware, or reasonably should have been aware, that the death was due to an employment-related disease.

c. Notice to Survivors of Right to Claim Compensation. All efforts to obtain a claim from survivors must be fully documented in the file.

(1) Eligible Survivors. The relationship of the survivor to the deceased is determined as of the date the death occurred (dependents who may be entitled to benefits are discussed in paragraphs 7-10). Section 8110 defines the classes of persons who qualify as "dependents" and thereby come within its scope. Those not specified are not included (see William S. Capeller, M.D., 28 ECAB 262).

(2) Spouses and Children. The spouse should be notified in writing of the right to claim compensation (Form CA-1064 may be used for this purpose). If no reply to this letter is received, a second notice will be sent 60 days later. In cases involving minor children, particularly orphans, the CE must send at least two notices to the guardian or custodian of the child. The case may be closed if no claim is received or if the replies to these notices indicate that further follow-up is not needed.

(3) Other Dependents. Generally, only one notice of the right to claim compensation need be sent to a survivor other than a spouse or child. If no claim is received within 60 days, the case may be closed as provided in paragraph 18 below.

(4) Compensation Due at Death. The CE should send Form CA-1085 to the administrator of the estate or to the next of kin to determine if compensation was due at death and, if so, to whom the money should be sent. See paragraph 14c below concerning payment of funeral and burial expenses from compensation due at death.

d. Relationship Between Disability and Death File. If a death is claimed due to an injury already of record, the death case should be doubled into the disability case under the number already assigned to the disability case.

e. Autopsy Reports. Initial reports of death received by telephone or telefax within 48 hours of death should immediately be brought to the attention of the District Medical Adviser (DMA) so that the need for an autopsy can be determined before burial, assuming that the cause of death is not obvious. If an autopsy appears to be necessary, the DMA will telephone or prepare a telefax to the next of kin requesting permission to perform the procedure, which will be carried out at OWCP expense (see FECA PM 3-400).

f. Development. Upon receipt of the case, and after completion of the telephone call noted in paragraph 4a above, the CE will send Form CA-1063 or a narrative equivalent to the employing agency, and attach Form CA-5 or CA-5b and Form CA-6. If the name and address of the spouse are known, Form CA-1064 may be sent directly. If a claim is received, the case should be developed in accordance with the five basic requirements as described in FECA PM 2-801 through 805. Form CA-1072 or a narrative letter may be used to obtain information needed to establish causal relationship. In addition, the employing agency should be asked about pay rate and health benefits information, and the claimant must also submit the following evidence:

(1) Death certificate.

(2) Name(s) and address(es) of next of kin.

(3) Marriage certificate (civil certificate).

(4) Birth certificate for each child (to show the legal relationship upon which the claim is based).

(5) Divorce, dissolution, or death certificate for prior marriages.

(6) Itemized burial bills, receipted if paid (see paragraph 14).

6. Adjudication.

a. If the record shows that any of the five basic requirements with regard to the employee's death is not satisfied, or the claimant is ineligible for benefits, the CE will prepare a formal decision (see FECA PM 2-1400). Form CA-1079 is used to transmit the decision. If the case satisfies the five basic requirements and there is at least one eligible beneficiary, the CE will:

(1) Complete Form CA-674, which is a checklist with a section which applies specifically to death cases. The form is a permanent part of the record and should remain at the top of the file.

(2) Obtain the concurrence of the SCE in accepting the case as indicated by certification of the CA-674.

(3) Initial and date Form CA-800 to indicate the acceptance.

(4) Determine whether a dual benefits situation exists with respect to benefits from the Office of Personnel Management or the Veterans Administration (VA) and take appropriate steps (see FECA PM 2-1000).

(5) Complete Form CA-24, FECA Fatal Benefit Payment worksheet, to authorize payment of applicable benefits if no dual benefits situation or other impediment to payment exists.

(6) Advise the claimant of the acceptance by narrative letter, which should contain information regarding:

(a) Four-weekly and monthly compensation entitlement for each eligible beneficiary (see paragraphs 7 through 10. The amount should be certified before release of the letter.)

(b) "Lump Sum" provision upon remarriage, if applicable (see paragraph 7).

(c) Basis for continued entitlement of children (see paragraphs 8 and 10).

(d) Amount of allowable burial expenses (see paragraph 14).

(e) Entitlement to \$200 administrative fee (see paragraph 15).

(f) Requirements for election if dual benefits are at issue (see FECA PM 2-1000).

Entitlement to compensation begins the day after death and is determined according to the schedule from 5 U.S.C. 8113 (see Exhibit 1 Page 1 ([Link to Image](#)), Page 2 ([Link to Image](#))). When the beneficiaries are placed on the roll, the CE should prepare Form CA-180, Compensation Order (Death).

b. Where no one is eligible for compensation, or where the eligible beneficiaries must first make an informed election, the burial benefits and administrative closing payment may be made immediately to the appropriate parties, using Form CA-24.

7. Compensation to Widow/Widower. To determine if a spouse is entitled, the CE should examine the status of the marriage at the time of the employee's death. If neither the decedent nor the surviving spouse was previously married, a copy of the marriage certificate will establish that the survivor is an eligible beneficiary. If either was married previously, the surviving spouse must also submit copies of the divorce or annulment decree showing dissolution of the previous marriage, or death certificate showing the demise of the former spouse, as the case may be.

a. Living Circumstances. If the surviving spouse was not living with the deceased at the time of death, the CE should investigate the circumstances surrounding the separation. According to 5 U.S.C 8101(6) and (11), a spouse separated from the decedent must have been "living apart for reasonable cause or because of. . . desertion." The following examples show how the facts may apply in different cases to determine reasonable cause:

(1) Where the parties maintain separate abodes but all other evidence points to the existence of a marital relationship at the time of death, the claimant is entitled to compensation benefits as the surviving spouse.

(2) If the parties lived apart for reasonable cause (e.g., hospitalization due to the fatal illness), or because of desertion by the employee, entitlement exists. If evidence shows that the spouse claiming benefits deserted the employee, the CE must develop the case to determine whether the spouse did in fact desert the employee. This may require personal investigation by an OWCP representative.

(3) If the parties lived apart for other reasons, entitlement may exist if the spouse was dependent on the decedent. The CE should obtain a copy of any court order directing the decedent to contribute to the spouse's support. If none existed, obtain letters from the family explaining the reason(s) for the separation and stating whether the surviving spouse received contribution from and was dependent upon the employee.

(4) If common law marriage is at issue, the CE must determine the status of the marriage according to the law of the state(s) in which the participants lived. The CE should obtain the concurrence of the SCE in determining eligibility.

b. Remarriage. Prior to September 7, 1974, all remarriages resulted in termination of compensation benefits. For remarriages between that date and May 28, 1990, entitlement continues if the beneficiary is age 60 or over (see 5 U.S.C. 8133(b)(1)), but not if he or she is under that age. After May 29, 1990, entitlement continues if the beneficiary is age 55 or over (see Public Law 101-303), but not if he or she is under that age.

(1) To terminate compensation on the ground that a spouse has remarried, OWCP has the burden of establishing that the subsequent marriage took place. In the case of a common law marriage,

OWCP must establish that the parties have met the criteria of the state where the parties reside. Cohabitation in and of itself is not sufficient to establish the existence of a bona fide common law marriage unless it is accepted by the state in which the spouse resides (see Marilyn M. Videto (William R. Videto), 23 ECAB 207, and FECA Program Memorandum 156).

(2) Although entitlement to benefits ends with a spouse's remarriage before age 55 (or 60, depending on the date of remarriage), benefits may be reinstated if the marriage is annulled. In the case of a voidable marriage, compensation may resume as of the date the marriage is terminated, whereas in the case of a void marriage, compensation may resume as of the date of the marriage. However, a beneficiary who remarries and is subsequently divorced does not again become entitled to benefits. (See FECA Program Memorandum 4.)

(3) Following a spouse's remarriage, the other beneficiaries are entitled to compensation at the rate they would have received had they been the only beneficiaries.

(4) Under Section 8135(b), a lump sum payment may be made to a spouse who remarries before reaching age 55 (or 60, depending on the date of remarriage). The sum payable is equal to 24 times the amount of monthly compensation paid just prior to the remarriage. If the remarriage later proves to be void or voidable, the entire lump sum award then becomes an overpayment subject to waiver or recovery. Continuing payments should not be withheld while this overpayment issue is being resolved. (See FECA Program Memorandum 150.)

8. Compensation to Children. Section 8101(9) defines a "child" as one who is under 18 years old, or incapable of self-support, or a full-time student under age 23. Included are stepchildren and children who are legally adopted prior to the parent's death according to the laws of the state having jurisdiction (see Marie Jean Kennedy (Fred E. Kennedy), 11 ECAB 247 (1959)).

Illegitimate children and posthumous children of the deceased are also entitled to compensation (a posthumous child is entitled to benefits effective the date of its birth). Excluded are married children and foster children. Compensation payable to, or on behalf of, a child is continued until the child dies, marries, or becomes 18, or, if over 18 and incapable of self-support, becomes capable of self-support.

a. Student Status. Where a child has reached the age of 18 and has indicated no intention to attend school after high school, compensation should cease at the end of the month in which the child graduated from high school. Compensation paid on behalf of an unmarried child which would otherwise be terminated at age 18 may continue, however, if the child is a student pursuing a full-time course of study or training at an accredited institution. Such benefits may be paid for four years of education beyond the high school level, or until the beneficiary reaches age 23, whichever comes first [see 20 C.F.R. 10.417 and 5U.S.C. 8101(17)].

(1) A "year of education beyond the high school level" is defined as:

(a) The 12-month period beginning the month after the child graduates from high school, if the child has indicated an intention to continue in school during the next regular session, and each successive 12-month period, provided that school attendance continues.

(b) The 12-month period beginning on the date the child actually enters school to continue education, if the child has indicated that he or she will not attend during the next regular session, and each successive 12-month period, provided that attendance continues.

(2) A year of entitlement based on student status means any year during all or part of which compensation is paid based on school attendance. Therefore, if a beneficiary should decide for any reason not to attend school for part of a year during which benefits were paid on account of student status, that beneficiary would be charged with having used an entire year of eligibility out of the allotted four years, even though compensation terminates when the beneficiary leaves school. If a child has already completed one or two more years of college before turning 18, they would be deducted from the four years of entitlement.

(3) If the child does not begin post high school education immediately but later decides to enter school full-time, compensation would begin on the date school attendance began, as stated in (1)(b) above. In this situation, the individual would remain entitled to four years of compensation based on school attendance, provided he or she did not turn 23. In either case, compensation is continued during any interval between school terms if the interval does not exceed four months and if the beneficiary demonstrates a bona fide intent to continue in school the following year. In the absence of specific contrary evidence, the CE may consider the student's decision to begin or continue full time studies a bona fide statement of intent.

(4) Where a student is prevented by reasons beyond his or her control (such as brief but incapacitating illness) from continuing in school, compensation may be continued for a period of reasonable duration. However, any such period would be counted toward the four years of entitlement. The CE will determine what constitutes "reasons beyond the control" of the beneficiary and decide what may be considered a period of reasonable duration during which compensation may be continued. The CE will also place a memorandum in the file outlining the circumstances of the case and the reasons for the decision. (See paragraph (7)(c) below concerning declarations of overpayments in these situations).

(5) The CE obtains proof of student status through the use of Forms CA-1615 and CA-1617. The CA-1615 should be forwarded to the dependent's parent or guardian at least three months before the dependent's 18th birthday. Where compensation is being paid for school attendance, Form CA-1617 should be sent twice each year at least two months prior to the date the current semester (or quarter, etc.) is scheduled to end. The CE should note on the CA-674 the number of years of eligibility remaining for each beneficiary based on student status.

(6) If the beneficiary is still receiving student benefits on turning 23, compensation should terminate at the end of that semester or enrollment period.

(7) Following are examples of common situations:

(a) John Smith's birth date is February 10, 1977. He has received compensation since 1983, and he will graduate from high school in May 1994. John has completed Form CA-1615 to indicate that he will attend college on a full-time basis starting in the fall of 1994. John's first "year of education beyond the high school level" will begin in June 1994, even though he is still entitled to benefits by virtue of being under 18 until February 1995.

(b) Steve Jones' date of birth is January 13, 1976. He received compensation beginning in 1984 and graduated from high school in June 1994. He completed Form CA-1615 to indicate that he would not attend college. He was entitled to receive compensation through June 1994, the month of his high school graduation (he was 18 when he graduated). Should Steve decide at some future date to continue his education, he would begin receiving compensation the month that he actually entered school and would be entitled to the entire four years of eligibility until he turns 23.

(c) Jane Doe's date of birth is April 15, 1974, and she received compensation beginning in 1988. She graduated from high school in May 1992 and indicated on Form CA-1615 that she would continue her education in the fall. Because of this evidence of a bona fide intent to attend school, her compensation was continued over the summer. In September she advised OWCP that she had reconsidered and decided to work instead of attending school.

Compensation was terminated effective October 1, 1992, without declaring an overpayment since 5 U.S.C. 8101(17) states that an individual "is deemed not to have ceased to be a student during an interim between school years if the interim is not more than 4 months and if he shows to the satisfaction of the Secretary that he has a bona fide intention of continuing to pursue a full-time course of study" during the following semester.

Since Jane received compensation after high school based on school attendance, the period for which she was paid represents one full year of eligibility out of her four year allotment. Had she decided at some future date to attend, she would have had three years of eligibility remaining. However, if she had decided to begin attending school in, for example, January 1993, she would still have been within her first year of eligibility, which began in June 1992 and ended in May 1993.

b. Marriage. A dependent child's eligibility for benefits terminates on the date of the child's marriage. A child whose marriage ended prior to the employee's death will not be barred from receiving survivor's benefits if otherwise entitled. A child whose marriage is annulled after the employee's death is eligible for survivor's benefits from the effective date of the annulment or the date of death (see FECA Program Memorandum No. 4) if otherwise entitled, but a child who is divorced or widowed is not eligible for benefits.

c. Children Over 18 Who are Incapable of Self-Support. When claims are made by or for children over 18 who are physically or mentally incapable of self-support, the CE must investigate the extent and expected duration of the illness involved.

(1) Eligibility. To be entitled to benefits, a child over 18 at the time of the employee's death must have been incapable of self-support at the time of the death by reason of a mental or physical

disability. Also, a child over 18 who becomes incapable of self-support after the employee's death, but before reaching 18, is eligible. A child over 18 is not entitled to benefits because of inability to obtain employment due to economic conditions, lack of job skills, etc.

(2) Definition. A claimant is incapable of self-support if his or her physical or mental condition is such that he or she is unable to obtain and retain a job, or engage in self-employment that would provide a sustained living wage. This determination must be based on medical evidence. When medical evidence demonstrates incapacity for self-support, this determination will stand unless refuted by the sustained work performance.

(3) Medical Evidence. A medical report covering the child's past and present condition must be submitted and referred to the DMA to determine whether it establishes incapacity for self-support. A physician's opinion must be based on sufficient findings and rationale to establish unemployability.

d. Method of Payment. In death cases, payment of compensation is made to a child as follows:

(1) Under Age 18. Compensation will be paid to a parent, guardian, or other competent individual responsible for the child's welfare. If a child under age 18 without a parent, guardian or other individual responsible for supervision is found to be competent to receive payments, compensation can be paid directly to the child. Sources of information concerning competency include local juvenile authorities, school officials, police, and relatives. The CE should obtain information from such sources as well as any other pertinent evidence, then make a determination of competency. If necessary, the CE should ask juvenile authorities in the area of the child's residence to appoint a conservator.

(2) Students. Compensation will be paid directly to a child who is a student if he or she is of legal age in the state of residence. If not, and the parent or guardian requests payment of the compensation, the CE must determine whether direct payment of compensation would be in the child's best interest, based on factors in the specific case.

(3) Physically or Mentally Incompetent. On request, compensation will be paid directly to a child of legal age who is incapable of self-support due to physical disability. Compensation on behalf of mentally incompetent individuals must be paid to a parent, guardian, or other person responsible for the individual's welfare.

9. Compensation to Parents. Parents, stepparents, and parents by adoption may be entitled to survivors' benefits, but foster parents and in-laws are excluded. Proof of parentage is established by a copy of the birth certificate for the employee, or, in the case of adoption, copies of the legal documents. In the case of a stepparent, the file must contain proof of the stepparent's marriage to the natural or adoptive parent of the deceased, along with the birth certificate indicated above.

a. Whole or Partial Dependency. Section 8133(a)(4) provides benefits to parent(s) who were wholly or partly dependent on the employee at the time of death. Note that this differs from the provision of Section 8110(a)(4), which provides augmented compensation to a disabled

employee on the basis of a parent wholly dependent on and supported by the employee. Form CA-1074 may be used to develop information bearing on this issue.

b. Dependency Criteria. The test of dependency under the FECA is not whether the claimant is capable of self-support without the amount which was previously provided by the deceased. "It is only necessary to show that the person claiming as a dependent. . .looked to and relied upon the contributions. . .in whole or in part, as a means of maintaining or helping to maintain a customary standard of living" (see Viola Davidson, 4 ECAB 263).

c. Percentage of Entitlement. The amount of entitlement for parents is stated at 5 U.S.C. 8133(a)(4) as follows:

(1) If there is no widow, widower, or child:

(a) 25% if one parent was wholly dependent on the employee at the time of death and the other was not dependent at all.

(b) 20% to each if both were wholly dependent.

(c) A proportionate amount in the discretion of the Secretary of Labor if one or both were partly dependent.

(2) If there is a widow, widower, or child, a portion of these percentages may be paid such that the total amount paid to the widow or widower, children and parents will not exceed 75%.

d. Minimum Payable. The minimum amount to which partially dependent parents are entitled was established by the decision in the case of Minnie Ballard, 8 ECAB 716:

To establish the minimum parental compensation entitlement, ...first determine the percentage that the decedent's contribution [during the 12 months immediately preceding death]. . .bears to the total moneys the parent received from all sources during the same period of time. Multiply the resulting percentage by the 25% [to one parent partially dependent or 20% to each if there are two parents partially dependent] and the result thus obtained is the payable percentage of dependency.

e. Change in Employee's Financial Status. Where the employee's earnings and/or contributions changed significantly over time, the controlling factors are those present at the time of death. In the case of an employee whose Federal earnings represented his or her first full-time employment, the most important factor in determining the amount of compensation payable is the amount the employee was earning and contributing at the time of death, not the amount earned and contributed during the preceding year (see Robert C. Boyd (Roger D. Boyd), 18 ECAB 639).

f. Criteria for Continued Payments. Survivor's compensation is payable from the day after death until the parent dies, marries, or ceases to be dependent. A parent whose entitlement is based on financial dependency should be removed from the rolls when the current income received, less

compensation, equals or exceeds the total income from all sources at the time of death. CPI adjustments should be included when making this determination. OWCP has the burden of proving under this formula that the parents are no longer dependent.

10. Compensation to Siblings, Grandparents, and Grandchildren. As with parents, the relationship on the date of death and the degree of financial dependence determines entitlement to benefits for siblings, grandparents, and grandchildren. The term "sibling" includes stepbrothers and stepsisters, half brothers and half sisters, and brothers and sisters by adoption. The category of grandparents does not include step-grandparents. The term grandchildren includes all biological and adopted grandchildren, whether born into a marriage or not, but does not include step-grandchildren. Unlike posthumous children, posthumous siblings are not entitled to benefits, even if the mother of the deceased employee was dependent on the employee at the time of death and she was pregnant, the reasoning being that the unborn child was dependent on its mother, not the employee, prior to its birth (see J. Quackenbush, 19 ECAB 251).

a. Documentation. The person claiming compensation, or someone acting on this person's behalf, must complete Form CA_5b. Proof of relationship and proof of dependency at the time of death are required. Evidence which establishes physical or mental incapacity is also required if a sibling or grandchild is over age 18 and incapable of self_support.

(1) Proof of relationship is established in the same manner as for a child or parent.

(2) Proof of dependency is established in the same manner as for a parent, but the percentage of entitlement for partly dependent beneficiaries differs:

(a) Section 8133(a)(5)(C) allows 10% to a partly dependent sibling, grandparent, or grandchild rather than the "proportionate amount" allowed to parents by 5 U.S.C. 8133(a)(4).

(b) Therefore, the CE need not calculate the prorated degree of dependency required by the Minnie Ballard decision (8 ECAB 716).

(3) Proof of physical or mental incapacity is established in the same manner as for a child over 18 years of age.

(4) Proof of student status is established in the same manner as for a child of the deceased.

b. Percentage of Payments. The percentages payable are as follows, in accordance with Section 8133(a)(5):

(1) 20% if one survivor was wholly dependent on the employee at the time of death.

(2) 30% if more than one survivor was wholly dependent, divided among the survivors share and share alike.

(3) 10% if no survivor was wholly dependent but one or more was partly dependent, divided among the survivors share and share alike.

If there is a widow, widower, or child, a portion of these percentages may be paid such that the total amount paid to the widow or widower, children and siblings, grandparents, and/or grandchildren will not exceed 75%.

c. Length of Payment. Compensation is payable until:

(1) The sibling or grandchild dies, marries or becomes 18 years old, or, if over age 18 and incapable of self_support, becomes capable of self_support.

(2) The grandparent dies, marries or ceases to be dependent.

d. Marriage. As with children, a beneficiary in this group who is otherwise entitled may receive survivor's benefits if his or her marriage terminates prior to the employee's death. Annulment of a beneficiary's marriage may result in re-entitlement from the effective date of the annulment if the survivor is otherwise entitled.

11. Payments. Pay rate determinations are addressed in FECA PM 2-900. The minimum (GS-2) and maximum (GS-15) basic rates of pay provided by Section 8102 are applicable in death cases, and the amount to which survivors are entitled can never exceed 75% of the decedent's pay rate (before CPI adjustments). To calculate the monthly pay rate, the CE should determine:

a. The Effective Date of the Pay Rate. Compensation for death is based on the pay rate on the date of injury, date disability began, or date of recurrence, or following re-computation under Section 8113.

b. The Monthly Wage. If the employee was working in private industry when death or disability occurred, non- Federal pay may be used in determining the pay rate (see Elizabeth F. Keough, 35 ECAB 347).

c. Entitlement to Health Benefits Coverage. The survivors will be eligible for continued coverage if the decedent was enrolled at the time of death in a health benefits plan for which the agency (or OWCP) was making deduction. (Note that when only a spouse survives, the health plan needs to be changed from a family plan to a self-only plan.)

d. The Number of Beneficiaries. When a survivor dies or otherwise becomes ineligible for compensation, the benefits of the remaining survivors are recomputed. This action usually results in an increase for each beneficiary, though payments may not exceed the maximum 75%.

e. The Number of Payees. Payment to a subsidiary recipient as well as a primary beneficiary will always involve multiple payees, since the subsidiary survivor always gets a separate check (see Exhibit 2 (Link to Image)).

f. CPI Entitlement, if any. Such entitlement depends on whether the deceased employee was receiving disability compensation prior to death.

(1) If so, survivors are entitled to CPI adjustments effective more than one year after compensable disability began, even though the date of death may be less than one year prior to the effective date.

(2) If not, survivors are entitled to CPI adjustments beginning one full year after the date of death, even if an earlier pay rate is used.

12. Apportionment. The FECA provides that a spouse and children have the first right to compensation, which means that other classes of dependents may be excluded if necessary. Thus, the subsidiary dependents (i.e., parents, siblings, grandparents, and grandchildren) may receive compensation only after the entitlements of the spouse and/or children have been satisfied fully.

The only exception to this rule occurs where OWCP reapportions the award in the manner provided by Section 8133(d). For example, in the rare event that the survivors include a spouse, two children, and dependent parents, the spouse and the children are entitled to 75%, and the parents are not entitled to benefits. The CE may invoke Section 8133(d), however, to designate a small amount (e.g., 5%) for the parents. Many factors influence this decision. The CE should:

- a. Obtain the spouse's opinion.
- b. Determine whether the spouse has other income.
- c. Consider the actual amount of benefits in proportion to need (e.g., if they are sizable/sufficient for "primary" beneficiaries, then allocating a small amount for parents would not be harmful).
- d. Determine whether the parent(s) live with the spouse. If so, benefits may not need to be divided as the parents will receive them indirectly.

The CE should prepare a memorandum for the file fully explaining the rationale for or against reapportionment, and the SCE must certify it.

13. Third-Party Cases. The CE is responsible for referring to the designated CE any case in which third-party liability may exist (see FECA PM 2-1100). In accordance with Section 8132, a third-party recovery will result in suspension of death benefits to the recipients of the settlement until the credit is absorbed. During this period, any beneficiaries who did not participate in the third-party recovery will continue to receive compensation at the rate established.

14. Burial Expenses. Section 5 U.S.C. 8134 provides for the payment of burial and funeral expenses by the U.S. not to exceed \$800. Like related medical expenses in a disability claim, funeral expenses in a death case may be paid even if the case as a whole is denied on the basis of timeliness as long as causal relationship is established and the requirements for giving notice are met. They may be paid without regard to any life insurance or burial insurance policy which may be in force.

a. Allowable Expenses. Normally the following services are paid: transporting body from place of death, embalming, shaving, dressing, clothes, storage, casket, vault, funeral services, clergy, hearse to cemetery, cars, lowering device, digging grave, grave rental, perpetual care of grave, grave marker, and funeral notice.

(1) Acceptability of other items must be determined on an individual basis according to necessity and reasonableness.

(2) Costs for such items as monuments, obituary notices, and copies of extra death certificates (one for the spouse and one for submission to OWCP are allowed) should be deducted from the itemized bill.

(3) When authorizing payment of the burial allowance, the CE should note on the burial bill which items are allowable. If the reason for allowing a specific item is not apparent, the notation should include a brief explanation of the reasons for allowing it.

b. Payments by Other Agencies. If another Federal agency pays any part of the burial expense for the deceased employee, OWCP's payment shall not exceed the difference between the amount paid by the other agency and \$800.

Neither the \$225 Social Security lump sum death benefit nor benefits from life insurance or burial policies are deducted from OWCP funeral benefits, however.

The VA will not authorize a burial allowance when the veteran dies from an injury or disability sustained in the performance of Federal employment. Since the VA is no longer the primary benefit payer in such cases, it is not necessary to check with the VA Regional Office (VARO) to determine the amount paid or payable. Rather, the VA will contact OWCP if it appears that the veteran was a Federal employee whose death was work-related. While the VA and OWCP have agreed not to exchange funds where elections are concerned, such a transfer will be made if burial expenses are awarded in error.

c. Method of Payment. OWCP can reimburse, in proportion to the part of the total expense paid, any person who paid part of the burial expenses. In no case will OWCP's payment for burial expense exceed the amount allowed under the FECA, and all claims for burial allowance must be accompanied by an itemized bill prepared by the undertaker who furnished the services. The order of payment is as follows:

(1) If a survivor furnishes proof of payment of burial costs, OWCP pays the \$800 to the survivor. If burial costs have not been paid, the \$800 is paid to the executor of the estate. If there is no legal representative and the bill is unpaid, the funeral director may claim direct payment. In most, if not all, legal jurisdictions in the U.S., undertakers and others who provide burial services are considered priority creditors, and they therefore have a priority claim against the proceeds of the decedent's estate and any entitlements the decedent's death might create.

(2) If the funeral bill is unpaid or a balance exists, direct payment must be made to the funeral home. For example, if a friend paid funeral expenses of \$600 and an unpaid balance of \$300

remains, and OWCP allows \$550 (\$800 less \$250 from the VA), OWCP will pay the funeral home \$300 with the balance of \$250 going to the friend.

Section 5 U.S.C. 8130 prohibits assignment of compensation and exempts it from claims of creditors. Therefore, no claim for compensation due at death by an undertaker or other creditor may be recognized.

d. Transportation and Medical Costs. If the employee died away from home, charges for returning the body and the sealed casket may be paid over and above the \$800 allowance. In cases where related medical and transportation expenses were incurred prior to death, the CE should authorize payment.

15. Termination of Employee Status. An additional sum of \$200 is payable to the personal representative of the decedent to reimburse the cost of terminating his or her status as a Federal employee. A spouse is considered to be the personal representative unless incompetent. If no spouse survives, the payment will be made to the administrator of the estate.

a. Pay Status. A personal representative is entitled to receive the \$200 payment regardless of whether the deceased was in pay status with the employing agency at the time of death. For example, the personal representative of an employee who retired in 1973 and died of work-related causes in 1978 would be entitled to the \$200 payment.

b. Employee Status. The \$200 payment may be made only in cases of deceased employees as defined by Section 8101(1). Therefore, payment is usually not made to members of groups to which FECA benefits are extended by separate legislation, such as ROTC cadets, Civil Air Patrol volunteers, members of the National Teacher Corps, and non-Federal law enforcement officers. On the other hand, Peace Corps and VISTA volunteers and Job Corps enrollees are considered employees of the U.S. as defined in Section 8101(1) and are therefore entitled to payment of the \$200.

16. Disappearance Cases. Under 5 U.S.C. 5565, when a Federal employee has been missing for at least 12 months and no official report of death or the circumstances of continued absence has been received, the head of the employing agency is authorized to review the case and either continue the missing status, which may result in a continuance of pay status, or make a finding of death, which will terminate pay status. A finding of death must include the date on which death is presumed to have occurred, and a determination made under this section of the law is binding on all other agencies of the U.S. Such a determination can therefore be used as proof of death (in lieu of a death certificate) in a disappearance case. In such cases, especially those occurring outside the U.S., the claimant should be instructed to request such a determination from the employing agency if one has not been made.

a. Pay Status. In some disappearance cases the employee's pay is terminated as of the date of disappearance, while in others it is continued until an official finding of death is made. The claim file must show the date the employee's pay stopped, as compensation cannot be paid for any period prior to that date. If the presumed date of death and the date pay stopped are not the same, the latter date should be used to determine when compensation payments should begin.

b. Findings by Local Courts. In all disappearance cases occurring within the U.S. where a local court makes a finding of death and directs the issuance of a death certificate, OWCP will give full credit to all findings of the court and will not challenge the findings in another court. If no finding of death has been made, the claimant should be instructed to request one from a local court.

c. Unusual Cases. In some very unusual cases of disappearance, a finding of death may not be made. In such a case, the CE must determine whether death likely occurred and, if so, the date it occurred. Such a determination will necessarily require discretion and judgment, and the CE must obtain the best available evidence about the circumstances surrounding the disappearance. The CE should prepare a memorandum which outlines the facts and provides a recommendation for the SCE.

17. Periodic Roll Review. The CE should review the case at least once a year to verify continuing entitlement to benefits, ensure that benefits are being paid at the proper level, resolve third party issues, and discontinue benefits when warranted. See paragraph 18 below concerning suspension of benefits for non-receipt of reports of dependents.

a. Rescission. Once OWCP has accepted a fatal case and paid benefits, the CE should not reexamine the basis for acceptance or attempt to rescind it unless the file contains blatant error or clear indication of fraud. A recommendation to vacate the original decision must be routed through the District Director to the Director for Federal Employees' Compensation for review and final decision.

b. Form CA-12, Claim for Continuation of Compensation. This form is sent annually to all recipients of death benefits. If the form has not been returned within 60 days of release, the CE should send a follow-up request for completion. Upon receipt of the form, the CE should check for changes in address, marital status, and financial dependency status. Particularly with elderly recipients of the form, the CE should be alert to changes in the beneficiary's signature; such changes may indicate that someone other than the intended recipient of benefits is completing the affidavit. The CE should also ensure that any address changes are also noted properly in the Automated Compensation Payment System (ACPS) and take any other actions required as noted below.

c. Widows and Widowers. If the spouse has remarried, the CE will need to determine her or his age at the time of remarriage. A widow or widower over age 60 (prior to May 29, 1990) or over age 55 (May 29, 1990 or later) is entitled to continue receiving monthly benefits. If the surviving spouse is younger, the CE must initiate action to terminate benefits and pay the 24-month lump sum.

d. Children, Grandchildren, and Siblings. Form CA-1615 should be released to the guardian three months before the child reaches the age of 18 to determine continuing entitlement to compensation on the basis that the child is a student or is incapable of self-support.

(1) Student Status.

(a) ACPS automatically deletes the records of beneficiaries when they reach age 18 and adjusts the percentages payable to other survivors. The CE should check the CP-285, however, to ensure that benefits are not interrupted if the child's entitlement continues after age 18.

(b) Form CA-1617 should be released twice a year to determine continuing entitlement to compensation based on student status. The CE will need to determine if the student is regularly pursuing a full-time course of study; if the student has completed four years of education beyond the high school level; the end of the semester or enrollment period in which the student turns 23; and any interim periods between school years. Form CA-1617 also includes a question concerning the election of VA or other educational benefits.

(2) Incapable of Self-Support. A person entitled to benefits because of incapacity for self-support, or his or her guardian, should be asked to submit medical evidence to support continued payments of compensation. Such requests should be made at least yearly.

e. Parents and Grandparents. Under 5 U.S.C. 8133(b)(3), survivors' benefits cease when "a parent, or grandparent dies, marries, or ceases to be dependent."

(1) A parent or grandparent should be removed from the rolls when the current income less compensation equals or exceeds the total income from all sources adjusted to compensate for changes in the cost of living at the time of death. This action is taken because the beneficiary would no longer be dependent upon compensation to sustain a living standard equivalent to that enjoyed at the time of the employee's death.

(2) OWCP has the burden of proving that the parent or grandparent is no longer dependent. Approval authority in such cases rests with the SCE and cannot be delegated to the CE.

18. Suspension of Benefits. Compensation for beneficiaries in death claims may be suspended for failure to provide timely reports concerning their status.

a. Determining if Benefits Should be Suspended. If the initial Form CA-12 has not been returned, a second request should be made allowing an additional 30 days to return the completed form (unlike the CA-1032 where no second request is issued). If the completed CA-12 is not received after the second request, all benefits should be suspended unless extenuating circumstances exist (for example, the beneficiary is hospitalized or has just moved and had no time to notify OWCP), even if a current Form CA-1617 is in file for a college-age child unless the child is receiving benefits in his or her own name.

(1) If extenuating circumstances exist or the form is received but not substantially completed, the CE should advise the beneficiary of the specific information still required and indicate that benefits will be suspended within 30 days if the information is not received within that time.

b. Advising the Beneficiary. Suspension (whether of all benefits or the percentage paid for a particular dependent) should be accomplished by narrative letter which specifies the dependents whose compensation is being suspended; references the letter which was sent and the date; cites the pertinent regulation; and advises the claimant that benefits will be restored retroactively once

the necessary information is received as long as it supports continuing payment. Appeal rights should be provided with this letter (a sample is shown in Exhibit 3).

c. Fiscal Action.

(1) Compensation should be suspended as of the date of the final decision. No deductions for health benefits will be made during the period of suspension.

(2) If suspension is effected for a particular dependent, the percentage payable for other beneficiaries remains the same during the period of suspension. For instance, if a widow and student are receiving 45% and 15% respectively, and the student's benefits are suspended due to non-receipt of Form CA-1617, the widow should remain on the roll at 45%.

(3) The CE should take prompt action to restore benefits in cases where the requested information concerning dependents is received after benefits have been suspended. Compensation should be reinstated retroactive to the date of suspension where the evidence submitted supports the payment of benefits.

19. Closure. The CE should take the following steps to close a death case:

a. Cancel any outstanding call-ups.

b. Write the reason for closure on Form CA-800 and Form CA-674.

(1) Where other benefits have been elected, the closing entry should identify the benefit elected, e.g., "elected Civil Service Retirement annuity."

(2) Where no claim is filed because there are no eligible dependents, the closing entry will be "no dependents"; otherwise, the closing entry will be "no claim filed."

20. Gratuity from Employing Agency

Public Law 104-208 authorized payment of a gratuity not to exceed \$10,000 to survivors of employees who died in the line of duty on or after August 2, 1990. These payments are made by employing agencies, not the OWCP. The payments do not constitute dual benefits, and no election is required. However, any burial and administrative expenses paid by the OWCP are deducted from the entitlement. CEs will therefore need to advise employing agencies of the amounts of burial and administrative expenses paid by the OWCP when requested to do so in particular cases.

21. FECA Death Gratuity. The National Defense Authorization Act for Fiscal Year 2008, Public Law 110-181, amended the FECA, creating a new section 8102(a). The section establishes a new FECA benefit for eligible survivors of federal employees and Non-Appropriated Fund Instrumentality (NAFI) employees who die of injuries incurred in connection with service with an Armed Force in a contingency operation.

Section 8102a states that the United States will pay a death gratuity of up to \$100,000 to those survivors upon receiving official notification of the employee's death. Section 8102a also states that the United States will pay the death gratuity to the eligible survivors "immediately upon receiving official notification" of an employee's death. There is a retroactive payment provision, stating that the death gratuity will be paid for employees of certain agencies who died on or after October 7, 2001, due to injuries incurred in connection with service with an Armed Force in the theater of operations of Operation Enduring Freedom and Operation Iraqi Freedom. Regulations implementing the FECA death gratuity are set forth at 20 C.F.R. 10.900-916. The \$100,000 death gratuity is offset and reduced by any other death gratuity paid for the same death.

All claims for benefits under 8102(a) will be processed by the Special Claims Unit. As a result, all claims for a death gratuity are to be transferred to immediately upon receipt for handling and response. The original death claim, if applicable, should also be transferred to to Special Claims at that time. Once received, each case will be assigned a specific claim number, beginning with the prefix "DG." A DG claim number will be assigned to each person making a claim. That means that more than one DG claim could be created as the result of one death. This also means that if a claim for a death gratuity is made in an existing FECA case, a new DG claim number will be assigned to the death gratuity – distinct from the existing FECA case number.

FECA death benefits payable under section 8133 and burial expenses payable under section 8134 of the Act do not constitute a dual benefit and, therefore, do not affect this FECA death gratuity payment made under section 8102(a).

More detailed procedures on processing these cases will be provided in Part 4 (Special Case Procedures) of the FECA Procedure Manual.

- Note: On December 31, 2011, Congress amended 5 U.S.C. 8102a, the law authorizing death gratuities under the FECA, by Section 1121 of Public Law 112-81. Pursuant to that amendment, federal employees may now designate the entire FECA death gratuity to an alternate beneficiary (previously, this designation was limited to 50% of the FECA death gratuity). Effective December 31, 2011, the employing agency is required to notify the federal employee's spouse, if one exists, if that employee designates a person other than the spouse to receive all or a portion of the FECA death gratuity. These changes took effect on enactment.

22. Additional Payment Considerations. This paragraph discusses other payment considerations in death cases.

a. Period of Entitlement. For death cases, a beginning date is supplied for all beneficiaries, and an expiration date is provided for each individual claimant in accordance with the person's situation, e.g. eighteenth birthday, end of student status, etc.

If a widow/widower receiving death benefits dies, compensation is payable through the date of death, just as it is if a claimant dies while receiving compensation.

b. Compensation for Death. Compensation in death cases is always calculated on a monthly basis. When there is more than one claimant, the gross compensation is calculated for all beneficiaries and then prorated to determine each individual's compensation. Death benefits are always paid on calendar days.

(1) Periodic (28-day) payments are calculated as follows:

Monthly pay rate x compensation rate = amount (rounded to the nearest \$.01) x 12 months per year ÷ 13 pay periods per year

(2) Supplemental payments (any period of calendar days not evenly divisible by 28) are calculated using calendar days:

Monthly pay rate x compensation rate = amount (rounded to the nearest \$.01) x no. calendar days ÷ 30 days per month.

(3) If there is a widow(er) and children but only the widow(er) claims compensation under the FECA (while any children may elect to receive other benefits), the widow is only entitled to 45% of the pay, even though he/she may be the only one technically making a claim under the FECA.

c. Minimum (MIN) Compensation. In a death case, the CE should compare the current MIN to the deceased employee's pay rate. If the pay rate is less than the minimum, the MIN is used as a basis for computing each beneficiary's entitlement. If the pay rate is greater than MIN, the pay rate is used as a basis for compensation payment.

Compensation to a beneficiary may not exceed the deceased's monthly pay rate for compensation purposes (except by the addition of CPIs effective September 7, 1974). Therefore, if the compensation rate times a new MIN would be more than 100 percent of the pay rate, the new MIN is not applied, and the basic compensation becomes 100 percent of the pay rate. MIN rates are discussed in more detail in FECA PM 2-0901-13.

d. Maximum (MAX) Compensation. To determine whether a MAX applies in a death case, the combined compensation rate for all entitled beneficiaries must be computed and multiplied by the decedent's salary. All applicable cost-of-living increases must be added. If the total is greater than MAX, each claimant's entitlement is computed as a proportionate share of the MAX.

When a new maximum applies, each case previously paid at MAX must be recomputed to determine the new entitlement. If the recomputed total entitlement for all beneficiaries is less than the new MAX, each claimant may receive the regular entitlement. If not, a proportional share of the MAX is allotted to each claimant. MAX rates are discussed in more detail in FECA PM 2-0901-14.

e. Health Benefit Insurance (HBI) Deductions. If the claimant was enrolled in a Federal Employees Health Benefit Plan (FEHBP) at the time of death, deductions for HBI premiums will be taken from the compensation entitlement. Insurance deductions are discussed in more detail in FECA PM 2-0901-15 and 5-0400.

(1) Since death payments are made on the periodic roll, the transfer of Health Benefits Enrollment also applies to beneficiaries who are on the Death Roll.

(2) If OWCP is accepting the widow/widower's claim for death benefits, request that the name of the enrollee be CHANGED, and be sure the coverage level is appropriate (single rather than family). OPM's CLER system is updated regularly to ensure claimants' continued entitlement. Properly maintaining the enrollment and making the correct deductions is part of this process, and the responsibility of OWCP.

f. Consumer Price Index (CPI) Adjustments. Under 5 U.S.C. 8146a, compensation payable on account of death which occurred more than one year before March 1 of each year, shall be increased each year on that date. The amount of any increase is represented by the change in the CPI published for December of the preceding year over the price index published for December of the preceding year, adjusted to the nearest one-tenth of one percent. CPIs are discussed in more detail in FECA PM 2-0901-16.

(1) The CPI increase is applicable to death cases where the compensable disability occurred more than one year prior to the effective date, although the death may have occurred less than a year before the effective date.

(2) CPI adjustments are rounded in death cases to the nearest dollar on a monthly basis.

Exhibit 1: [Percentages of Entitlement Page 1 \(Link to Image\)](#)

Exhibit 1: [Percentages of Entitlement Page 2 \(Link to Image\)](#)

Exhibit 2: [Entitlement of Multiple Payees \(Link to Image\)](#)

Exhibit 3: Sample Letter Suspending Benefits When Report of Dependents Is Not Received

Dear NAME OF BENEFICIARY:

I am writing in reference to the compensation benefits you receive from the Office of Workers' Compensation Programs (OWCP).

Section 10.126 of the OWCP's regulations states that entitlement to compensation for dependents in death claims may be suspended for failure to provide timely reports concerning their status. If the requested information is subsequently received, compensation for dependents is reinstated retroactive to the date of suspension where the evidence submitted supports the payment of compensation.

On DATE, Form (CA-12, CA-1617, ETC.) was sent to you for completion. No reply has been received, and compensation for NAME OF DEPENDENT has been suspended as of DATE. If you complete and return the enclosed copy of Form (CA-12, CA-1617, ETC.) compensation will

be restored retroactive to the date it was suspended as long as the information provided shows entitlement to payment.

This is a formal decision, and your appeal rights are attached.

Sincerely,

NAME OF SIGNER
SENIOR CLAIMS EXAMINER

Chapter 2-0800, Initial Development of Claims

1. Purpose and Scope. This chapter describes the fundamentals of claims development. Along with FECA PM 2-0801 through 2-0805, it covers the factors which all claims have in common. Initial acceptances are covered in FECA PM 2-0806 and formal denials are covered in FECA PM 2-1400. Additional material about death claims is covered in FECA PM 2-0700. The development of special act claims, in which entitlement is based on legislation extending FECA benefits to such groups as Peace Corps and VISTA volunteers, is described in FECA PM 2-1700.

2. Types of Claims. When a claim is submitted, it is classified based on the type of injury and the nature of injury. See Nature of Injury codes. (Exhibit 1)

a. Traumatic Injury (TI) -- a wound or other condition of the body caused by external force, including stress or strain. The injury must be identifiable as to time and place of occurrence and member or function of the body affected. It must be caused by a specific event or incident or series of events or incidents during a single day or work shift. 20 CFR 10.5 (ee).

The following are examples of a traumatic injury: dog bite, knee strain after a trip and fall, neck strain after an auto accident, or a broken ankle after a slip on ice.

b. Occupational Disease (OD) -- a condition which is produced by continued or repeated exposure to elements of the work environment such as noxious substances or damaging noise levels over a period longer than one work day or shift. OD claims are classified as either basic or extended. 20 CFR 10.5(q).

(1) Basic OD -- Most claims for skin, orthopedic, viral, infectious, and parasitic diseases can be adjudicated with an initial request for information and perhaps a follow-up query for

clarification. Some will clearly address all five basic requirements and may be adjudicated if all necessary evidence is in file. These cases are considered basic OD claims.

The following situations illustrate the kinds of cases which may be considered basic OD:

- (a) A claim for poison ivy where the claimant's employment involves exposure to the plant, and the medical evidence confirms the diagnosis.
- (b) A claim for a stress fracture of the foot from a letter carrier who walks a route, where the medical evidence confirms the diagnosis and relates it to extensive walking.
- (c) A claim for carpal tunnel syndrome from a postal letter-sorting machine operator where medical tests establish the diagnosis.

(2) Extended OD -- Most other types of OD claims require full-scale development because 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.

The following situations illustrate the kinds of cases which may be considered extended OD:

- (a) Hearing loss due to continuous noise exposure.
- (b) Asbestos-related illnesses.
- (c) Stress-related conditions (cardiac, emotional, gastrointestinal).
- (d) Other conditions, such as pulmonary conditions, gastrointestinal illnesses due to physical causes, certain types of loss of vision, dental conditions, cancers, nerve (neurological) injuries and tumors.

c. Death -- Death claims are discussed in FECA PM 2-0700.

d. Administrative authorization of limited benefits (AR) -- an uncontroverted traumatic injury claim in which medical bills are not expected to exceed \$1500 and a wage loss claim has not been filed. These cases are automatically closed upon case creation, without Claims Examiner (CE) review.

AR cases can be reopened automatically or manually. Such reopened cases will usually contain some medical evidence and may be adjudicated immediately. Extent and duration of injury-related disability do not have to be fully developed before adjudication. However, if one or more of the five basic requirements (timeliness, civil employee, fact of injury, performance of duty, causal relationship) is not met, the CE will proceed with development as with any other TI case. See 2-0800-4.

(1) Automatic Reopening. AR cases will be automatically reopened if the medical bills exceed \$1500, a wage loss or recurrence claim is received, the "controverted indicator" in the case

record is changed to "Y" due to receipt of a late agency controversy, or the COP nurse has closed the case without a return to full time employment by the claimant.

(2) Manual Reopening. AR cases may also be reopened manually. The case should be reopened when, for example, a request for surgery is received.

3. Forms Used for Initial Claims.

a. In injury cases, the appropriate forms are:

(1) Form CA-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation.

(2) Form CA-2, Notice of Occupational Disease and Claim for Compensation.

(3) Form CA-7, Claim for Compensation on Account of Traumatic Injury or Occupational Disease, may be submitted in conjunction with the CA-1 or CA-2.

b. In death cases, the appropriate forms are:

(1) Form CA-5, Claim for Compensation by Widow, Widower, and/or Children.

(2) Form CA-5b, Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren.

(3) Form CA-6, Official Superior's Report of Employee's Death.

Death claims are discussed in FECA PM 2-0700.

c. Completion of Forms. It is essential that Form CA-1 or CA-2 be completed by both the claimant and the employing agency.

(1) Incomplete form. If enough information is provided on the CA-1 or CA-2 to permit creation of the case, OWCP should do so and obtain the missing information from the appropriate party.

However, if not enough information is provided on the CA-1 or CA-2 to allow creation of the claim (see FECA PM 1-0400), OWCP should return the form for completion.

(a) Employing Agency Known. When a CA-1 or CA-2 is received directly from the claimant, OWCP should send a copy to the employing agency with a request for completion of the reverse side of the form.

(b) Employing Agency Unknown. When a CA-1 or CA-2 is received directly from the claimant and the employing agency is not known or it cannot be determined from the information provided, OWCP should return the form to the claimant with instructions to forward the form to the employing agency for completion.

(2) Incorrect form. While submission of an incorrect form is a technical error, it is improper to deny a case on the basis that the claimant failed to submit the correct form. In some cases, the claimant may have been provided that form by the employing agency. Proper handling of the incorrect form depends on whether OWCP can determine the actual benefits claimed.

(a) If, upon review of the incorrect form, the actual benefits claimed by the claimant can be determined, OWCP should convert the claim to the correct type and notify the claimant and employing agency (and any representative, if applicable) via letter that the claim has been converted to a different type of injury than what was originally claimed and explain the reasons for the conversion.

Example: The claimant files Form CA-2, Notice of Occupational Disease and Claim for Compensation, and OWCP creates an occupational disease claim. However, based upon the statements contained on the Notice of Occupational Disease as well as the medical evidence submitted, the claimant is describing a traumatic injury rather than an occupational disease claim. In such an instance, the Office can convert the claim from an occupational disease claim to a traumatic injury claim. The claimant and employing agency (and any representative, if applicable) should be notified via letter that the claim is now a traumatic injury, and the reasons for the conversion should be explained. If the claim was filed within 30 days of the injury date, the claimant should also be notified of the entitlement to Continuation of Pay (COP).

(b) If the actual benefits claimed by the claimant cannot be determined from review of the form, OWCP should develop the claim based upon the claim form filed and direct questions to the claimant to determine the type of benefits claimed. Based upon the response to the development letter, OWCP should make a determination as to whether the correct claim was established and, if not, OWCP should convert the claim to the proper type of claim and notify the claimant and employing agency (and any representative, if applicable) of the conversion.

Example: The claimant files a CA-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation, and OWCP creates a traumatic injury claim. However, upon review of the CA-1, the CE determines that the statements made on the claim form are so vague that it cannot be determined whether the claim is for a traumatic injury claim or occupational disease claim. The CE issues a development letter to the claimant requesting a statement on the nature of the injury. Based upon the response to the development letter, the CE determines that the claimant is not describing a traumatic injury but an occupational disease claim. OWCP will convert the claim to an occupational disease claim and notify the claimant and employing agency (and any representative, if applicable). In this particular circumstance, it is important that the CE also address the claimant's entitlement to COP.

4. Responsibilities.

a. Claimant. A person claiming compensation must submit sufficient evidence and demonstrate cause for OWCP to proceed with processing and adjudicating a claim. It is the claimant's responsibility to establish the five basic requirements of a claim, which is known as the "burden of proof." OWCP has the obligation to aid in this process by giving detailed instructions for developing the required evidence. The claimant must submit the essential evidence that

demonstrates entitlement to compensation. The five basic requirements of a claim, which must be considered in the order given, are as follows:

(1) Statutory Time Requirements Have Been Satisfied. Compliance with this requirement is demonstrated when the notice of injury, disease, or death shows that prompt notice and claim were given and filed. The claimant has no particular responsibility unless the claim is not filed within three years after the injury. See FECA PM 2-0801.

(2) The Injured or Deceased Individual Was a Federal Civilian Employee or considered an employee for purposes of FECA. Compliance with this requirement is usually a routine matter which is demonstrated by inspection of the notice or claim. The claimant has the burden, however, when the employer is not an agency of the United States or the Federal agency denies the employment status of the injured or deceased. See FECA PM 2-0802.

(3) The Occurrence, or "Fact" of Injury (FOI). Once the first two elements are established, it must be determined whether an injury occurred. See FECA PM 2-0803. This element of the claim consists of two components, which must be considered together:

(a) Whether the claimant actually experienced the accident, untoward event, or employment factors alleged to have occurred. This is a factual determination. The claimant must show that the accident or work exposure that is claimed did in fact occur at the time and place and in the manner alleged.

In occupational disease cases in which the claim is not based upon a specific incident, the claimant must submit sufficient evidence to identify fully the particular work conditions alleged to have caused the disease and substantiate exposure to the conditions claimed.

(b) Whether a medical condition has been diagnosed in connection with this event or employment factor. To make this determination, medical evidence is required. However, there are a few instances when a claim may be accepted without a medical report. See paragraph 6 in this chapter.

(4) The Injury Occurred in the Performance of Duty (POD). The claimant must show not only that an injury occurred but that he or she was performing official duties (or an activity incidental to employment) at the time of injury. The injury must arise out of and in the course of employment. See 5 U.S.C. 8102; FECA PM 2-0804.

(5) The Disability (or Death) Was Caused by the Injury Claimed (CR). The claimant must show that the injury was causally related to the event or employment factors. This requirement is satisfied on the basis of medical evidence, which is usually supplied by the attending physician. See FECA PM 2-0805.

b. Employing Agency. Although the employing agency is not formally a party to the claim, the agency bears a responsibility to assist in developing the claim. The FECA requires the employing agency to report to OWCP any injury resulting in death or probable work-related disability and to submit any further information requested by OWCP. 20 CFR 10.118. As

evidence appearing in the employer's files is not generally available to claimants, the employing agency must assemble and submit such evidence.

(1) In addition to supplying evidence on its own behalf, the agency is expected, wherever possible, to aid the claimant in assembling and submitting evidence. In cases in which OWCP receives the claim long after the employee has left the agency's employment rolls, a claimant may need to assist OWCP in identifying any potential sources of evidence.

(2) Additional evidence from other sources may be needed where the agency's confirmation of the claimant's allegations is not sufficient to establish the claim, or where the official superior or injury compensation specialist disagrees with the claimant's allegations, has no knowledge of the facts concerning the allegations, or is unable to furnish sufficient details.

(3) Since OD claims generally require more detailed evidence, a supervisor or injury compensation specialist can, when issuing Form CA-2 to the claimant, also provide the claimant with a checklist showing the type of evidence which should be submitted. The checklists can be found in the CA-810 publication, Injury Compensation for Federal Employees, which is available on the Department of Labor's website. Conditions covered include: hearing loss, asbestos-related illness, coronary/vascular disease, skin diseases, pulmonary conditions (other than asbestos), psychiatric conditions, and carpal tunnel syndrome.

c. OWCP. In administering the FECA, OWCP must attempt to obtain any evidence which is necessary for the adjudication of the case which is not received when the notice or claim is submitted. To adjudicate claims promptly and manage them effectively, the CE should choose the most efficient, direct, and proactive approach, given the individual circumstances of a claim and the nature of injury.

OWCP is responsible for the following:

(1) Providing Information. The CE must provide information about the procedures involved in establishing a claim, including instructions for developing the required evidence, to the claimant, the employing agency, and the representative, if any.

(2) Requesting Evidence. Upon initial examination of the case, if it is determined that the evidence is not sufficient to establish the essential elements of the claim (timeliness, civil employee, fact of injury, performance of duty, causal relationship), the CE should inform the claimant of the additional evidence needed. The CE should attempt to clarify any discrepancies which exist based on information already in the file at the time of development. The claimant will be allowed at least 60 days to submit the evidence required. OWCP is not required to notify the claimant a second time if the evidence submitted in response to its first request is not sufficient to meet the burden of proof. 20 CFR 10.121. However, approximately halfway through the 60-day development period in traumatic injury, administrative authorization of limited benefit cases and basic occupational disease cases, if the evidence remains insufficient to accept the case, the CE should conduct a second review of the evidence and explain to the claimant why such evidence does not meet their burden of proof, reminding them that a final decision will be issued at the end of the 60-day period.

(3) Identifying Potential Third Party Cases. The CE should be alert for situations where a party other than another Federal employee or agency may be responsible for the injury (see FECA PM 2-1100). The claimant should be notified promptly of his or her obligation to pursue the responsible third party and to refund the government under 5 U.S.C. 8131 and 8132 so that attempts at recovery may begin before the applicable state statute of limitations expires.

(4) Making Prompt Decisions. It is OWCP's obligation to render a decision on each case as promptly as possible. Prompt action is particularly important in those disability cases where the injured employee is losing pay. The Office must notify both the claimant and the employing agency (and any representative, if applicable) of its decision in all cases, other than those that were administratively reviewed and have not reopened. If the case is accepted, OWCP should also respond to any agency challenges or controversions to COP.

5. General Development. This section provides general information for developing claims. The following sections will address the initial development of a claim for factual evidence and medical evidence. Claims that require extended development are discussed in paragraph 9 of this chapter.

a. Evidence. Decisions on claims are based on the written record, which may include forms, reports, letters, and other evidence of various types such as photographs, videotapes or drawings.

Evidence may not be incorporated by reference, nor may evidence from another claimant's case file be used. Evidence contained in another of the claimant's case files may be used, but a copy of that evidence should be placed into the case file being adjudicated. All evidence that forms the basis of a decision must be in that claimant's case record.

b. Developing the Case. Development is usually undertaken in writing. Communication by fax may be used when an expeditious reply is required. A phone call can be made where the request involves answers to specific and simple questions, such as verifying that an inoculation resulting in an adverse reaction was performed by the employer. Evidence obtained by telephone must be carefully documented in writing (on Form CA-110) and depending on the complexity of the information obtained, written confirmation should be requested from the source. In developing a case, the CE should:

(1) Identify and request all information that will be required to adjudicate the claim for all conditions claimed.

(2) Acknowledge receipt of any Form CA-7 which has been submitted and indicate that the CA-7 will be reviewed when the case is adjudicated. This can be done in the development letter.

(3) Attempt to secure evidence in the custody of a Federal agency, as it is more readily available to OWCP than to the claimant. An example of this is exposure data of a historical nature such as in an asbestos case.

(4) Avoid requesting evidence which is already contained in the file or for which no need is anticipated. Such requests place an unwarranted burden on the individual or entity asked to submit the information and result in a duplication of documents in the case file.

(5) To the extent possible, the same CE should handle all claims involving the same part of the body for a given claimant. If another claim already exists for an injury to the same body part, the CE should generally double the case files. See FECA PM 2-0400.

c. Requesting Information. The CE should contact the claimant in writing to obtain information or clarification wherever possible. At times the CE may contact the claimant via telephone if only basic information is needed. This is discussed further in paragraph 7 of this chapter.

Correspondence Library has development letters which may be used when making initial requests for information from the claimant and the agency. When composing the letter, the CE should state what evidence is already in the case record and why it is not sufficient to make a decision. The CE should specifically request only the information necessary to adjudicate the case at hand. Any letter used should be tailored to the specifics of the individual case.

Where the claimant's statement is essential to understanding the basis of the claim (e.g., in emotional stress cases), the CE should wait until the claimant's statement has been received before sending the letter to the agency.

d. Lack of Response. The CE must allow at least 60 days for a response to all initial development letters prior to denying a claim. 20 CFR 10.121. If information is requested of the employing agency, a reasonable period of time should be allowed for the agency's response. Approximately halfway through the 60-day development period in traumatic injury, administrative authorization of limited benefit cases and basic occupational disease cases, if the evidence remains insufficient to accept the case, the CE should conduct a second review of the evidence and explain to the claimant why such evidence does not meet their burden of proof, reminding them that a final decision will be issued at the end of the 60-day period.

(1) If an employing agency fails to respond to a request for comments on the claimant's allegations, the CE may usually accept the claimant's statements as factual. However, acceptance of the claimant's statements as factual is not automatic in the absence of a reply from the agency, especially in instances where performance of duty is questionable. The Employees' Compensation Appeals Board has consistently held that allegations unsupported by probative evidence are not established. James E. Norris, 52 ECAB 93 (1999), Michael Ewanichak, 48 ECAB 354 (1997). The CE should consider the totality of the evidence and evaluate any inconsistencies prior to making a determination.

(2) If the claimant fails to respond, the CE will need to decide whether to adjudicate the claim without the requested information. Often the CE can continue to develop a claim and reach conclusions on the five basic requirements even when some evidence is lacking.

For example, if the CE asks the claimant to submit medical records for a prior hospitalization or operation, but the claimant does not do so, the CE may still be able to adjudicate the case without

them. While records of past medical treatment are helpful, their absence may not necessarily prohibit further development of the claim or a decision on causal relationship. If the missing records are essential, the claim may be denied and the decision should explain why causal relationship cannot be accepted without the missing medical records.

6. No Development Necessary - Visible Injury. When the following criteria are satisfied, a case may be accepted without a medical report and no development of the case need be undertaken:

- a. The condition reported is a minor one which can be identified on visual inspection by a lay person (e.g., burn, laceration, insect sting or animal bite); and
- b. The injury was witnessed or reported promptly, and no dispute exists as to the occurrence of an injury.

Corroborating evidence that the injury was actually identified on visual inspection by a lay person is not needed to establish a visible injury. Certain conditions, such as a bee sting or needle prick, may not be readily apparent to an agency reviewer. The appearance of contusions may vary depending on the employee's skin tone, the location of the injury, etc. Thus, employing agency challenges on the basis that an agency representative did not visually identify the condition will hold limited probative value.

Should an agency challenge be submitted on the basis that the agency could not identify the injury on visual inspection, the claims examiner should advise that there is no requirement that a visible injury be verified to establish a claim; rather the claims examiner should develop as appropriate the issue of whether the claimed factual incident occurred in the time, place and manner alleged. For additional information on employing agency challenges, see PM 2-0806.7.

In cases where there is a serious injury (motor vehicle accidents, stabbings, shootings, etc.), the agency does not dispute the facts of the case, and there are no questionable circumstances, the case may be accepted for a minor condition (such as a laceration in a stabbing case) without a medical report, while simultaneously developing the case for other more serious conditions. In these cases, once a Field Nurse is assigned (see FECA PM 2-0811), he or she can assist with obtaining the necessary evidence. Sound judgment should be employed in these serious cases to provide appropriate and immediate medical care for the injured worker since expeditious treatment for these injuries is critical.

7. Development of Factual Evidence. The purpose of this paragraph is to identify the kinds of factual evidence needed in traumatic injury and occupational illness cases, and how to obtain this evidence. Before making any inquiries, the CE should carefully review all material in the case record, both to identify evidence needed for adjudication and to avoid requesting evidence already provided or not needed.

- a. Sources of Factual Evidence. The type of evidence necessary to adjudicate a claim will determine how the CE obtains the evidence and from whom he or she will request information.

(1) Claimant. In disability cases, the claimant is the injured employee, while in death cases the claimant is the dependent seeking benefits. Whenever there is a factual discrepancy in a case, the claimant should be contacted to clarify the facts of the case. Depending on the facts of the case, it may be necessary to forward the claimant's statement to the employing agency for comment.

(2) Employing Agency. The employing agency is required to complete the reports and statements needed and then submit the evidence to the OWCP. In several types of claims (e.g. stress claims, claims with POD issues such as premises, temporary duty travel, or recreational injuries), a statement from the employing agency is imperative to properly develop and adjudicate the claim.

(3) Witnesses. Statements from witnesses are not required to adjudicate a claim; a claim may be approved in the absence of witness statements. They are very useful, however, when the employing agency is unable to confirm or refute the claimant's allegations. Such statements may be obtained by the claimant or the employing agency.

(4) Other Sources. In most cases, the required evidence will be available from one of the sources noted above. In certain cases, however, the CE will need to request evidence from other sources. This will vary by case and circumstance.

b. Factual Discrepancies.

(1) Nature of Claim. If doubt exists, the claimant should be asked to clarify what condition is being claimed, or whether the claimed condition is due to an occupational disease, a traumatic injury, or a recurrence. Any discrepancies found must be clarified by obtaining the necessary factual evidence before the claim can be properly adjudicated.

(2) Description of Job Duties. This will almost always be required to adjudicate an occupational disease claim, and occasionally will be required for a traumatic injury, especially if it is not clear what the claimant's occupation entails.

(a) The employing agency should be asked to provide a position description, including physical requirements, and clarification of job duties.

(b) The claimant should usually be asked to describe the physical and environmental requirements of the job, and the supervisor or injury compensation specialist should review that statement and provide comments if there is any disagreement.

(c) Where the position description accurately describes the factors claimed as the basis of a medical condition in a claim for occupational disease, it is not always necessary to request a detailed statement from the claimant describing these factors. For example: where aggravation of degenerative disc disease due to repeated heavy lifting is claimed, and the position description states that frequent lifting over 50 pounds is required, it can be accepted that the claimant often lifted heavy objects. If an employee claims a reaction to breathing paint fumes, and the position description states that he or she works with paint in poorly ventilated areas, this can usually be accepted as factual.

(3) Employment History. This information is primarily required for occupational disease claims. The employing agency is often the best source for a chronological history of employment because of the recordkeeping involved in a personnel office. The claimant should also be asked to submit this information, especially for jobs held prior to employment with the employment agency.

(4) Exposure to and Identification of Substances. The employing agency is usually the best source for this data. However, if the agent to which the claimant was exposed was clearly encountered in the work place, it is preferable but not always necessary to identify the specific agent. For example, if the case involves a respiratory condition clearly related to exposure to fumes at work, or dermatitis from contact with a cleaning solvent used at work, the agent need not necessarily be specified.

(5) Content of Substances. If the employing agency is unable to identify the contents of the substance, the manufacturer will likely be the best source for obtaining that information. If such exposure is claimed, the CE should consider whether potential third-party liability exists. If so, the case must be processed according to FECA PM 2-1100.

(6) Personal History. The claimant is the best source for information concerning off-the-job exposure to potentially injurious conditions or substances. However, medical reports containing history elicited by physicians who have examined the claimant sometimes include useful factual information. For example, personal or family history may appear in a claim for a psychiatric or heart condition. The CE should ask the claimant to verify any facts obtained from a medical report.

(7) Various Performance of Duty (POD) Scenarios. In traumatic injury claims, a variety of POD issues may present themselves. These include injuries sustained off premises; injuries sustained while the employee is on TDY status; recreational injuries; and injuries sustained in parking lots/garages. In these instances, the CE should obtain a statement directly from the claimant identifying the circumstances surrounding the injury. The CE should also obtain a statement from the employing agency concerning whether the injury was sustained in the performance of duty. See PM 2-0804 for a complete discussion of POD.

(8) Affirmative Defense. The FECA states that an injury caused by the claimant's intoxication, willful misconduct, or intent to injure self or another is not compensable. These factors are described and their development discussed in FECA PM 2-0804, Performance of Duty. The claimant enjoys an affirmative defense against any finding that one of these factors applies to a claim, and OWCP must overcome such a defense. These factors must be considered and developed prior to the initial adjudication of the claim, since an affirmative defense cannot be raised for the first time on appeal. Adverse decisions of this type should be made at an adjudicative level above that of the CE. See FECA PM 2-0804.

c. Obtaining Information by Telephone. Use of the telephone is encouraged to obtain information when appropriate. If the claimant has difficulty with written communication, the CE should contact the claimant by telephone. In other instances, especially if the CE lacks just one or two pieces of information to take an action, it may be expedient to contact the claimant by phone and

document the case file. The CE should complete a comprehensive and informative Form CA-110 for the case record as soon as possible.

However, where there are disputes in the factual evidence, the case should be considered for conferencing.

d. Conferencing. The CE may use conferencing as a method to obtain necessary data or to clarify significant disputes or discrepancies in the case record prior to adjudication. Procedures for conferencing are fully described in FECA PM 2-0500. The CE should consider conferencing in situations where:

(1) Conflicting evidence exists on an issue important to the adjudication of the case, and the CE has not been able to resolve the issue.

(2) The employing agency has challenged the claim on the issue of fact of injury or performance of duty.

(3) The evidence clearly shows the claimant cannot communicate effectively in writing.

(4) The agency challenges the claimant's allegations and provides conflicting factual evidence.

(5) The agency has not responded to a written request, or its response requires clarification.

e. Phrasing Questions. The way a question is asked can affect the amount and quality of information which will be received. Broadly speaking, development questions can be asked in three ways:

(1) Open Questions. These are phrased so that minimal information is presented in the question and allows the respondent to provide all the specific details about the particular issue at hand.

Example 1: How were you harassed on February 3, 2011? What happened that day? Provide details including names and titles of any witnesses or participants as well as what they said and what occurred.

Example 2: You indicated that you suffered an injury at work on February 4, 2011. How did the injury occur? What type of injury did you sustain?

(2) Direct Questions. These require either yes/no answers or very short responses.

Example: You indicated on Form CA-1 that you tripped while delivering the mail, injuring your foot. What part of the foot did you injure? Describe precisely how you injured your foot - Did you twist it? Turn it? Did you get an x-ray of your foot following the injury?

(3) Leading Questions. These are phrased to suggest what the answer should be.

Example: Your supervisor indicates that you were not scheduled to work on February 7, 2011 and therefore counseling did not occur on this date. Is this correct?

Although leading questions can be helpful when trying to solicit specific factual information from the claimant or employing agency, particularly if the respondent is unwilling or unable to respond to open or direct questions, they should be used only as a last resort.

Note - Leading questions may never be used in the context of a referral to an impartial medical specialist.

(4) Combined Questions. Open questions are best used when little information about a given matter is available. The drawback to this type of question is that while a great deal of information may be received, it may not adequately address the issue if the question is not specific enough. Therefore, it is best to follow an open question with a direct question, since it requires more specificity.

8. Development of Medical Evidence. The purpose of this paragraph is to identify the kind of medical evidence needed in traumatic injury and occupational illness cases, and how to obtain this evidence. Before making any inquiries, the CE should carefully review all material in the case record, both to identify evidence needed for adjudication and to avoid requesting evidence already provided or not needed.

a. Medical Sources. These sources include reports of physicians and hospitals providing examination or treatment to the claimant either before or after the injury. The claimant is responsible for obtaining the necessary medical evidence; however, the CE may also obtain medical evidence from a physician who examined the claimant through direct referral or authorization by OWCP (for example, a second opinion medical referral).

The CE should direct the employing agency to submit all medical documentation related to the claim which is in its possession, including documentation of any treatment the claimant received at the employing agency's medical facility or health unit.

Medical records may also be requested directly from the claimant or the attending physician. If necessary, the CE should send the claimant an authorization for release of records (Form CA-57) to sign and return. The CE may also authorize diagnostic tests for the part of the body that has been injured if he or she determines the results of such testing would be useful.

b. Initial Review and Development of Medical Evidence.

(1) Upon initial review of a new claim for injury, the CE should evaluate any medical evidence which has been received in the case record. For most conditions, the attending physician's opinion may be considered conclusive for adjudicating the claim if he or she is a specialist in the indicated field of medicine; has a complete and accurate history of the employment factors; and provides sufficiently detailed information, including the medical reasoning required to determine diagnosis and causal relationship.

There are some circumstances in which medical evidence is not required to adjudicate a claim or where a rationalized medical opinion is not required. This is addressed in FECA PM 2-0805. See also the discussion of Visible Injuries in paragraph 6 of this chapter.

(2) If after initial review, the medical evidence is not sufficient to accept the claim (or no medical evidence has been received), the CE should request the medical evidence necessary to support the claim. The request should be tailored to the specifics of the case, but should note that the medical evidence must be obtained from a physician, as defined by the FECA. The letter must also inform the claimant that he or she has 60 days to submit the requested evidence. In general, medical reports must provide a history of injury or work factors; a diagnosis; objective findings supporting the diagnosis; and a rationalized medical opinion on the issue of causal relationship.

In most cases, the CE should request that the claimant obtain the medical evidence from the physician as part of the initial development letter. If the CE writes directly to the attending physician to obtain this information, the letter should contain a clause addressed to the claimant which clearly informs him or her that although the letter is written directly to the physician, it is still the claimant's responsibility to ensure that the requested information is provided within the time allotted.

(3) Following the issuance of the initial development letter, the CE should review any new medical evidence submitted. If no medical evidence has been submitted or the medical documentation does not contain *prima facie* medical evidence (see paragraph below), the claim may be adjudicated based on the evidence of record without further development. The CE should ensure that all medical evidence in the case record is considered at the time of adjudication and that the claimant has been provided at least 60 days to submit the medical evidence requested.

For OWCP to undertake additional medical development, the claimant must establish a *prima facie* case by submitting medical evidence from a physician which, at the least, states a diagnosis and clearly supports causal relationship. However, in some cases, the medical opinion need not be fully rationalized in order for the CE to undertake further development. For example, the attending physician may provide a diagnosis and an opinion which is not well-reasoned but nonetheless supports causal relationship. In such cases, further clarification is needed to establish the case, and the medical development should be undertaken by the CE.

c. Request for Additional Medical Evidence. If further development of the medical evidence is required, the CE must undertake such development prior to rendering a decision. Further medical opinion may be requested from attending physicians, second opinion specialists, and referee specialists. The roles of these physicians and the weighing of medical evidence are addressed in FECA PM 2-0810.

(1) Requests to the Attending Physician. Unless the medical history of the case demonstrates that an inquiry to the attending physician will not be productive, it is usually proper to write to the attending physician at least once to obtain the missing information before arranging a second opinion referral. The attending physician should be given the opportunity to bill OWCP for a comprehensive report.

The CE should send the claimant a copy of this and all other letters to the attending physician and advise the claimant that even though OWCP is attempting to obtain the evidence needed to adjudicate the claim, it remains the claimant's responsibility to ensure that the required evidence is submitted.

When sending the letter to the Attending Physician, the CE must be sure to:

- (a) Provide a factual background and pose specific questions;
 - (b) Advise the physician that OWCP will pay for a comprehensive report;
 - (c) Notify the claimant that the requested medical opinion is necessary to further develop the claim; and
 - (d) Advise the claimant that he or she is responsible for ensuring that the physician submits the report within the time allotted.
- (2) If the CE determines that questioning the attending physician further would not be productive, a referral to a second opinion specialist may be warranted. If there is a conflict in the medical evidence between the attending physician and the second opinion specialist and the evidence is of equal but opposing value, a referral to a referee physician may be needed. The procedures for referring cases to second opinion and referee specialists are addressed in FECA PM 3-0400.
- (3) Statement of Accepted Facts (SOAF). A SOAF is often necessary when requesting such medical evidence from the attending physician and required when referring the claimant to a second opinion or referee in this circumstance. Refer to FECA PM 2-0809 for instructions on preparation of a SOAF.
- (4) Questions to Physicians. Questions to a physician should address all unresolved medical issues. The CE should not request medical evidence from the physician which he or she has provided already. When preparing questions for a physician, the CE should:
- (a) Include questions about the history of injury, diagnosis, examination or diagnostic findings, causal relationship (with medical reasoning), and nature and extent of injury-related disability for regular and light duty.

With respect to the issue of causal relationship, it may be useful to provide the physician with OWCP's definitions of direct causation, aggravation, etc. See FECA PM 2-0805.

- (b) Clarify a potential aggravation. If there is a question of whether the diagnosis was a pre-existing condition which was aggravated by the work injury/factors, the CE should ask the physician to clarify this.

Example: "You have opined that the claimant's right knee arthritis is related to the duties of handling luggage as a baggage screener over the last two years. Please clarify whether the right

knee arthritis was directly caused by the work factors identified or if this diagnosis was a pre-existing condition which was aggravated by the work factors claimed."

The physician should also be asked to clarify whether an aggravation of a pre-existing condition is permanent or temporary, and if only temporary, when the condition is expected to return to baseline (pre-injury) status.

With respect to injury-related disability, the CE should be particularly careful to clarify its extent and duration in cases involving aggravation of an underlying condition.

(5) Phrasing Questions. The way a question is asked can affect the amount and quality of information which will be received. Questions can be asked in three ways: Open Questions, Direct Questions and Leading Questions. These types of questions are defined in paragraph 7(e) above and examples of each follow.

(a) Open Question Examples: What is the history of injury as provided by the claimant? What is the diagnosis? What are the objective exam findings/diagnostic findings? Please provide a well-explained opinion on whether the condition was caused or aggravated by the work injury on 04/10/2010.

(b) Direct Question Example: You have opined that the claimant's pre-existing right knee arthritis was aggravated by the work injury on 04/20/2010. Please explain whether this is a permanent aggravation or a temporary aggravation. If temporary, when did the aggravation cease, or when do you expect the aggravation to resolve?

(c) Leading Question Example: Given that the claimant has only been on the job carrying mail for three days, isn't it more likely that his condition of plantar fibrosis is the result of non-work related factors?

Note - The CE should avoid leading questions when requesting evidence from a physician, especially if the question is phrased in such a way as to elicit a response which would invalidate the claim, and leading questions may never be used in the context of a referral to an impartial medical specialist. Stanislaw M. Lech, 35 ECAB 857 (1984) (ECAB found "Give date when aggravated disability ceased" to be leading).

(d) Combined Questions Example: You have indicated that the claimant tripped over a log and has "abnormal findings about the right ankle." What is the diagnosis? What are the "abnormal" exam findings/diagnostic findings? Was the diagnosed condition caused by the trip and fall? Please provide medical reasoning in support of your opinion.

d. Lack of Response. When a CE requests an opinion from the attending physician but receives no reply within a specified period of time, the claim may be adjudicated based on the evidence on file without further development if the CE has:

(1) Provided a factual background and posed specific questions to the attending physician;

- (2) Advised the physician that OWCP will pay for a comprehensive report;
- (3) Notified the claimant that the requested medical opinion is necessary to further develop the claim; and
- (4) Advised the claimant that he or she is responsible for ensuring that the physician submits the report within the time allotted.

e. Medical inquires by telephone. The telephone may be used to schedule examinations, request reports, and address other administrative matters. However, long-standing ECAB precedent provides that oral statements of doctors to OWCP personnel do not constitute competent medical evidence (see John M. Fuller, 9 ECAB 320).

In addition, OWCP examiners may not communicate orally with a referee medical specialist with regard to the examination details or information contained within the report. Such communication must be made in writing. See FECA PM 3-0500. OWCP may communicate with a referee specialist's office for administrative matters such as scheduling an examination or requesting a report.

As with any other telephone call requiring documentation, OWCP personnel should complete a comprehensive and informative Form CA-110 for the case record.

9. Extended Development. Some initial claims require full-scale medical development because 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.

a. Requirements for development and documentation of certain types of conditions.

(1) Hearing loss and asbestosis claims. OWCP should refer the claimant for examination by a qualified specialist if the report submitted by the claimant does not meet all of OWCP's requirements for adjudication (see FECA PM 3-0600).

(2) Cardiac and psychiatric conditions. If the medical evidence submitted by the claimant clearly addresses the necessary requirements and the physician is of the appropriate specialty, the CE should prepare a memo to file stating where in the medical reports of record the questions have been answered. After completing the memo, the CE may adjudicate the claim.

If the report submitted by the claimant does not meet all of OWCP's requirements for adjudication but establishes a *prima facie* case, the CE should prepare a detailed SOAF and questions for the physician. The CE then can write directly to the attending physician (if of the appropriate specialty) as outlined in paragraph 8(c) of this chapter or refer the claimant for examination by a qualified specialist.

10. Obtaining Evidence from Employing Agencies. OWCP will attempt to obtain evidence in possession of another Federal agency. Following is a description of the procedures which should be used with respect to requests for information from employing agencies.

a. Factual Evidence. If the agency has factual evidence which is necessary to make a decision in the claim, the CE should make a written request with a copy to the claimant, indicating a time period within which the agency should reply. The agency should be advised that if it fails to provide the requested information, a decision will be made on the basis of available evidence and that the claimant's statements, if sufficiently clear and detailed, may be accepted on matters of which the claimant is knowledgeable.

b. Medical Evidence. If it appears that the agency has medical records in its possession pertaining to the injury or to any relevant pre-existing condition, the CE should ask the agency to submit copies of such records if they are not sent with the original submission.

c. Transferred Employees. When a Federal employee transfers from one agency to another, the employee's Official Personnel Folder (OPF) and Employee Medical Folder (EMF) should be sent to the new agency. If the OWCP requires information from the OPF or EMF after the employee has transferred from the agency where the injury occurred, the original employing agency may be unable to supply it. The CE should request the information from the current employing agency.

11. Withdrawal of Claim. A claimant or survivor may submit a written request to withdraw his or her claim prior to the adjudication of the claim. This includes claims for traumatic injury, occupational disease, and survivor benefits. It also applies to administrative authorization of limited benefits cases that have not been formally adjudicated. Although a claimant or survivor may withdraw a claim, the notice of injury itself cannot be withdrawn. [See FECA Regulations, 20 C.F.R. 10.100(b)(3), 10.101(a), and 10.105(a)].

a. Upon receipt of a written request from the claimant or survivor, the CE must take the following actions:

(1) In any compensation case where a written notice of intent to withdraw a claim is received from the claimant or survivor prior to the adjudication of the claim, the CE must advise the claimant or survivor in writing that the claim is now considered withdrawn.

(2) The case file will then be coded as withdrawn and the imaged copy retained by the Office. The CE should code the claim as follows:

Adjudication Status: SU

Case Status: CL

(3) No ICD code can (or should) be entered.

(4) In traumatic injury cases, determine if COP was paid. Any COP that was paid will be charged to either sick or annual leave or become an overpayment with the employing agency.

b. Employing agencies are not permitted to compel any employee or survivor to withdraw a claim. Upon notification of a credible allegation that the employing agency improperly compelled the claimant or survivor to withdraw a claim, the District Director or other designated individual, should immediately contact the employing agency by telephone or written correspondence to discuss the matter and to prevent any future occurrences. The telephone conversation must be documented on Form CA-110 and the form imaged in the case record.

c. A claim may be reinstated if there is evidence that a claimant or survivor may have been compelled by the employing agency to withdraw his or her claim. If the claim is reinstated, the claimant or survivor should be notified in writing that the claim is now considered reinstated.

d. If a request is received to reopen a withdrawn claim, a new case number should be assigned. The CE should use the information from the previously withdrawn claim to develop any issues (e.g., performance of duty) in the new case.

12. Group Injuries. When possible, where two or more employees are injured in the same incident, such as an explosion or auto accident, or by the same substance, such as contaminated drinking water, the entire group of cases should be adjudicated by the same CE in order to ensure ☐ uniformity of action.

Exhibit 1: Nature of Injury Codes

(T) Traumatic Injuries

TA	Amputation
TB	Back strain
TC	Contusion; bruise; abrasion
TD	Dislocation
TE	Exposure (including frostbite, heat stroke/exhaustion)
TF	Fracture
TG	Effects of Electrical Current
TH	Hernia (inguinal)
TJ	Crush injury
TK	Concussion
TL	Laceration; cut
TN	Superficial Wounds
TO	Pain, Swelling, Redness, Stiffness (not in joint)
TP	Puncture (not insect bite)
TS	Strain (not back)
TT	Tooth injury
TU	Burn, scald, sunburn
TV	Foreign body in eye
TY	Insect bite

TI	Traumatic skin diseases/conditions, including dermatitis
TR	Traumatic respiratory disease
TQ	Traumatic food poisoning
TW	Traumatic tuberculosis
TX	Traumatic virological/infective/parasitic diseases
TY	Insect Bite
TZ	Pain, Swelling, Redness, Stiffness (in joint)
T1	Traumatic cerebral vascular condition; stroke
T2	Traumatic hearing loss
T3	Traumatic heart condition
T4	Traumatic mental disorder; stress; nervous condition
T5	Headaches
T6	Death sudden/Violent
T7	General Symptoms
T8	Traumatic injury - unclass. (except disease, illness)

(G) Gastrointestinal

GD	Diarrhea
GH	Hiatal, umbilical or ventral hernia
GO	Hernia, Other
GP	Abdominal Pain
GU	Ulcer
G9	Gastrointestinal, not otherwise classified
TQ	Gastrointestinal Conditions

(S) Skin Disease or Condition

SB	Biological (including poison ivy, poison oak)
SC	Chemical
SL	Skin lesion (including blister, bunion, callus and corn)
S9	Dermatitis, not otherwise classified

(M) Musculoskeletal and Connective Tissue

MA	Arthritis
MB	Back or neck strain, sprain
MC	Carpal Tunnel Syndrome
MD	Degenerative Disc Disease; spondylosis; spondylitis
MI	Inflammatory Disease (including bursitis, tendinitis)
MK	Chondromalacia
MP	Pain/Swelling/Stiffness/Redness (in Joint)
MS	Pain/Swelling/Stiffness/Redness (not in Joint)
M9	Musculoskeletal condition, not otherwise classified

(R) Respiratory Disease

RA	Asbestosis
RB	Bronchitis, asthma
RC	Asthma
RE	Emphysema
RP	Pneumoconiosis (Black Lung)
RR	Reaction to smoke, fumes, chemicals
RS	Silicosis
R9	Respiratory disease, not otherwise classified
TR	Respiratory Condions

(V) Virological, Infective and Parasitic Diseases

VA	Acquired Immune Deficiency Syndrome (AIDS) and HIV
VB	Brucellosis
VC	Valley Fever (Coccidioidomycosis)
VD	Anthrax
VF	Rabies
VH	Hepatitis
VL	Lyme Disease
VM	Malaria
VP	Parasitic Diseases
VR	Rocky Mountain Spotted Fever
VS	Staphylococcus
VT	Tuberculosis
V9	Virological/Infective/Parasitic, not otherwise classified

(C) Cardiovascular/Circulatory

CA	Angina
CB	Blood Disorder
CH	Hypertension
CM	Myocardial Infarction (Heart Attack)
CP	Phlebitis; varicose veins
CS	Stroke; cerebral vascular condition
C9	Cardiovascular/circulatory, not otherwise classified

(O) Occupational disease, non-complex

OF	Food poisoning
OG	Tooth and gum-related problems
OL	Inguinal Hernia
OP	Pregnancy (Peace Corps only)

(D) Other Disability, Occupational

DA	Headaches
DB	Seizures/Convulsions
DC	Coma
DF	General Symptoms: Syncope, Dizziness, Vertigo, Fatigue
DH	Hearing loss
DI	Vision/sight loss
DM	Mental disorder; emotional condition; nervous condition
DN	Nerve injury, incl. paralysis, after exposure to toxins
DR	Radiation
DT	Tumors and other cancer-related conditions

Chapter 2-0801, Time

1. Purpose and Scope. This subchapter presents policies and procedures for determining if a report of injury or claim for benefits under the Federal Employees' Compensation Act (FECA) is timely filed under the provisions of the Act. (Consult the FECA PM Index under "Time" for reference to Program Memorandums on several complex time issues.)

2. "Time" is the First Requirement Considered. All cases must first satisfy the statutory time requirements of the FECA. The Claims Examiner (CE) must therefore determine whether timely notice of injury and claim for compensation have been given and filed in all primary cases. To determine whether there has been compliance with the time requirements in any case, it must be decided what requirements govern that case.

3. Statutory Filing Requirements. This paragraph discusses the provisions of the FECA which apply to timeliness of filing. The date of injury governs which time limitation provisions apply in a case. The date of injury is the date that a traumatic injury occurs, the date of death, or the date of last injurious exposure in the case of occupational disease.

a. Injuries and Deaths on or After September 7, 1974.

(1) Written notice of injury or death must be filed within 30 days after the occurrence of the injury or death, under 5 U.S.C. 8119.

The Office of Workers' Compensation Programs (OWCP) should accept as a notice of injury or death any written document received by the employing agency or by the OWCP which is signed by the claimant or someone acting on the claimant's behalf and which contains the name of the employee, the date and location of the injury or death, and the cause and nature of the injury, or the employment factors believed to be the cause.

(2) An original claim for compensation for disability or death must be filed within three years after the occurrence of the injury or death under 5 U.S.C. 8122. If claim is not filed within three years, compensation may still be allowed if:

- (a) Written notice of injury or death was given within 30 days as specified in 5 U.S.C. 8119; or
- (b) The immediate superior had actual knowledge (including verbal notification) of the injury or death within 30 days after occurrence. The knowledge or notification must be such as to put the immediate superior reasonably on notice of an on-the-job injury or death.
- (3) Knowledge by the immediate superior, another official at the employing agency, or any agency physician or dispensary that an employee has sustained an injury, alleges that an injury has been sustained, or alleges that some factor of the employment has resulted in a physical condition constitutes actual knowledge. Such knowledge does not have to be firsthand or acquired as an eyewitness to the accident.

(a) For confirmation in doubtful cases a statement should be requested from the person named as having actual knowledge, showing what specific knowledge the person has of the injury or disease, how and from whom this knowledge was acquired, and when it was acquired. Where treatment was received from the physician or dispensary of the employing agency, a copy of the medical record should be requested.

(b) Such knowledge or notification must be such as to put the employing agency reasonably on notice of an on-the-job injury or death. It is not sufficient that the immediate superior, official or dispensary worker at the agency was aware that the employee complained of back pain, suffered a myocardial infarction, etc. To constitute actual knowledge, it must be found that the immediate superior, other official, or dispensary worker was aware that the employee related the back pain, MI, etc. to an injury sustained while in the performance of duty or to some factor of the employment.

(c) If an agency, in connection with a recognized environmental hazard, has an employee testing program and a test shows the employee to have positive findings this should be accepted as constituting actual knowledge. For example, an agency where employees may be exposed to hazardous noise levels may give annual hearing tests for exposed employees. A hearing loss identified on such a test would constitute actual knowledge on the part of the agency of a possible work injury.

(4) OWCP may excuse the failure to comply with the three-year time requirement under 5 U.S.C. 8122 on the ground that notice of injury or death could not be given because of exceptional circumstances. One "exceptional circumstance" recognized is a case of a claimant who could not file a claim because that person was a prisoner of war during the entire three-year period.

b. Injuries and Deaths Occurring Between December 7, 1940 and September 6, 1974.

(1) Written notice of injury should be given within 48 hours under 5 U.S.C. 8119. This requirement is automatically waived if the employee filed notice within one year after the injury or if the immediate superior had actual knowledge of the injury within 48 hours after occurrence.

(2) An original claim for compensation for disability or death must be filed within one year after the injury or death under 5 U.S.C. 8122.

(3) Waiver of the requirements for giving notice and filing a claim within one year could be granted under 5 U.S.C. 8122 if a claim was filed within five years after the injury or death, and

(a) The failure to comply was due to circumstances beyond the control of the individual claiming benefits; or

(b) The individual claiming benefits could show sufficient cause or reason in explanation of the failure to file within one year, and material prejudice to the interest of the United States did not result from such failure. Material prejudice to the interest of the United States may result in rare situations because the OWCP is unable to investigate the facts because of the passage of time, the employing agency has been deactivated, there are no available records, and the claimant is unable to supply evidence to corroborate allegations made. In these cases, the burden is on OWCP to show that material prejudice has resulted.

The second reason for waiver can often be applied. Some examples include lack of knowledge of causal relationship between injury and disability (James T. Nunn, 1 ECAB 165) and immediate disability for work did not follow injury (Theodore E. Holmbug, 2 ECAB 195).

(4) Medical treatment for the results of an injury can be provided if timely written notice of injury was filed in accordance with 5 U.S.C. 8119, or if the immediate superior had actual knowledge of the injury within 48 hours. This is so even if a claim for compensation was not timely filed so as to permit an award for monetary compensation. For a full discussion of this situation, see Edward T. Lowery (8 ECAB 745).

c. Injuries and Deaths Prior to December 7, 1940. The FECA required that written notice of injury and claim for compensation for disability or death be given or filed within one year after the injury or death. There is no waiver provision with respect to such cases or any provision for delayed filing for latent disease or any other such circumstances.

4. Determining Date Claim is Filed. This paragraph addresses how the date of filing is determined. This date is the date of receipt of a claim by the OWCP or by the employing agency, rather than the date the claim was completed.

a. Forms CA-1, CA-2, CA-5, CA-5b and CA-7 constitute claims for the purpose of considering the time requirements. The CE must determine whether the claim was received by OWCP or the employing agency within the time specified in paragraph 3. In most cases, this may be established by:

(1) The entries on Form CA-1 or CA-2;

- (2) The date of receipt noted by the employing agency or OWCP;
- (3) The date the employing agency transmitted it to OWCP;
- (4) The date the official superior completed the claim form; or
- (5) A statement from the official superior confirming the date the claim was received by the employing agency.

b. If a prescribed claim form has not been timely filed, the CE should consider any written documents from the person claiming benefits, or someone acting on this person's behalf, from which the substance of a claim can be reasonably deduced.

(1) If the injured employee is still working, the official superior should be asked to examine the official personnel file or other records, and provide OWCP with any communication from or on behalf of the claimant which may contain words of claim.

(2) Where the injured employee is not still employed by the Federal Government, and if there is any indication of earlier communication about a claim, the CE should request the official personnel file from the Federal Records Center. If any document in this file contains words of claim the CE should place a copy in the OWCP file along with memorandum identifying the document and its source.

(3) Decisions concerning the use of a document other than a prescribed form as a claim, should be made at an adjudicative level above that of the CE.

(4) If a claim is not received by OWCP or the employing agency within the statutory time frame after the date of injury, the CE must determine when time begins to run. Time begins to run as stated in the following paragraphs depending upon the type of injury or the status and location of the person claiming benefits.

5. Traumatic Injury Claims. This paragraph discusses how determinations of timeliness are made in traumatic injury cases. Time begins to run from the date of injury where the injury can be identified as to time, place, and circumstances of occurrence. The CE must be reasonably certain that the date of injury has been correctly stated. This question should receive particularly careful consideration if the reporting has been delayed to the extent that the injury may not have been reported within the appropriate time frame. Additional evidence should be obtained when the CE questions whether the date has been properly reported. Sources used to verify the date of injury include:

a. Statements from the claimant, official superior, or witnesses explaining why they believe the date of injury has been correctly stated. A statement from the official superior may address the leave and attendance records showing whether the employee (and the witnesses where so indicated) was in fact present for duty on the alleged date of the accident or during the period claimed;

- b. Copies of the medical records covering the medical examinations immediately following the injury with particular emphasis on the date of the accident shown in the history; and
- c. Copies of any documents prepared immediately following or soon after the accident relating to the injury.

6. Occupational Disease and Latent Injury Claims. This paragraph discusses how determinations of timeliness are made in occupational disease cases. In these cases, time begins to run when the injured employee becomes aware, or reasonably should have been aware, of a possible relationship between the disease or condition and the employment. Where the exposure to possible injurious employment-related conditions continues after this knowledge, the time for filing begins to run on the date of the employee's last exposure to the implicated conditions.

- a. Form CA-2 requests the date the claimant first realized the presence of an occupational disease and related it to the employment, and how the employee came to this realization. Form CA-2 also requires the official superior to comment upon the claimant's statements. Where necessary, the CE should obtain additional information to clarify this issue.
- b. If the claimant did not file within the statutory time limitations after exposure to the employment factors ceased, the medical reports should be examined to determine whether the claimant was aware, or reasonably should have been aware, of the illness and its possible relationship to employment. For example, the history obtained at the time of the first and subsequent examinations, the date when a definite diagnosis was made, or the advice given by the doctor to the claimant, may assist the CE in determining the issue of possible awareness.
- c. If the employing agency gave regular physical examinations which might have detected signs of illness (for example, regular X-rays or hearing tests), the agency should be asked whether the results of such tests were positive for illness and whether the employee was notified of the results. [If the claimant was still exposed to employment hazard on or after September 7, 1974 and the agency's testing program disclosed the presence of an illness or impairment, this would constitute actual knowledge on the part of the agency, and timeliness would be satisfied even if the employee was not informed (see paragraph 3 a (2)(b) above.)]

7. Death Claims. This paragraph discusses how determinations of timeliness are made in death cases.

- a. The statutory time requirements for filing such claims begin to run from the date of death, which normally will be determined by the official death certificate.
- (1) In cases of death due to disease, time does not begin to run until the beneficiary is aware of, or by the exercise of reasonable diligence should have been aware of, the causal relationship of the death to the factors of employment [see 20 C.F.R. 10.105(c)]. Development of the question of when time begins to run in this situation should follow that outlined in subparagraph 6 above.

(2) In cases of deaths on and after September 7, 1974, the timely filing of a disability claim will satisfy the time requirements for a death claim based on the same injury.

b. For individuals who are missing under circumstances not affording immediate proof of death or those coming within the scope of the Missing Persons Act (Pub. Law 77-490), the OWCP must make its own independent finding on date of death, since the findings and date of presumptive death made under the Missing Persons Act are not binding upon OWCP. To make this finding, the following should appear in the record:

(1) Disappearance During a Period of Hostilities. The employing agency should advise the date of disappearance; whether the employee disappeared while actively participating in combat or under comparable conditions; whether the employee is accounted for as a prisoner of war or as a parolee or internee; whether there has been any official or other information concerning the employee's existence after the disappearance; and whether after termination of hostilities or declaration of peace, any information has been received which would rebut the inference of death arising from the facts. The claimant should advise whether the family has received any information as to the employee's whereabouts subsequent to the disappearance or after the restoration of normal conditions.

(2) All Other Disappearances. The employing agency should advise the date when the employee was last seen; a full description of the particular circumstances leading up to and resulting in the disappearance; and whether there has been any official or other information concerning the employee after the disappearance. The claimant should advise whether the family has received any information as to the employee's whereabouts subsequent to the disappearance.

c. A finding of death shall be made, and the date of death determined, as soon as practicable after the claim is filed, when the situation leaves little or no doubt that death occurred at the time of disappearance. Where the facts lead to a reasonable presumption that the employee may have escaped death, the determination should be deferred until enough time has elapsed to overcome the presumption of survival. In cases coming within the scope of the Missing Persons Act, the determination will not be made while the employee is being carried in a missing status.

8. Special Circumstances. The purpose of this paragraph is to address determinations of timeliness in unusual situations.

a. For a Minor. The time limitations do not begin to run until this person reaches the age of 21 or has had a legal representative appointed.

b. For an Incompetent Individual. The time limitations do not begin to run while this person is incompetent and has no duly appointed legal representative. A determination of incompetence must be based on probative medical evidence and must be consistent with other actions by the claimant during the period in question (Paul S. Devlin, 39 ECAB 715).

c. For an injury or death occurring outside the United States between December 7, 1941 and August 10, 1946. The time for giving notice and filing claim began to run on October 14, 1949.

d. Posthumous Claim. Such a claim may be made by the estate or a survivor of a deceased employee for medical benefits only. A posthumous disability claim cannot be accepted. If OWCP receives a claim within the statutory requirement outlined in paragraph 3 (three years on and after September 7, 1974 and one year prior to September 7, 1974), the claim is timely filed and no further development of this issue is necessary.

9. Further Development. Where timely written notice of injury was given or the immediate superior had timely actual knowledge of the injury, it should be accepted that the time requirements are met for further consideration of eligibility for compensation or medical benefits as appropriate. Findings must then be made on the issues of civil employee, fact of injury, performance of duty and causal relationship.

Chapter 2-0802, Civil Employee

1. Purpose and Scope. When it is determined that the notice of injury or claim for compensation was timely given or filed, the Claims Examiner (CE) must consider whether the injured or deceased individual was a civil employee of the United States within the meaning of 5 U.S.C. 8101(1). This chapter contains policies and procedures for making this determination.

2. Additional References. Further information may be obtained from the following sources:

- a. FECA Program Memoranda (ProM), which discuss numerous groups of employees and provide rationale for many decisions.
- b. PM Chapter 2-1700, which addresses Peace Corps and VISTA Volunteers, Neighborhood Youth Corps and Job Corps enrollees, law enforcement officers not employed by the United States, and members of the D.C. Metropolitan Police Reserve Corps.
- c. PM Part 4, which discusses non-Federal law enforcement officers, claimants under the War Hazards Compensation Act and the War Claims Act, Civil Air Patrol volunteers, Reserve Officers' Training Corps (ROTC) Cadets, various Federal relief workers, foreign nationals, and Panama Canal Commission employees.
- d. The FECA PM Index, which lists many groups of workers under the heading of "Employee." Also consult the Index to the decisions of the Employees' Compensation Appeals Board (ECAB).

3. Proof that the Employer is an Instrumentality of the U.S. The CE must first determine whether the reporting agency is a "branch of the Government of the United States" as that term is used in 5 U.S.C. 8101(1) of the FECA. Completion by the official superior of the report of injury is prima facie proof of the status of the reporting office. The CE should examine the claim forms to identify the particular agency reporting the injury.

The CE may decide this question affirmatively when the evidence clearly shows the reporting agency is a component of the legislative, judicial, or executive branch of the Government of the United States. For this purpose, the executive branch includes the Executive Office of the President, the executive departments, the independent agencies and instrumentalities of the United States. The CE should refer to the United States Government Organization Manual if the reporting agency is unfamiliar. The CE should consult with a Quality Assurance and Mentoring Examiner or supervisor if not satisfied that the requirements have been met.

If further information is needed, the reporting office should be asked to clarify its status as a branch or instrumentality of the United States by citing the statutory authority for its existence and providing a copy of the pertinent statute. The agency should also be asked to state the source of its operating funds. The issue should then be referred, with the supporting documents, to the Director for Federal Employees' Compensation. Or, the agency may request a determination directly from the National Office.

4. Proof that the Injured/Deceased Individual is an "Employee". The CE must next decide whether the injured or deceased individual had status as an officer or employee of the reporting office at the time of the injury. Here again, the supervisor's completion of a report of injury or death is prima facie proof of the worker's status as an "employee."

The CE may decide this question affirmatively when the evidence clearly shows that the service performed for the reporting office by the individual was of a kind usually performed by an employee, as distinguished from an independent contractor, and that a contract of employment was entered into prior to the injury.

Questions may arise concerning the status of volunteers or enrollees in social assistance programs. The employing agency should be asked to cite the statutory basis for accepting the services of volunteers or enrollees and to provide a copy of this legislation. The issue should then be referred, with the supporting documents, to the Director for Federal Employees' Compensation. Or, the agency may request a determination directly from the National Office.

5. Question of Applicant vs. Employee. This question must be considered where it is unclear that a contract of hire was established before the injury or if the claimant worked at the agency prior to the injury.

a. The most usual situations involve cases where:

(1) The claimant is a casual employee;

(2) The injury occurs about the time the employment contract began or was about to begin; or

(3) The injury occurs in connection with a pre-employment examination, vaccination or immunization, or an event of a similar nature where the individual may not have as yet acquired the status of an "employee."

b. Where the claimant's status is unclear, the CE should obtain the information noted below. Any material discrepancy in the statements must be clarified by requesting supplemental statements from principals, or by obtaining similar evidence from other sources. The CE should ask the worker and reporting agency:

(1) The precise time when the worker accepted an offer of employment from the reporting agency;

(2) Whether such agreement was verbal or written (a copy should be requested if there was a written agreement; otherwise, particulars of the agreement should be furnished);

(3) Whether the worker was required to take an oath of office and, if so, whether the oath was taken prior to the injury;

(4) What work, if any, the worker had performed for the reporting office prior to the injury; and

(5) The precise time when the worker began rendering this service and when pay began accruing.

6. Question of Independent Contractor vs. Employee.

a. Contract Employees. Not every person rendering service for the Federal government is necessarily an "employee."

Many such individuals are independent contractors or employees of independent contractors and have no status under the FECA. For this reason the CE must be particularly careful to determine whether the worker is an independent contractor or an "employee." Where this issue becomes a factor, the CE should request statements from the worker and the reporting agency, to show:

(1) Whether the worker performs services or offers services to the public generally as a contractor or is permitted to do so by the reporting agency and, if so, a full explanation;

(2) Whether the worker is required to furnish any tools or equipment and, if so, a full explanation;

(3) The period of time the work relationship is to exist;

(4) Whether the reporting agency has the right to discharge the worker at any time and, if so, when and under what circumstances;

(5) Whether the reporting agency has any right to control or direct how the work is to be performed and, if so, a full explanation;

(6) The manner in which payment for the worker's services is determined; and

(7) Whether the activity in which the worker was engaged was a regular and continuing activity of the reporting agency and, if not, a full explanation.

b. Proof of Status. Any material discrepancy in these statements must be clarified by requesting supplemental statements from the principals, or by obtaining similar evidence from other sources. A copy of the contract or agreement should be obtained if there was a written instrument to support the agreed-upon work relationship. Proofs of employee status are similar to those for regular employees of the United States.

7. Postal Service Mail Messengers. Determinations of whether mail messengers who perform service for the U.S. Postal Service are considered civil employees are made on a case-by-case basis. These cases should be referred to a Quality Assurance and Mentoring Examiner.

Before referral, the CE should ask the reporting agency for copies of any written agreement or work contract executed by the mail messenger or the Postal Service when the injured individual began working or at any later date, and of any oath executed by the worker. Absent a written contract, the postmaster and the mail messenger should be asked to submit statements showing in full detail the terms of the oral agreement and the precise manner in which it was reached.

The reporting agency should also be asked to submit a statement showing:

- a. The manner in which the worker qualified and was selected to act as mail messenger;
- b. The distance the mail was carried;
- c. The kind of equipment used and by whom it was furnished;
- d. Whether the mail messenger was required to personally perform the service or whether assistants or substitutes were permitted and, if so, under what conditions and circumstances;
- e. Whether the mail messenger had any other employment or performed or offered like or similar services to the public as an independent business service and, if so, this should be explained fully;
- f. The manner and circumstances under which the relationship could be terminated;
- g. The manner in which the pay was determined;
- h. Who determined how, when, and in what manner the mail would be carried; and

i. What right, if any, the postmaster had to direct or supervise the work performed by the mail messenger and to what extent the postmaster exercised this right.

8. Contract Job Cleaners Used by the Postal Service. In lieu of using employees with civil service appointments, the U.S. Postal Service frequently contracts for the services of individuals to perform janitorial work. The contracts consist of signed agreements, which may result from negotiation or invitation-bid. Determinations of whether contract job cleaners are civil employees under the FECA are made on a case-by-case basis and will depend on the particular facts of each case.

Cases of contract job cleaners are to be referred to a Quality Assurance and Mentoring Examiner (QAM) for adjudication. The QAM should request:

- a. A copy of the Postal Service agreement form under which the worker was serving when injured;
- b. A statement from the postmaster showing the extent to which there was a right to control the manner of the worker's performance and the amount and extent of the control exercised over the worker; and
- c. A statement from the contract job cleaner showing whether the injured person worked for any employer other than the Postal Service during the year before the injury and, if so, the employers' names and addresses and the inclusive dates worked, the kinds of work performed, the rates of pay, and the total amounts earned from each employer.

9. Workers Serving Without Compensation. Except for cases of certain volunteers with the Department of Veterans Affairs (see paragraphs 10-12 below) and certain volunteers with the U.S. Department of Agriculture, Forest Service (see paragraph 13 below), determinations of civil employee status for volunteers must be made by a Quality Assurance and Mentoring Examiner or higher adjudicative authority.

- a. Statutory Authority. In any case where status as a civil employee is claimed by reason of 5 U.S.C. 8101(1)(B), the CE must obtain a statement from the reporting agency citing the statutory authority by which the services of the injured or deceased individual were used. (See paragraph 4 concerning referral of such issues to the National office.)
- b. Kind of Service Rendered. The CE must also ensure that the evidence shows whether the injured or deceased individual was "rendering a personal service of a kind similar to those of civilian officers or employees of the United States." If such evidence is not received with the initial submission, the CE should ask the reporting agency to submit a statement which fully describes the services rendered by the injured or deceased individual and shows whether the agency has persons on its payroll who render similar services and, if so, the job titles for those positions.

c. Employee Performing Similar Services. In order for an individual to be an employee within the meaning of 8101 (1) (B), the Employees' Compensation Appeals Board (Board) has found that two elements must be established; 1) the individual was rendering personal services to the United States without pay or for nominal pay which were similar to those of an employee of the United States, and (2) that a statute authorized the acceptance or use of the services by the employing agency or authorizes that payment of that individual's expenses. *Rivieene Levin and Jami Smilgoff*, 45 ECAB 391 (1994); *Nora Lewis*, 37 ECAB 245 (1985); *George Abraham*, 36 ECAB 194 (1984); *Sandra Davis*, Docket No. 97-117 (issued July 8, 1999); *Roslyn C. Marinoff*, Docket No. 88-157 (issued December 30, 1988). The Board has further held that this section should be liberally construed to affect the stated intent of Congress to provide workmen's compensation benefits for those who pursuant to statutory authority are serving the Federal government. The Board stated that it was apparent Congress utilized broad language to cover many situations so as not to limit coverage to other volunteers performing necessary services directly for the Federal government in accordance with statutory authority in carrying out the functions and obligations of its departments and agencies. *Jeane M. Baldwin*, 12 ECAB 260 (1960). The Board has also elaborated on how to compare the services performed by a volunteer with the services of a civil officer or employee of the U.S. and how the term "similar" should be defined. When making the comparison between the civil service position and the volunteer position, it is the duties of the jobs that are compared and not the job designation. *Jeane M. Baldwin*, 12 ECAB 260 (1960). Moreover, in looking for a similar position, the search is not confined only to the same organizational levels or units but is compared at least to the agency as a whole. *Nora Lewis*, 37 ECAB 245 (1985); *Jeane M. Baldwin*, 12 ECAB 260 (1960). In defining the word similar the Board has held that similar does not mean "precisely like" or "like in all respects" but only "somewhat like" or "substantially like." *Florence Zimmerman*, 8 ECAB 435 (1955); *Jeane M. Baldwin*, 12 ECAB 260 (1960).

10. Volunteer Workers with the Department of Veterans Affairs. OWCP has determined that the Department of Veterans Affairs (DVA) has statutory authority to use the services of persons who serve without compensation in its Volunteer Service Program. Therefore, the CE need not ask the DVA to cite its statutory authority for using the services of these individuals.

However, the CE must be certain that the injured or deceased individual was "rendering a personal service of a kind similar to those of civilian officers or employees of the United States" as required by 5 U.S.C. 8101(1)(B). (See instructions in preceding paragraph.)

The CE may affirmatively determine the status of these individuals when the service performed by the injured or deceased individual is clearly like the services in well-established positions in the Federal service, e.g., nurse's aide, recreation supervisor, etc. Otherwise, the question should be submitted for determination by a Quality Assurance and Mentoring Examiner or higher adjudicative authority.

11. Attendants Authorized to Travel with DVA Patients. OWCP has ruled that a person has status as an "employee" while traveling under an authorization from the DVA as an attendant for one of its beneficiaries. The authority for the DVA to use the services of these

individuals appears in Pub. Law 76-432 (38 U.S.C. 76), as amended. In any case of this nature, the CE should ask the DVA to submit:

- a. A copy of the authorization issued to the attendant by the Department of Veterans Affairs; and
- b. A statement showing whether the services of the injured or deceased individual were used pursuant to the provisions of Pub. Law 76-432 (38 U.S.C. 76), as amended. The CE may affirmatively determine the status of these individuals when the attendant was serving under a valid authorization and it is shown it was issued pursuant to this legislation.

12. Affiliate Student Nurses of the DVA. OWCP has determined that an affiliate student nurse of the DVA has status as an "employee" when appointed for training pursuant to section 14A, Pub. Law 79-293. In any case of this nature the CE should ask the DVA for a statement showing whether the services of the injured or deceased individual were used pursuant to the provisions of this section. The CE may determine the status of these individuals affirmatively when it is shown they were serving under the authority of this legislation.

13. Volunteer Workers with the Forest Service. A volunteer with the U.S. Department of Agriculture, Forest Service, whose services are accepted or used under the authority of Pub. Law 92-300 (Volunteers in the National Forests Act of 1972) has status as an employee by virtue of section 3(c) of that Act. Therefore, in cases of volunteers with the Forest Service, the CE should ask the employing agency for a statement showing whether the services of the injured or deceased individual were used pursuant to the provisions of that law. The CE may determine the status of the individual affirmatively when it is shown that the services were accepted or used under the authority of this legislation.

14. Volunteer Weather Observers of the National Oceanic and Atmospheric Administration. The National Oceanic and Atmospheric Administration (NOAA) has many small weather stations where, by agreement, individuals make observations on a voluntary basis without pay. They are known as "volunteer weather observers." The operation of the station may be by agreement with:

- a. Individuals who make observations on their own time. These individuals have status as employees while actually engaged in taking the observations or while performing activities incidental to making the observations. The CE may determine the status of these individuals affirmatively when the evidence clearly shows the agreement to operate the station was with the individual.
- b. A company or institution, where its employees take the observations as part of their regular duties. These individuals do not have status as employees.
- c. Individuals who are employees of a company or institution and who are permitted to take observations on company time. The status of these individuals is questionable and such cases should be referred to a Quality Assurance and Mentoring Examiner for final determination after the facts have been developed fully. The CE should ask the NOAA to submit a copy of the

agreement made with the individual, company, or institution for the operation of the weather station. If this agreement is not sufficiently detailed or otherwise fails to clarify the status of the injured or deceased individual, additional information should be requested of the NOAA, the injured individual or claimant, or the company or institution which may also be involved. In many of cases involving individuals (subparagraphs 14a or 14c), the more difficult issue is whether the injury occurred in the performance of duty, and particular attention should be given to the guidance in FECA PM 2-804.

15. Employees of the U.S. Property and Fiscal Officers (National Guard).

All cases in this category must contain a statement from the U.S. Property and Fiscal Officer (or from some other responsible and knowledgeable official of the National Guard) certifying that the injured or deceased individual was a civil employee of the U.S. paid from Federal funds, and at the time of injury was performing duties in a civilian status. These agencies have been instructed to submit this certification with the original reports on Form CA-1 or CA-2. It should be requested from the reporting agency if it is missing.

a. This certificate is required because these civilian caretakers and technicians serve in a dual capacity:

(1) As members of the State National Guard in a military capacity, and

(2) As employees of the U.S. Property and Fiscal Officer in a civilian capacity. This certification is prima facie proof that at the time of the injury, the injured or deceased individual had status as an employee.

b. The CE may accept this certificate and affirmatively determine the employee's status on this basis, unless the particular facts and circumstances of the case or other evidence creates doubt whether the certification is correct. The CE should consult with the Quality Assurance and Mentoring Examiner or supervisor if it is felt that certification is not valid.

16. Employees Transferred to International Organizations. A Federal employee who transfers to an international organization retains the coverage, rights and benefits of the FECA if, prior to the transfer, the employee was serving under a Federal appointment not limited to one year or less, and the head of the Federal agency consented to the transfer (see Pub. Law 85-795).

In any case of injury or death to a Federal employee after transfer to an international organization, the CE should ask that the forms, reports, or certificates required of an official superior be completed and signed by an appropriate official of the Federal agency which originally employed the claimant.

Alternatively, forms, reports, claims, etc., will be acceptable when completed by an official of the international organization if they are either countersigned by an official of the Federal agency, or accompanied by a certificate from the Federal agency confirming the employee's employment status and duty status at the time of the accident.

Additionally, an appropriate official of the Federal agency should be asked to submit a statement showing the following:

- (1) Whether, prior to the transfer to the international organization, the employee was serving with the Federal agency under a Federal appointment not limited to one year or less; and
- (2) Whether the employee transferred to the international organization with the consent of the head of the Federal agency as provided by Pub. Law 85-795. In this situation the Federal agency should always be asked to act as the reporting office.

17. Loaned Employees. Careful consideration must be given to the employment status of Federal employees who are injured while performing service for a private employer. The CE must determine whether the injured or deceased individual was merely loaned to the private employer and retained status as a Federal employee, or whether a transfer of employment occurred, thereby terminating the prior status as a Federal employee. The CE should obtain a statement from the reporting agency which shows:

- a. The citation of any statute which authorizes the injured or deceased individual to perform service for a private employer;
- b. The name of the person who had immediate control and direction of the work activities of the injured or deceased individual at the time of the injury;
- c. What right or general responsibility, if any, the reporting agency had at the time of the injury to direct or control the work activities of the injured or deceased individual;
- d. From whom the injured or deceased individual received salary at the time of the injury. If the private employer paid the salary, did the reporting agency reimburse that employer from Federal funds appropriated for the payment of personal services, and if so, how;
- e. Whether after completion of the assignment the injured or deceased individual was expected to resume the performance of service for the reporting agency and, if so, when and under what circumstances;
- f. What interest, if any, the reporting agency had in the work being performed by the private employer; and
- g. What benefit, if any, the reporting agency derived from the service performed for the private employer by the injured or deceased individual.

18. Cadets at State Maritime Academies. OWCP has determined that cadets at state maritime academies in Maine, Massachusetts, New York, Texas and California are eligible to receive the benefits of the FECA by reason of their status as enrolled members of the United States Maritime Service. The reports and certificates which OWCP requires of an official superior may be completed by an appropriate official of the state academy, who will in turn

forward them to the Director, Office of Maritime Labor and Training, U.S. Department of Transportation, Maritime Administration, 400 Seventh Street, S.W., Washington, D.C. 20590.

The Washington office of the Maritime Administration will make the necessary inquiries and otherwise determine the accuracy of the reports and then forward them to the proper OWCP office. The original submission of the basic compensation reports must include a certification from the Supervisor for State Maritime Academies showing whether at the time of the injury the individual was enrolled as a cadet in the U.S. Maritime Service.

19. PHS Employees Detailed to a State or Local Agency. U.S. Public Health Service employees who are assigned to state or local agencies either maintain their Federal status in all respects, including entitlement to compensation, or are carried by PHS on leave without pay status and are paid by the state. In either case, they are entitled by law to benefits of the FECA.

In all cases of PHS employees injured while assigned to state or local agencies, inquiries should be made to determine if they are receiving or have received benefits under a state compensation law. If so, the Public Health Service Act of 1943 requires that an election should be requested and must be made within one year. If the claimant elects FECA coverage, the state should be reimbursed from any compensation due, and the balance should be paid to the claimant.

20. Grand and Petit Jurors. Pub. Law 97-463, effective January 12, 1983, provides that persons serving as grand or petit Federal jurors are entitled to benefits under the Act, for injuries occurring on or after that date.

a. Coverage of jurors is limited to injury in, or arising from, situations where the juror is:

(1) In attendance at court pursuant to a summons.

(2) In deliberation.

(3) At a location, such as the scene of a crime, for the purpose of taking a view.

(4) Sequestered by order of a judge.

A juror is not covered while traveling to and from home.

b. The pay rate for compensation purposes for grand or petit Federal jurors will be that of a GS-2, step 1, unless the juror is a Federal employee. In that case the pay rate is based on the juror's actual Federal employment and is determined in accordance with 5 U.S.C. 8114. Entitlement to compensation for disability does not begin until the day after termination of service as a juror.

c. The continuation of pay provisions of 5 U.S.C. 8118 would only apply if the juror is a Federal employee who would be entitled to COP by virtue of the definition given at 5 U.S.C. 8101(1)F.

d. Jurors who are not otherwise Federal employees are entitled to all rights and benefits under the FECA, aside from COP.

e. The clerk of the court, or a designee, will serve as the official superior in these cases.

21. Alaska Railroad Employees. The Federal Railroad Administration and the State of Alaska have transferred the Alaska Railroad to State control. As part of the transfer agreement, it was determined that all compensation cases involving injuries or occupational diseases occurring on or after January 6, 1985 were the responsibility of the State of Alaska through the Alaska Railroad Corporation. On that date, employees of the Alaska Railroad ceased to be employees of the Federal government for purposes of the Act.

a. Injuries sustained before January 6, 1985 are covered under the FECA, and the Federal Railroad Administration of the Department of Transportation is the responsible Federal agency. Inquiries about cases arising because of injury or exposure which occurred on or after January 6, 1985 should be referred to:

Mr. Marvin Yetter
Comptroller
Alaska Railroad Corporation
Pouch 7-2111
Anchorage, Alaska 99510

b. In an occupational disease case where exposure to employment factors claimed as injurious occurs on or after January 6, 1985, the CE should return the claim to the claimant and advise that the FECA does not apply. The claimant should be instructed to contact the Alaska Railroad Corporation at the address noted above. Where exposure ended prior to January 6, 1985, the FECA continues to apply, and such cases will be handled in the usual manner.

c. If it is not clear when exposure ceased, or whether a "recurrence" is a "new injury," it may be necessary to create a case and develop the issue. In any event, any request from a claimants for a formal decision on the coverage of the FECA should be honored.

22. Participants in Community Work Experience Programs (CWEP). On July 18, 1984, the Congress passed Pub. Law 98-369, which determined that participants in community work experience programs at Federal agencies are not to be considered Federal employees. Further, it held that:

The State agency shall provide appropriate workers' compensation and tort claims protection to each participant performing work for a Federal office or agency...on the same basis as such compensation and protection are provided to other participants...in the State.

While CWEP participants hosted by Federal agencies would qualify as Federal employees for the purpose of the FECA, as long as a Federal supervisor controlled the work activities, the intent of Congress in passing the above-cited legislation is clear. Therefore, it has been determined that

for the purpose of the FECA, a participant working at a Federal installation under the supervision of a Federal employee prior to July 18, 1984 is entitled to coverage under the Act.

a. Where an injury is sustained before July 18, 1984, the CE should determine if it occurred while the participant was hosted at a Federal facility and whether the work activities were controlled by a Federal employee. If so, the participant is to be considered covered under the FECA.

b. Where an injury is sustained on July 18, 1984 or later, the case should be denied on the basis that the claimant is not considered an employee of the Federal government for purposes of the FECA.

23. The Job Training Partnership Act (JTPA). The JTPA superseded the Comprehensive Employment and Training Act (CETA), and training programs covered under the JTPA have superseded CETA training programs, which have been discontinued. (The JTPA continues to fund the Job Corps, whose enrollees are covered under 5 U.S.C. 8143.)

Some Federal agencies host participants in JTPA training programs (participants are sponsored by State agencies, local organizations which have contracted to operate programs, etc.) Similar to CETA enrollees, program participants hosted at a Federal installation who are under the technical direction and supervision of a Federal employee are employees for compensation purposes under 5 U.S.C.8101(1).

a. Where a participant in a JTPA training program is hosted at a Federal installation, the participant will be considered to be an employee for the purposes of the FECA, where the work performed is under the technical direction and supervision of a Federal employee.

b. The hosted participants who meet the criteria in subparagraph 23a above are considered to be civil employees under the provisions of 5 U.S.C. 8101(1)(B) and are not entitled to continuation of pay (COP) under 5 U.S.C. 8118. They are not direct employees of the Government.

24. U.S. Park Police and Secret Service Employees. The Federal Employees' Retirement System Act of 1986 removed U.S. Park Police officers and Secret Service officers hired after December 31, 1983 from entitlement to certain medical and disability benefits granted in Title 4 of the District of Columbia Code. These individuals are now covered under the FECA.

a. Park Police and Secret Service officers and agents hired after December 31, 1983 are covered by the FECA for injuries at work which occurred on or after January 1, 1987. In occupational disease cases, injurious exposure on or after January 1, 1987 would entitle the officer to FECA coverage for periods of disability subsequent to that date.

b. For these officers, any recurrence of disability due to an injury or illness occurring prior to January 1, 1987 is covered under Title 4 of the District of Columbia Code. If such a claim is filed with FECA, it should be denied, and the employing agency should be notified of the recurrence of a prior injury.

However, an event at work on or after January 1, 1987, which aggravated a previously established condition would bring the officer under FECA coverage for subsequent disability, since a new injury would be involved. Medical records of previous treatment may be requested from the claimant and the employing agency.

25. Volunteer Workers with the National Park Service. Pub. Law 91-357 (Volunteers in the Parks Act of 1969) authorizes the U.S. Department of the Interior, National Park Service to use the services of volunteers in the national parks, and such individuals are considered employees by virtue of section 3(c) of that Act. Therefore, in any case involving a volunteer with the Park Service, the CE should ask the reporting agency to state whether the services of the injured or deceased individual were accepted or used according to the provisions of Pub. Law 91-357. If so, the individual may be considered a civil employee.

26. Employees of Wholly-Owned Instrumentalities of the U.S. Section 8101(1)(A) of the FECA provides coverage for employees of "an instrumentality wholly owned by the United States". Such entities may include corporations established for the specific purpose of supporting a government agency, as with research corporations funded to support projects directed by the Department of Veterans Affairs, and which are authorized by Pub. Law 100-322. Workers in such organizations may be considered civil employees.

27. Student Volunteers, International Trade Administration. These volunteers for the U. S. Department of Commerce may be U.S. citizens or foreign nationals. Their services are specifically authorized under 5 U.S.C. 3111, which states that they are considered Federal employees under 5 U.S.C. 8101 et seq. They work under a Volunteer Service Agreement (VSA) and are supervised by the Foreign Commercial Service Officer at the assigned mission. According to the VSA, their duties include assignments such as conducting market research, preparing reports, drafting replies to correspondence, and promoting and recruiting exhibitors for trade events. These volunteers may be considered civil employees.

28. National Guard Civilian Youth Opportunities Pilot Program. Participants in this program, which was established by the Defense Authorization Act of 1993 and which is also known as the Youth Challenge Program, undergo military-based training which includes supervised work experience in community service and conservation projects. The enrollees may be considered civil employees for purposes of coverage under the FECA, since the Defense Authorization Act specifically authorizes their services and states that they will be considered Federal employees under 5 U.S.C. 8101 et seq.

The law defines performance of duty for these enrollees much as FECA PM Chapter 2-1700.6c describes it for Job Corps enrollees.

The guidance in that chapter should be used in making performance of duty determinations for enrollees in the Youth Opportunities Pilot Program.

29. NASA Exchange Employees. Employees of exchanges operated by the National Aeronautics and Space Administration (NASA) work in cafeterias and other facilities designed for the welfare of NASA employees. These exchanges are similar to those operated by the armed forces, whose employees are covered under the Longshore and Harbor Workers' Compensation Act (LHWCA) rather than the FECA. Because the LHWCA covers only employees of the armed forces, it has been determined that NASA exchange employees are to be considered civil employees under the FECA.

30. AmeriCorps Members. The Commission on National and Community Service administers the American Conservation and Youth Corps, which makes grants to states or other applicants (non-profit groups) to fund youth service corps. The participants are not generally considered Federal employees, even though some may work directly for Federal agencies. However, section 42 U.S.C. 12655n (b)(2) states in part that:

a participant or crew leader serving in a program that receives assistance under this subtitle...shall be considered an employee of the United States...as defined in section 8101 of title 5, United States Code, and the provision of that subchapter shall apply, except--

(A) the term "performance of duty", as used in such subchapter, shall not include an act of a participant or crew leader while absent from the assigned post of duty of such participant or crew leader, except while participating in an activity authorized by or under the direction and supervision of a program agency (including an activity while on pass or during travel to or from such post of duty); and

(B) compensation for disability shall not begin to accrue until the day following the date that the employment of the injured participant or crew leader is terminated.

The CE should inquire whether the crew leader or participant was serving with a Federal agency, a non-profit agency which received a grant directly from the Commission on National and Community Service, or with a state program. Only in the first two instances may the AmeriCorps member be considered a Federal employee for purposes of coverage under the FECA.

The pay rate for these workers is set at the GS-5, step 1 level. They are not entitled to receive continuation of pay (COP).

31. Department of Defense Volunteers. The National Defense Act of 1995 (Pub. Law 103-337) authorized a six-month pilot program expanding the Department of Defense's authority to accept the services of volunteers at designated installations. The pilot will end on August 31, 1995, but it is anticipated that the program will continue after that date.

a. Services. These volunteers will perform a variety of services in medical, dental, nursing, and other health-care settings; museums and natural resources programs; and family support programs, child development and youth activities, libraries, educational and religious settings, housing referral, spouse employment assistance, and morale, welfare and recreation programs.

b. Coverage. The law specifically provides coverage under the FECA for these volunteers, except that those volunteers working for non-appropriated fund instrumentalities are covered for workers compensation purposes by the Longshore and Harbor Workers' Compensation Act.

c. Pay Rate. The law also specifies that the monthly pay rate for these volunteers is to be determined by multiplying the average monthly number of hours that the person provided the services by the minimum wage determined under the Fair Labor Standards Act.

32. Federal Emergency Management Agency (FEMA) Volunteers. The Robert T. Stafford Disaster Relief and Emergency Act, P.L. 93-288, as amended, 42 U.S.C. 5121, et. seq., authorizes the FEMA to form Urban Search and Rescue (US&R) Response system member squads from state and local police, firefighter and emergency medical personnel. The squads train at FEMA's direction and according to FEMA's requirements, so they are ready when activated in case of a disaster. FEMA transports them to the disaster and directs their actions for the duration of the crisis. A FEMA employee will complete the supervisor's part of the notice of injury, illness or death.

33. Contract Observers on Vessels. Public Law 104-297, enacted on October 11, 1996, provides that observers on vessels who are under contract to carry out responsibilities under the Magnuson-Stevens Fishery Conservation and Management Act or the Marine Mammal Protection Act of 1972 shall be considered Federal employees for the purpose of compensation under the FECA.

Contract observers are employed in private industry to carry out the requirements of these Acts, which are under the jurisdiction of the Department of Commerce. Since these individuals are not Federal employees, the Department of Commerce will not be directly involved in the claims process. All claims from contract observers and their survivors will be forwarded to the Special Claims Unit.

Chapter 2-0803, Fact of Injury

1. Purpose and Scope. After the elements of "time" and "civil employee" have been considered, the Claims Examiner (CE) must decide whether the employee sustained a personal injury. This requirement is labeled "fact of injury." This chapter contains guidelines for determining fact of injury (FOI).

The CE should refer to the FECA PM Chapter 2-0800 (Initial Development of Claims) for specific information regarding how to properly develop claims.

2. Components of Fact of Injury. This element has both a factual and medical component, FOI-Factual and FOI-Medical. *See generally R.V.*, Docket No. 15-1911 (issued December 11, 2015). The CE must decide whether FOI-Factual has been met before addressing

FOI-Medical. Both criteria must be satisfied before proceeding to consider the fourth basic element of a claim, performance of duty.

a. FOI-Factual. The CE must review the evidence of file to determine whether the claimant actually experienced the accident, untoward event, or employment factor which is alleged to have occurred. This is a factual determination.

b. FOI-Medical. The CE must review the evidence of file to determine whether a medical condition has been diagnosed in connection with the event. To make this determination, medical evidence is required.

3. Fact of Injury – Factual. The criteria for establishing the factual aspect of Fact of Injury can vary depending on the circumstances of the claim. Traumatic injury claims are a result of a specific event which would have occurred in a single day or work shift, therefore, to determine whether the injury in fact occurred, the emphasis is on time, place, and circumstance.

In occupational disease cases, the evidence should establish that the claimant was, in fact, exposed to the claimed work factors, the emphasis is on amount, volume, frequency, duration, etc. The evidence required to satisfy the factual aspect of Fact of Injury will vary depending on whether the claim is a traumatic injury, a basic occupational disease or an extended occupational disease. Claims for stress-related or emotional conditions usually require significantly more detail and development to establish the factual elements of the claim.

In general, the types of evidence the CE will be expected to review will include:

- a. The claimant's statement of the event(s) or work factor(s) believed to have caused the injury or condition;
- b. The employing agency's statement either confirming or challenging the allegations presented by the claimant; and
- c. Statements from any witnesses to the event(s) or factor(s) described by the claimant.

4. Fact of Injury – Factual in TI Claims

Traumatic injuries (TI) are defined as a wound or other condition caused by a specific event or incident or series of events or incidents during a single day or work shift. As such, to determine whether the injury in fact occurred, the emphasis is on time, place, and manner of the alleged event(s). See PM 2-0800-2a.

a. The CE should thoroughly review all factual information submitted on and with the claim form CA-1. The following evidence should be reviewed to determine whether FOI-Factual has been met:

1) Claimant Statement. A statement from the claimant or someone acting on the claimant's behalf is mandatory. The statement can be stated on the form CA-1 or provided in a written factual statement. In traumatic injury cases, the statement should indicate the nature of the injury and address when, where, and how it occurred.

a) Most traumatic injuries are straightforward in terms of how the injury occurred. These can vary in range from catastrophic events resulting in multiple injuries or simple accidents that result in visible injuries. For instance, if a clerk is filing papers and sustains a paper cut, this is a visible injury, and as long as there is no contrary evidence of record, there is generally no reason to question or develop that this incident occurred as alleged.

An employee's statement alleging that an injury occurred at a given time and in a given manner is of great probative value and will stand unless refuted by strong or persuasive evidence. *See, D.B., Docket No. 20-0797* (issued August 5, 2021).

Example: A Letter Carrier sustains an injury related to a motor vehicle accident while delivering a route. On the CA-1, the claimant merely indicates "motor vehicle accident". The EA did not dispute that an accident occurred, however, argued that they did not witness the event so they cannot confirm that it occurred as alleged. The claimant's statement is enough to establish that the claimant was involved in a motor vehicle accident. The EA is not required to witness the injury and they have not offered any reasons for questioning the events as presented by the claimant. The specific time, place and events surrounding the accident may take the claimant out of Performance of Duty (POD); however, POD is a separate element from FOI – Factual. Because the EA did not dispute that the claimant was involved in a motor vehicle accident, FOI – Factual may be considered established.

b) Occasionally, traumatic injuries involve single events or a series of events that may be more complicated than the straightforward instances described above. It is possible for a claimant to sustain a traumatic injury that may be more commonly associated with an extended occupational disease. For instance, a federal employee may sustain a stress-related or emotional condition as the result of being the victim of an armed robbery. Although the injury alleged is a stress-related or an emotional condition, which normally may require significant factual development, since the alleged event is a traumatic incident which occurred in one work shift, the CE can interpret the criteria above for establishing FOI: Factual. However, if the incident is more interpretive in nature such as a claim alleging a single incident of harassment, or a single day of exposure to a temporary hazard in the work environment, such as inhalation of dust, debris, mold spores, etc., or an exposure during one shift while working directly with potentially caustic chemicals, in those instances the CE should use the criteria outlined below for Extended ODs or Stress Claims.

2) Employing Agency (EA) Statement (and any documentation submitted). A statement from the employing agency confirming that the alleged injury or work exposure occurred is very useful when establishing a claim. A positive statement from the employing agency is not required, however, and lack of a positive statement from the employing agency does not defeat a compensation claim. Any disagreement by the employing agency, though, should be carefully considered. The statement should be reviewed with the totality of the evidence and further developed only if it casts significant doubt on the statement made by the claimant.

Example: A federal employee stated that they slipped and fell in the parking lot while coming into work. The EA challenges the claim, stating that their security cameras showed no slip and fall in the location at the time of the alleged incident. The validity of the claimant's allegations are justifiably in question based on the video evidence provided by the EA, thus requiring further development of FOI-Factual. *See generally* J.C., Docket No. 19-0542 (issued August 14, 2019).

3) Witness Statements. Statements from witnesses confirming or refuting the claimant's allegations concerning the occurrence of the injury are useful, but not mandatory. While statements may be helpful, the Employees' Compensation Appeals Board (ECAB) has held that an injury does not have to be confirmed by an eyewitness to establish the fact that an employee sustained an injury in the performance of duty as alleged. *See M.A.*, Docket No. 22-0661 (issued August 29, 2022).

b. Inconsistencies. The ECAB has held that the employee's statements must be consistent with the surrounding facts and circumstances and their subsequent course of action. *S.W.*, Docket No. 17-0282 (issued April 5, 2018). Such circumstances as lack of confirmation of injury, continuing to work without apparent difficulty following the alleged injury, and failure to obtain any medical treatment may cast doubt on an employee's statements in determining whether they have established their claim. *D.F.*, Docket No. 21-0825 (issued February 17, 2022).

Inconsistencies may be exhibited within the claimant's own statement, elucidated by a challenge from the EA or demonstrated by a conflicting witness statement. A factual history contained in a medical report may also cast doubt as to the veracity of the claim.

Example: An employee claims that he accidentally steps on a nail at work but didn't notice it until six days after. The employee provided an explanation from his physician, who explained that because of the employee's diabetic neuropathy, it is possible that he did not notice it right away. Further, the employee provided a statement from his spouse explaining that she found a hole in the bottom of his work boots where something had pushed up through the sole of his boot. The ECAB found that the statements provided by the physician and spouse explained the inconsistencies in the employee's earlier statement and that he had met his burden of proof. *D.F.*, Docket No. 21-0825 (issued February 17, 2022).

c. Development of Factual Evidence. If the evidence in the case file is unclear or inconsistent, the case should be developed as outlined in PM 2-0800. Depending upon the specifics of the case, evidence can be requested directly from the claimant and/or the Employing Agency. However, it is the responsibility of the CE to thoroughly review the available factual evidence to determine what, if anything, is lacking to establish the factual aspect of the claim and develop accordingly by asking questions that are crafted to obtain new evidence that is not in the case file.

(1) Claimant. The CE may need to request a statement from the claimant addressing one or more of the following issues:

(a) The specific details surrounding the injury if the statement provided by the claimant was vague or contested. The CE should determine the exact details that are necessary to establish that the alleged incident occurred.

This also may include questioning to determine whether the claimant is claiming an occupational disease or traumatic injury. In these instances, it is helpful to provide the definitions for each and ask the claimant to clarify the circumstances.

(b) If there is evidence that the medical condition predates the injury, the CE should ask the claimant for a statement regarding any similar disability or symptoms before the injury (with submission of all prior treatment records) and how the disability or symptoms have increased or been worsened.

(2) Employing Agency. In traumatic injury claims, the CE will generally not need to inquire with the EA. For most TI claims, the CE may be able to accept the claimant's statement without question. If there are inconsistencies within the claimant's own statement and reporting of the injury, or if the EA has submitted a claim for challenge that casts serious doubt on the claimant's allegation that may require further clarification, the CE may inquire with the EA. The CE may need to request a statement regarding how the information submitted about the injury was obtained, and when it was acquired.

Example: A TSA security screener claimed that their left thumb was poked by an object in a bag while performing a baggage screening at Checkpoint A. No evidence or statement on the CA-1 was received to refute injury. An additional EA statement is not required as the claimant's statement, by itself, is sufficient to establish that the incident occurred as alleged because the statement is consistent with surrounding facts and circumstances. *See generally, R.I.*, Docket No. 20-1616 (issued February 11, 2022) (finding that the employee's statement was sufficient to establish the appellant's employment duties as a rural letter carrier included repetitive activities using his hands and fingers).

Example: A VA nurse claimed to have sprained their back maneuvering a patient in bed. The EA claims the employee was not at work that day. Whether the claimant was working or not on the date in question is a verifiable piece of information. Therefore, a copy of the claimant's work schedule and time sheet can support whether the claimant worked on that date and should be requested from the EA. *See L.M.*, Docket No. 22-0159 (issued February 15, 2023); *Lester C. Wright*, Docket No. 98-309 (issued Dec. 14, 2000).

(3) The CE may also request witness statements directly from the claimant and/or the Employing Agency. However, a witness statement should only be sought if there is a genuine reason to question the validity of the claimant's statement and the incident was one that could reasonably be witnessed.

5. Factual of Injury – Factual in Basic OD Claims

In occupational disease cases, the evidence should establish that the claimant was, in fact, exposed to the claimed work factors (amount, volume, duration, etc.). However, the nature of

prolonged exposure leads to the potential for more serious and involved conditions. As such, Occupational Diseases are separated into two categories based on the severity of the injury: Basic and Extended.

Basic ODs involve injuries and conditions that are usually less severe than those considered Extended ODs and the specificity of evidence needed is less to satisfy the factual element of FOI.

a. Basic ODs generally involve either repetitive use of one or more body parts, or minor exposure to a hazard of the work environment. Examples of Basic ODs include:

- Nerve entrapment (Carpal or Cubital Tunnel Syndrome, radiculopathy, etc.)
- Degenerative conditions (Osteoarthritis, Degenerative Disc Disease, etc.)
- Inflammations (tendonitis, bursitis, plantar fasciitis, etc.)
- Orthopedic repetitive use injuries (stress fractures, strains/sprains, etc.)

b. The CE should thoroughly review the factual information and documentation submitted with the claim form and consider the following evidence to determine whether FOI-Factual has been met:

1) Claimant Statement (and any documentation submitted). A statement from the claimant or someone acting on the claimant's behalf is mandatory. In basic occupational disease claims, the statement should describe the employment factors and/or exposures to which the claimed conditions are attributed.

a) In order to establish a repetitive use injury, the claimant's statement should describe the specific work duties believed to have caused the condition. Information on the extent and duration the claimant was expected to perform these duties may be helpful in cases where it is not readily apparent. When weighing the claimant's statement, consideration should be given for the type of employment. While it can safely be assumed that a Letter Carrier's position involves a significant amount of walking, such an assertion is not as apparent for an Office Clerk.

An employee's statement alleging that an injury occurred at a given time and in a given manner is of great probative value and will stand unless refuted by strong or persuasive evidence. *See, D.B., Docket No. 20-0797* (issued August 5, 2021). However, the CE should be cautious of any inconsistencies in the factual evidence of record and seek to obtain clarification and corroborating evidence if such inconsistencies exist.

Example: A Letter Carrier claims a rotator cuff tear related to casing mail. The EA has not provided any challenge or disagreement to the claimant's assertion. As casing mail for a regular portion of each work shift is a known and accepted responsibility for most Letter Carriers, no further evidence is required to establish the factual element of Fact of Injury. *See R.I., Docket No. 20-1616* (issued Feb. 11, 2022) (finding that the employee's statement was sufficient to establish the appellant's employment duties as a rural letter carrier included repetitive activities using his hands and fingers).

b) The type of employment will frequently affect the level of specificity necessary to establish the factual element of a claim. The factual statement from an employee whose occupation would lend itself to performing the claimed duties with some frequency can be accepted without further developing for specific times and durations of exposure (Please reference 2-806.7 if the EA controverts the claim). Some examples include:

- The position of a Letter Carrier requires frequent walking and carrying weight.
- A TSA Screener is frequently moving heavy bags.
- An Office Clerk involves frequent typing and computer work.

A Letter Carrier filing a claim related to excessive walking and carrying heavy bags requires less specific information to establish the factual element of their claim than an Office Clerk making the same allegation.

2) Employing Agency Statement (and any documentation submitted). As with traumatic injuries, a statement from the employing agency confirming that the alleged injury or work exposure occurred is useful when establishing a claim. A positive statement from the employing agency is not required, and lack of a positive statement from the employing agency does not defeat a compensation claim. Any disagreement by the employing agency, though, should be carefully considered. The statement should be reviewed with the totality of the evidence and further developed if it casts serious doubt on the statement made by the claimant. In addition to a statement, a Position Description of the type of work performed by the claimant may be requested.

Example: A secretary claims to have developed osteoarthritis of the right hip after moving heavy boxes of paper as part of their regular work duties. In addition to asking the claimant about this work factor, the EA should be asked about the claimant's job duties and a position description should be requested. Both parties respond to the inquiries. The claimant provides a specific outline of their daily job duties along with the time and extent each action is performed. The EA provides a general position description with a confirmation that this is an accurate reflection of the claimant's job duties. . Although the CE has obtained a position description, the fact that it only provides general duties that do not dispute the claimant's statement, the CE should accept as factual the specific duties as outlined by the claimant as they are undisputed.

3) Witness Statements. Similar to traumatic injuries, statements from witnesses confirming or refuting the claimant's allegations concerning the occurrence of the injury are useful, but not mandatory. A claimant's repetitive job duties or exposure would more accurately be supported by a statement from the claimant, a statement from the employer, and/or a position description. While statements may be helpful, the Employees' Compensation Appeals Board (ECAB) has held that an injury does not have to be confirmed by eyewitnesses to establish the fact that an employee sustained an injury in the performance of duty as alleged. *See M.A.*, Docket No. 22-0661 (issued August 29, 2022).

c. Inconsistencies. The ECAB has held that the employee's statements must be consistent with the surrounding facts and circumstances and their subsequent course of action. *See W.C.*, Docket

No. 15-1123 (issued November 13, 2015). Such circumstances as conflicting statements regarding exposure, reported job duties that don't readily lend themselves to the type of employment, or evidence of a subsequent injury may cast doubt on an employee's statements in determining whether s/he has established their claim.

Example: A TSA screener claims a lumbar injury after lifting and moving bags at a security check point over multiple days. The EA challenges saying that security footage shows the employee working their shift without an instance of injury. The EA has not provided a valid challenge as a repetitive usage injury is a gradual injury that occurs over a period of time and may not manifest itself until after the claimant is removed from the injurious work factors. Additionally, they have confirmed that the security footage supports that the claimant was working at the check point over a period of time lifting and moving bags, further establishing the reported factual element of the claim. *See D.H.*, Docket No. 20-0275 (issued Dec. 15, 2021) (noting that OWCP amended its FOI based on surveillance showing that appellant lifted five empty bins and placed them on a stack behind him).

Example: An Office Clerk submits a claim for Carpal Tunnel Syndrome, stating that they type and use a computer eight hours a day. The EA challenges the work duties performed by the claimant, noting that the claimant is responsible for other office tasks removed from the computer and only spends approximately six hours a day using the computer and typing. The work duties as described by the EA still establish repetitive usage of six hours satisfying FOI: Factual.

See M.S., Docket No. 22-0106 (issued April 4, 2022) (The ECAB held that appellant had established the factual component of fact of injury as he provided a consistent account of the employment incident of striking his knee against the frame of his postal vehicle door when exiting the vehicle. A letter from the EA challenged the claim because the incident was not reported until the following morning and because the claimant had pre-existing knee conditions. ECAB found that the statement from the EA was insufficient to cast persuasive doubt on the claimant's account of the employment-related incident.

d. Development of Factual Evidence. If the evidence in the case file is unclear or inconsistent, the case should be developed as outlined in PM 2-0800. Depending upon the specifics of the case, evidence can be requested directly from the claimant and/or the Employing Agency. However, it is the responsibility of the CE to thoroughly review the available factual evidence to determine what, if anything, is lacking to establish the factual aspect of the claim and develop accordingly by asking questions that search to obtain new evidence not already in the case file.

(1) The CE may request witness statements directly from the claimant and/or the Employing Agency. However, a witness statement should only be sought if there is a genuine reason to question the validity of the claimant's statement and the work conditions were such that one could reasonably corroborate the allegations.

(2) Claimant. The CE may need to request a statement from the claimant addressing one or more of the following issues:

(a) The specific details surrounding the work duties or exposure, if the statement provided by the claimant was vague or contested, if necessary.

This also may include questioning to determine whether the claimant is claiming an occupational disease or traumatic injury. In these instances, it is helpful to provide the definitions for each and ask the claimant to clarify the circumstances.

(b) If there is evidence that the medical condition predates the injury, the CE should ask the claimant for a statement regarding any similar disability or symptoms before the injury (with submission of all prior treatment records) and to describe how the work activity worsened the condition.

Example: A city Letter Carrier is claiming plantar fasciitis. On the CA-2, the job duties identified by the claimant are simply "walking mail route". The EA has not provided any challenge. No further factual evidence is required as the claimant's position implies a significant amount of walking.

Example: An Injury Compensation Specialist is claiming plantar fasciitis. On the CA-2 the job duties identified by the claimant are simply "repetitive walking". The EA did not provide any challenge. As the claimant's position is generally a seated, office position, further development is necessary to establish the extent and duration of walking performed.

(3) Employing Agency. In basic occupational disease cases, the CE may be able to accept the claimant's statement without question or additional response from the EA beyond that provided on the CA-2. If there are inconsistencies within the claimant's own statement, if the reported work duties or exposure is outside of what can reasonably be expected for the type of employment, or if the EA has submitted a claim for challenge that may require further clarification, the CE may inquire with the EA. In many instances, the work duties may be clarified with the submission of a Position Description. If special duties outside the routine Position Description are alleged and disputed by the EA, clarification may be requested.

Example: In the instance of the Injury Compensation Specialist noted in the example above, the CE should also reach out to the EA to obtain a position description and confirmation of any walking that may be necessary that is not noted on the position description.

6. Fact of Injury – Factual in Extended ODs

As opposed to basic occupational diseases, extended occupational diseases generally relate to significantly more severe conditions stemming from work duties, incidents and/or exposure that may be more difficult to define or support while being more likely to incorporate external factors not related to the Federal work environment.

As such, these cases may require significantly more development to establish the factual element of the claim, and claimant statements that might be readily accepted for other conditions may not be accepted for an extended occupational disease. Claims where specific exposure to loud noises,

specific chemicals, toxins, etc. are alleged the alleged exposure must be supported by the evidence of record.

a. Extended ODs generally focus on work exposure versus repetitive usage. Work exposure may relate to the performance of specific work duties; interaction with co-workers, superiors or subordinates; and external factors not related to the Federal employment. Types of extended ODs include:

- Hearing loss
- Infectious disease
- Stress/Emotional conditions
- Cardiovascular conditions
- Asbestosis
- Cancer

Establishing FOI-Factual in stress and emotional condition claims are addressed separately in paragraph 7 below.

b. The CE should thoroughly review the factual information and documentation submitted with the claim form and consider the following evidence to determine whether FOI-Factual has been met:

1) Claimant Statement (and any documentation submitted). A statement from the claimant or someone acting on the claimant's behalf is mandatory. In extended occupational disease claims the statement should describe the employment factors and/or exposures that are being attributed to the claimed condition(s). Often, extended ODs may involve conditions that could be congenital or influenced by factors outside of the Federal employment. A claimant's statement should identify any potential other contributing factor for the examiner to get a clear and accurate picture of all the potential sources related to the developed condition.

However, the presence of other potential factors does not negate the existence of the claimed work factors. Supporting that the claimed work factors, hazards, or exposures exist is sufficient to establish FOI: Factual. Whether those accepted factors contributed to the development of the condition or whether the noted external factors were responsible for the development of the condition are medical issues and must be weighed and determined by the opinion of the physician to satisfy the element of Causal Relationship.

a) Hearing Loss. In most instances, claims for hearing loss will require a referral for a Second Opinion. As such, in order to establish the factual element of FOI, a claimant's statement should provide a full history of any Federal and non-Federal exposure to industrial noise so that the Office can provide a complete and accurate history of exposure upon which the physician can make an informed opinion on causality. This should include a list of the various jobs held within and outside of the Federal government, dates of employment for each position, a description of job duties that required exposure to hazardous levels of noise, the sources of exposure, the frequency with which they were exposed, and any protection taken to prevent hearing loss. If they are no longer exposed, the claimant should be expected to provide the date that exposure

ceased. The claimant should also describe any additional exposure related to military service and/or hobbies.

b) Infectious disease. A claimant's statement to support the contraction of an infectious disease should generally identify the specific source and duration of exposure. However, the nature of an infectious disease means that a specific source may not be readily apparent. As such, the claimant should, at minimum, provide a statement explaining sources of exposure, the job duties they were performing which allegedly resulted in the exposure and the period in which they were allegedly exposed. To establish FOI-F, the claimant must establish that they were actually performing the claimed duties, etc. Whether those accepted factors contributed to the development of the infectious disease is a medical issue and must be weighed and determined by the opinion of the physician to satisfy the element of causal relationship.

Example: In the instance of an airport Transportation Security Administration Agent who alleges they contracted an infectious disease while screening passengers must establish that their employment duties actually required that they encounter passengers and/or others while performing security screenings.

c) Stress conditions. For a detailed discussion of establishing the factual aspect of FOI, see paragraph 7 below.

d) Other Extended ODs. Conditions such as asbestosis, cancer or various cardiovascular diseases may develop as a result of multiple different factors that may or may not be related to their Federal employment. The claimant should be required to submit a statement defining all of the potential elements that may have contributed to the development of their claimed condition. This will include a detailed statement of the relevant Federal exposure throughout their career as a Federal employee in addition to any potential exposure they may have experienced in employment held outside of the Federal government. Other factors the claimant should include if they can reasonably be seen as contributory factors include military history, hobbies, family history, history of smoking and history of drinking.

Cardiovascular conditions do not always manifest themselves immediately. There may be a latent period before the symptoms become apparent. As such, the claimant must also provide a statement identifying their actions immediately leading up to the onset of symptoms as well as a timeline of their actions 72 hours prior to the onset of symptoms.

2) Employing Agency. In extended occupational disease cases, the CE should generally request a more detailed response from the EA in order to support the claimant's statement. In addition to a Position Description, the EA may be required to provide a detailed statement regarding the claimant's Federal employment history, a history of any exposure, environmental studies (if available), or an explanation as to whether the employee should be classified as high-risk for the condition claimed.

Example: A Customs and Border Patrol Agent has filed a claim for hearing loss related to exposure to loud noises when firing weapons as part of required firearms certification. As this is a reasonably assumed requirement of this position, if the EA has not challenged the requirement

or duration as identified by the employee, the office may accept the claimant's statement without further development.

Example: An Office Clerk files a claim for COPD claiming that the working environment resulted in consistent exposure to air pollution. The claimant has alleged that the office ventilation system consistently pumped in external air coming from the loading docks where diesel engines are often left idling while trucks are loaded and unloaded. The EA should provide a response outlining the ventilation system in the office as well as any environmental studies conducted within the office that would show the levels of pollution that are present. Where the claimant has provided evidence beyond their own subjective opinion supporting their claim, a simple statement from the EA that contradicts the claimant's allegations is not sufficient to cast doubt on those allegations. The EA's evidence should be specific and address the claimant's proof; subjective opinions on the claimant's statement are not sufficient.

Example: The claimant indicates they have been diagnosed with the flu and alleges that they were in close contact to five individuals at work, which the claimant believes resulted in contraction of the flu. The CE should accept FOI-Factual if that the claimant was in fact in contact with five individuals at work.

3) Witnesses. Statements from witnesses confirming or refuting the claimant's allegations concerning the occurrence of the injury are useful, but not mandatory. Witness statements that include the job description and relationship to the claimant are of more probative value.

c. Inconsistencies. The ECAB has held that the employee's statements must be consistent with the surrounding facts and circumstances and their subsequent course of action. *L.F.*, Docket No. 19-1275 (issued Oct. 29, 2020). Such circumstances as late notification of injury, failure to obtain medical treatment, conflicting statements regarding exposure, reported job duties that don't readily lend themselves to the type of employment, evidence of a subsequent injury, or significant instances of factors outside of their Federal employment may, if otherwise unexplained, cast doubt on an employee's statements in determining whether they had established their claim. *M.F.*, Docket No. 18-1162 (issued April 9, 2019). The nature and severity of the conditions claimed require a greater level of detail in developing an extended occupational disease claim and leads to more instances of inconsistencies within the record. The CE may be required to weigh conflicts in factual statements provided by the claimant and the employing agency to determine a baseline for what the Office can accept as factual. This may also require the CE to perform additional levels of development as new evidence comes in to allow both the claimant and the employing agency to provide their input on the factual elements of the claim. The claimant shall be given the opportunity to address any adverse evidence from the EA which the CE finds sufficient to cast doubt on their statement.

Example: A claimant alleges they were exposed to industrial noise of 100 dB, 8 hours a day, 5 days a week for 20 years. The EA challenges this and provides an environmental survey that outlines the claimant's various jobs held over the past 20 years, and extent and duration of noise exposure at each position. The environmental survey shows that the claimant has been exposed to industrial noise in a range of 85-95 dBs for 3-5 hours a day. While the claimant's statement is diminished by the objective factual evidence provided by the EA, the EA has identified some

extended exposure to industrial noise, thus satisfying FOI: Factual of exposure to 85-95 dBs for 3-5 hours a day. The claimant should still be afforded the opportunity to establish the additional level of alleged exposures.

d. Development of Factual Evidence. If the evidence in the case file is unclear or inconsistent, the case should be developed as outlined in PM 2-0800. Depending upon the specifics of the case, evidence can be requested directly from the claimant and/or the Employing Agency. However, it is the responsibility of the CE to thoroughly review the available factual evidence to determine what, if anything, is lacking to establish the factual aspect of the claim and develop accordingly by asking questions to obtain new evidence.

Due to the complex nature of extended occupational diseases, it may be necessary for the CE to perform additional levels of development beyond the initial request. New evidence provided by the claimant that conflicts with information provided by the EA may need to be forwarded to the EA for comment. New evidence that conflicts with statements provided by the claimant may need to be forwarded to the claimant for comment. Each new level of development would require a new period of due process. While this new period of due process may be expedited beyond what is normally expected upon initial development, a reasonable amount of time should be afforded to either the EA or the claimant to allow for a response.

1) Claimant. The CE may need to request a statement from the claimant addressing one or more of the following issues:

(a) The specific, necessary details surrounding the exposure. The history of exposure throughout the claimant's Federal and non-Federal career including dates of exposure, types of exposure and extent and duration of exposure, unless it is already in the file.

(b) External factors that may have contributed to the development of the condition including: military service, hobbies, family history, relevant medical history, history of smoking/tobacco use, history of drinking, and a timeline of activities performed 72 hours prior to the onset of symptoms.

(c) A statement regarding any similar disability or symptoms before the injury.

2) Employing Agency. In extended occupational disease cases, the EA may be asked to provide a statement confirming any employment history provided by the claimant, a Position Description and environmental studies related to the claimed exposure. However, some information may be missing or non-existent. The claims examiner should assess whether the claimant's statement can be accepted as factual in the absence of a detailed statement from the EA depending on the specifics of the case. This determination hinges on (a) whether the claimant submitted evidence supporting the allegations and if not (b) whether the claimant can reasonably hold awareness of the existence of the factors claimed absent corroborating evidence.

Example: A retired aircraft mechanic files a claim for hearing loss due to loud aircraft noise over the course of employment. A knowledgeable supervisor should be asked to provide a statement addressing the claimant's allegations and outlining the claimant's history of exposure to loud

noise. If no supporting evidence is provided by the agency corroborating this claim, FOI-Factual can still be established because given the occupation, the claimant should reasonably be able to ascertain their exposure to noise.

Example: An operations analyst files a claim for a pulmonary condition due to toxic exposures in the ventilation system of their office building. A knowledgeable supervisor should be asked to provide a statement addressing the claimant's allegations and outlining the claimant's history of exposure to toxins. If no supporting evidence is provided by the agency corroborating this claim, FOI-Factual is not established absent any evidence establishing how the claimant was aware of toxic exposures in the ventilation system.

3) The CE may also request witness statements directly from the claimant and/or the Employing Agency. A witness statement should be sought when there is a genuine reason to question the validity of the claimant's statement and the work conditions were such that one could reasonably corroborate the allegations.

7. Fact of Injury Factual in Stress Claims. Emotional conditions resulting from an injury or illness that occurred over more than one work shift, as opposed to conditions arising from a traumatic incident (e.g., a Postal Window Clerk robbed at gunpoint while assisting a customer), are considered extended occupational stress claims. In extended occupational disease stress claims, to establish the factual basis of the claim, the evidence should establish that the claimant was, in fact, exposed to the claimed work factor(s), such as amount, volume, or duration of work, etc. Exposure may occur on a consistent basis, as a general condition of employment; or it may occur with cumulative trauma over the course of a closed period.

The claimant's burden of proof in establishing the factual basis of these type of claims generally require more than their statement alone.

If the evidence in the case file established that an incident(s) occurred, but is unclear whether performance of duty is satisfied, the case should be reviewed as outlined in PM 2-804.

Depending upon the specifics of the case, additional evidence can be requested directly from the claimant or the Employing Agency.

a. Factual information for review. For extended occupational disease stress claims, a supervisor statement or witness statement is generally necessary to corroborate the claimant's allegation(s).

(1) Claimant statement. The CE should thoroughly review the claimant's statement and documentation submitted with the claim form to determine whether FOI-Factual has been met. To meet the factual requirement, the evidence should establish that the incident or allegation occurred.

(a) Allegations and perceptions. The CE should review the claimant's statement and annotate those allegations that are established based on corroborative evidence received. Perceptions alone do not establish an allegation as factual.

The Employees' Compensation Appeals Board (ECAB) has held that the occurrence of an employment factor is not established merely because a claimant alleges that it occurred. *Donney T. Drennon-Gala*, 56 ECAB 469 (2005). In order to establish that an alleged incident is factual, it is the claimant's burden to provide probative evidence to substantiate that specific events occurred, and that these occurred in the time, place and manner alleged. This may be accomplished by the submission of credible witness statements, formal findings from EEO complaints or grievances, or sufficient detail as to frequency, location, and duration of claimed incidents (*C.R.*, Docket No. 19-1721 (issued June 17, 2020) and *M.C.*, Docket No. 14-1135 (issued June 7, 2016)).

Example: The claimant files a CA-2 alleging that their supervisor has been harassing them, but fails to explain the nature of the harassment, provide specific instances of harassment, or note who witnessed the alleged harassment. On its own, the claimant's mere allegation does not support a factual basis for a claim. See *A.G.*, Docket No. 07-2383 (issued June 19, 2008).

(b) Specific Incidents. A statement from the claimant or their authorized representative specifying each allegation is generally necessary unless the type of incident claimed is clear.

Example: A claimant has filed a CA-2 specifying that they were repeatedly sexually harassed by a co-worker. Along with the initial claim, the EA has confirmed the habitual harassment. It is not necessary to reach out for specific incidents, dates or times of harassing events if adequately detailed by the claimant as the factual evidence is sufficient to support that the claimant was sexually harassed and the EA has confirmed that the sexual harassment has occurred.

(2). Employing Agency statement. A statement from the EA corroborating that the incident occurred as alleged is necessary to establish the factual basis of the claim. In some instances, the EA may submit a statement from the claimant's co-worker or supervisor.

Example: The claimant files a CA-2 alleging that they were incapable of keeping up with their regular workload and that resulted in an emotional condition. The EA confirmed the claimant's work assignments and their inability to complete these assignments. This established FOI-Factual.

(3) Other factual evidence. The claimant and/or EA may provide a witness statement or other written documentation to corroborate whether an incident(s) occurred in the time, place, and manner claimed. To establish the factual basis of a claim, the witness should be privy to the conversation claimed and/or a party who observed the interaction between the claimant and the other party and provide detail on what they witnessed.

Example: The claimant files a CA-2 alleging that a co-worker has made frequent, unwanted and inappropriate sexual advances. A co-worker provides a statement that they witnessed these sexual advances and provides details regarding what they witnessed. This statement is considered corroborating evidence and further supports the validity of the claimant's allegations.

(4) Formal decisions or findings from other adjudicatory entities (grievances, EEO complaints, etc.). A *formal finding of fact* from the Merit Systems Protection Board, Equal Employment

Opportunity Commissions, EA investigation, Grievance Action, or similar documentation may be considered corroborating evidence to establish the factual basis of a claim. Preliminary determinations that have not been finalized are not considered formal findings of fact.

Example: An employee has alleged a hostile work environment created by a harassing supervisor. An EEO complaint has been filed and, upon review and final determination, it has been confirmed that the supervisor acted inappropriately. This finding is sufficient to establish the factual component of Fact of Injury.

(5) Credible reports. Police reports, accident reports, and investigation reports are considered corroborative evidence to establish whether an incident(s) occurred as claimed.

Example: An employee claims that they were assaulted by a coworker in the lobby of their building at the start of the workday. The EA contends that the employee reported to work with physical injuries from an altercation the prior evening. A police report establishes that the employee was involved in an assault the prior evening resulting in injuries consistent with the conditions claimed as work related. Further, an investigation report by building security officials confirms that no physical altercation occurred in the lobby as alleged. Therefore, the claimant has not met their burden of proof to establish that the assault occurred in the lobby of the EA.

b. Development of Factual Evidence. If the evidence in the case file is unclear or inconsistent, the case should be developed as outlined in PM 2-0800. Depending upon the specifics of the case, evidence can be requested directly from the claimant or the Employing Agency.

(1) Claimant. The CE may need to request a statement from the claimant addressing one or more of the following issues:

(a) The specific details of the employment related incidents/work factors which they believe contributed to their illness if the statement provided by the claimant was vague or contested. The CE should determine the necessary factual information to establish that the alleged incident occurred.

(b) Relevant dates, locations, required work duties, co-workers and/or supervisors involved in incident, who said what to whom, etc. For events or duties identified, description of how often they occurred and for how long.

(c) Witness statements from anyone who can verify the allegation(s) and/or corroborating documentation.

(d) A description of the claimant's medical condition between the date they first began experiencing symptoms and the date of first medical treatment, and the nature and frequency of any home treatment.

(e) A statement regarding any similar disability or symptoms before the injury (with submission of all prior treatment records).

(f) Any discrepancies in the manner in which an incident occurred or a challenge raised by the EA should be clarified.

(2) Employing Agency. A statement from the EA verifying/corroborating that the work incident occurred as alleged is necessary to establish the factual basis of the claim. In some instances, the EA may submit a witness statement from the claimant's co-worker or supervisor.

Example: The claimant has filed a CA-2 in which the claimant simply states "harassment" as the cause of the injury. Without any specific allegations, there is nothing upon which the EA can comment, so no development with the EA is necessary. However, if the claimant responds to the development with specific allegations, a copy of the allegations should be forwarded to the EA for comment.

Example: The claimant has alleged an emotional condition related to an increase in workload due to staffing shortages. The EA should be asked to confirm any staffing shortages, increases in workloads and the claimant's ability to perform these duties and meet deadlines. The EA should also be asked to provide objective corroborating evidence to support their statement and not just a simple statement advising that that claimant was readily capable of meeting certain deadlines.

(3) Follow up development. The CE has the responsibility of reviewing all the evidence to determine what is established as factual. Further development with the claimant or EA may be necessary to clarify inconsistencies in the evidence.

Example: A claimant has made various allegations of harassment against their employer. Upon initial development, the claimant is asked to specify incidents and provide times and dates for each instance. The claimant provides a statement. The statement is then forwarded to the EA for comment. The EA responds, in part, by asserting that one incident could not have occurred as the claimant was not scheduled to work that day. The EA's response is then sent back to the claimant for comment. The claimant provides a certified copy of their time sheet confirming that they were in fact on the clock on the day in question. This would be considered strong and persuasive evidence refuting the agency's response.

8. [Fact of Injury – Medical.](#)

a. The CE must consider the following when determining whether FOI-Medical has been met:

(1) A medical report is required from a qualified physician, as defined in 5 U.S.C. § 8101(2), which states that:

"physician" includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law." The term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist, and subject to regulation by the Secretary.

It must be clear that the medical report has been endorsed by a physician as defined by 5 U.S.C. § 8101(2). This is represented by either a wet or electronic signature. Reports provided by a medical professional who does not meet the requirements of a qualified physician are acceptable only if the report contains an endorsement of a physician as defined by the FECA. A report that is not signed by a qualified physician is insufficient under the FECA.

However, in traumatic injury cases where all five basics have been established with the exception that an otherwise sufficient medical report is signed by a nurse or physician's assistant, the CE should ask the District Medical Advisor (DMA) to review and provide concurrence to the medical component of the claim. If the DMA concurs, the claim should be accepted. If the DMA does not concur, the claim should be denied on a FOI medical basis.

Diagnoses that are speculative or provisional are insufficient to establish FOI: Medical. Diagnoses should be expressed positively as an actual diagnosis made by the physician, not as a suspected diagnosis requiring further examination or testing. Merely indicating the possibility that a diagnosis is present or speculating about a diagnosis while waiting for confirmation from a diagnostic test does not satisfy the requirements of FOI: Medical. However, if the physician establishes a baseline for the injury, it may be accepted while awaiting confirmation of the more serious condition. For example: if the physician provides a report that states the claimant at least has a lumbar sprain, but they are awaiting the results of an MRI to determine if there is a disc herniation; the CE may accept the lumbar sprain as FOI: Medical.

FOI: Medical may be met for one condition and not others. If there is an indication of multiple conditions, but the physician has only provided the clear, unspeculative diagnosis of a contusion of the right forearm, FOI: Medical has been met for the contusion of the right forearm. The CE may continue to review the claim to see if all five elements have been established to accept the contusion of the right forearm while also developing or denying entitlement to other claimed conditions.

a) Diagnostic Exams/Objective Findings. The findings of a diagnostic test alone may be sufficient to satisfy the medical aspect of FOI as long as the diagnosis provided is one that is associated with the claimed injury and the report has been endorsed by a qualified physician.

Diagnoses related upper extremity nerve entrapments (carpal tunnel syndrome, cubital tunnel syndrome, etc.) should be confirmed by diagnostic tests or objective findings. The record should indicate the presence of such entrapment revealed in a nerve conduction test. A positive finding from a Phalen's Test and/or Tinel's Sign is also sufficient to support such a diagnosis.

b) Emergency Room Reports. Reports from an Emergency Room visit must be signed by a physician. General discharge instructions provided by the hospital are not sufficient to establish FOI: Medical if not signed by a qualifying physician.

c) Serious and Catastrophic Cases. In instances where the nature of injury is serious as resulting from a catastrophic incident, the CE should work to accept any established condition as soon as possible. Initial medical reports may contain provisional diagnoses that require further testing to

support; however, the CE may move towards accepting minor conditions such as contusions or abrasions if they are specified in a medical report provided by a qualified physician.

d) **Electronic Signatures.** An electronic signature, or e-signature, is any electronic means that indicates that a person adopts the contents of an electronic message. Electronic signatures on medical reports are sufficient to establish such reports are signed by a qualifying physician. See L.S., Docket No. 16-0375 (issued April 22, 2016).

(2) The medical report must provide a diagnosis linked to the injury, except in cases of visible injury. See FECA PM 2-0800-6 for more details regarding the acceptance of a case for a visible injury without a medical report (e.g., burns, lacerations, insect bites, etc.).

See, L.T., Docket No. 20-0582 (issued Nov. 15, 2021) (ECAB noted that none of the medical reports contained a firm diagnosis of any condition and therefore did not establish a physical injury).

(3) The diagnosis does not have to match the exact condition claimed. For example, the employee claims an injury to the right arm as the result of slipping and falling on ice. A diagnosis of a right-hand condition, a right shoulder condition, or even a neck or back condition would satisfy FOI-Medical. A diagnosis of hypertension or diabetes would not satisfy FOI-Medical, as such diagnoses could in no way be reasonably connected to a slip and fall incident.

(4) The medical evidence does not need to address the issue of causal relationship in order for FOI-Medical to be substantiated. Causal relationship is a separate issue from fact of injury, even though medical evidence is needed to establish both aspects of the claim, except as noted in PM-2-805-3c. FOI-Medical is simply the firm diagnosis of a condition as provided by a physician in a medical report. As long as this exists in the file, FOI-Medical has been met.

Example: A Letter Carrier stumbles on a crack in the sidewalk while delivering mail on their route. The claimant doesn't fall, but in the process of maintaining their balance, they feel a twinge in their left shoulder. A physician has provided a medical report that has a diagnosis of a complete rotator cuff tear as demonstrated on x-ray. This is sufficient for FOI-Medical. Whether the diagnosis was caused by the work incident is addressed at Causal Relationship.

Example: A Rural Carrier files a claim for a left knee injury. A medical report from a qualified physician provides the diagnosis of a left knee sprain but does not provide any further details of how it occurred. FOI: Medical is established by the diagnosis of a left knee sprain.

(5) The medical evidence does not need to address any disability which may have resulted from the injury in order for FOI-Medical to be substantiated.

(6) Findings of pain, symptoms or discomfort alone do not satisfy the medical aspect of the fact of injury medical determination, but may be sufficiently descriptive to require development of the medical evidence to identify the underlying diagnosis responsible for the pain or symptom. Diagnoses ending in -algia or -ago (such as cervicalgia or lumbago) are simply indications of pain and not diagnoses of specific injuries by themselves. Indications such as shortness of breath,

fatigue, tenderness, cough, headache and the like are all simply symptoms of a greater condition. Such findings may be accepted in conjunction with the greater condition, but should never be accepted on their own without additional development of a proper medical diagnosis. Generally, treatment for the actual condition will cover treatment for the associated symptoms, so the claim should only include these symptoms if it is clear that the proposed treatment will not be covered based solely on the acceptance of the greater condition.

b. Development of Medical Evidence. If a diagnosis is not present, the claim should be developed for a medical diagnosis, as outlined in FECA PM Chapter 2-0800. In this instance, the claim should also be developed for causal relationship, since this is also required to establish a claim under the FECA.

Medical reports in the possession of the employing agency should be requested directly from the agency.

9. Denial Reason.

Following the regulatory period afforded for the development action, the CE must review the available evidence to determine if FOI has been established. If the claim was initially developed for FOI-Factual and the office sent the claimant a questionnaire for completion, the absence of a response to this questionnaire itself is not sufficient grounds to deny FOI. There may be reasons that a response to the questionnaire was not necessary. For example, other evidence may have been submitted making the response to the office's questions unnecessary. If the requested statement is absent or if the response fails to fully address the outstanding issues, the CE should review all of the factual information to determine if the totality of the record is sufficient to establish FOI. If it is not, the reason for denial must reflect how the factual evidence fails to establish that the incident(s) and/or exposure occurred as alleged.

a. If the factual evidence fails to establish that the alleged incident occurred, the claim should be denied on a FOI-Factual basis.

b. If the factual evidence establishes that the alleged incident occurred, but the medical evidence fails to establish that a medical condition has been diagnosed in connection with that event or claimed work duties, the claim should be denied on a FOI-Medical basis.

c. If the factual evidence fails to establish that the alleged incident occurred, and the medical evidence fails to establish a medical report from a qualified physician with a diagnosed condition in connection with that event or claimed work duties, the claim should be denied on a FOI-Factual basis.

Chapter 2-0804, Performance of Duty

1. Purpose and Scope. This chapter contains guidelines for determining the question of "performance of duty". Additional references may be obtained from the FECA Procedure Manual Index. Also consult the Index to the decisions of the Employees' Compensation Appeals Board (ECAB). After the questions of "time," "employee," and "fact of injury" have been determined affirmatively, the Claims Examiner (CE) should decide whether the employee was in the performance of duty when the injury occurred.

2. Adjudication. The performance of duty question may be decided affirmatively by the CE if there is no conflict in the evidence and if the facts establish that the employee was in a duty status. Adverse determinations and determinations requiring evaluation of conflicting evidence and/or involving borderline situations must be made at an adjudicative level above that of the CE. If it appears that any of the statutory exclusions to compensation set forth in 5 U.S.C. 8102(a)(1), (2) and (3) may be applicable, evidence to make a determination must be obtained in accordance with paragraphs 13 and 14 of this chapter.

3. Terminology and Sources of Evidence. Certain statutes administered by the Office, relating mainly to military or quasi-military establishments, stipulate that injury or death must have occurred in the "line of duty" for compensation to be paid. This phrase does not appear in most workers' compensation statutes. The Office's policy is to follow, to the extent possible, the principles and interpretations applied by the particular service which employed the disabled or deceased individual. Such "line of duty" determinations, however, are subject to review for conformance with the "performance of duty" concept. The question of performance of duty is determined by the same evidence outlined in FECA PM 2-800.6 and by the answers to questions on Forms CA-1, CA-2 and CA-6.

4. Industrial Premises. An employee who has a fixed place of employment, and is injured on the premises of the employer, has the protection of the FECA unless one of the statutory exclusions applies or the employee was doing something unconnected with the employment.

a. Injuries arising on the premises may be approved by the CE if it is shown the injury occurred on the premises and:

- (1) The employee was performing assigned duties, or
- (2) The employee was engaged in an activity reasonably incident to the employment such as:
 - (a) Personal acts for the employee's comfort, convenience and relaxation,
 - (b) Eating meals and snacks on the premises and
 - (c) Taking authorized coffee breaks, or

(3) The injury occurred while the employee was on the premises within a reasonable time before or after the end of the normal work shift.

b. Was Employee on Premises When Injured? If the employee has a fixed place of work, the CE must ascertain whether the employee was on the premises when the injury occurred. The answers to the appropriate sections of Forms CA-1, CA-2 and CA-6 contain information on this point. If clarification is needed, it should be secured from the official superior in the form of a statement which describes the boundaries of the premises and shows whether the employee was within those boundaries when the injury occurred. Where indicated, the clarification should include a diagram showing the boundaries of the industrial premises and the location of the injury site in relation to the premises.

c. What Was The Employee Doing When Injured?

(1) If the injury occurred on the premises, the CE must ascertain whether or not the employee was acting within the scope of employment. The appropriate portions of Form CA-1 and CA-6 request this information from the official superior. An affirmative response by the official superior is sufficient to establish that the employee was in the performance of duty unless there are facts or other evidence which indicate the answer may be incorrect.

(2) If the employee was not doing regular work, the record must show exactly what the employee was doing when injured and the location of the area where the injury occurred in relation to the regular workplace. In disability cases both the official superior and the claimant should submit a statement showing precisely what the employee was doing when injured. If the initial reports and statements do not contain precise information in this regard, the official superior should be asked to submit a supplemental clarifying statement. When the official superior has no knowledge of the facts and circumstances of the injury, statements should be obtained from coworkers or other witnesses who may have such knowledge. A conference should be held when conflicting statements are presented.

d. Before Starting Time and After Quitting Time.

(1) There is no need to inquire about an injury which occurs before starting time or after quitting time unless the interval between the injury and the work hours seems excessive. The official superior should be requested to:

(a) Submit a statement explaining why the employee was on the premises at the time of the injury, or

(b) Obtain statements from coworkers who may know why the employee was on the premises at the time of the injury, if the official superior does not have this information.

(2) In disability cases an explanatory statement should also be obtained from the injured employee.

e. Bunkhouse Rule.

(1) An employee has the protection of the FECA if injured during the reasonable use of premises which he or she is required or expected to occupy, and which are provided by the employer. In this category of cases, the official superior should be requested to submit a statement showing:

- (a) Whether the employee was required or expected to occupy the quarters where the injury occurred and, if so, this should be explained fully;
- (b) Whether the employer provided the quarters for the employee and, if so, this should be explained fully; and
- (c) In what activity the employee was engaged at the time of the injury.

(2) The statement from the official superior should be sufficient to make a proper determination in most cases. Where needed, additional information should be obtained from the official superior, injured employee, co-workers, and witnesses.

f. Parking Facilities. The industrial premises include the parking facilities owned, controlled, or managed by the employer. An employee is in the performance of duty when injured while on such parking facilities unless engaged in an activity sufficient for removal from the scope of employment. In such cases the official superior should be requested to state whether the parking facilities are owned, controlled, or managed by the employer, and whether the injury did in fact occur in the parking area. The CE may approve the case when the official superior's response is affirmative and consistent with the other evidence.

g. Proximity Rule.

(1) An employee who has a fixed place of employment generally is not in the performance of duty when the injury occurs off the employer's premises. There are certain recognized exceptions to this general rule. One of these is the so-called proximity rule. It concerns those cases where the industrial premises are constructively extended to encompass a hazardous condition proximate to the premises, such as a public highway or railroad crossing, and considered to be a hazard of the employment as distinguished from a hazard which is not peculiar to the employer's premises. In this type of case the official superior should be requested to submit:

- (a) A diagram showing the boundaries of the industrial premises and the location of the injury site in relation to the premises; and
- (b) A statement which
 - (i) Describes any particular hazard which may have caused or contributed to the occurrence of the injury, and shows what relationship, if any, such hazard had to the employment, and
 - (ii) Also shows what control, jurisdiction, or care, if any, the employer assumed or had the right to assume over the place where the injury occurred.

(2) Determinations of this question must be made at an adjudicative level above that of the CE.

h. Visit to Premises.

(1) An employee's presence on the premises does not of itself afford the protection of the FECA. At the time of an injury, the employee must be on the premises for a work-related purpose; otherwise, the employee is not covered by the premises rule. Therefore, the CE must be alert for injuries which occur when the employee is on the premises for a personal reason as distinguished from a purpose incidental to the work. This usually concerns visits to the premises on days when the employee is not scheduled to work.

(2) In these situations the CE should ask the official superior for a statement which explains the reasons for the employee's presence on the premises at the time of the injury. In disability cases, the injured employee should be requested to submit such a statement. Similar statements should be obtained from co-workers or witnesses if the evidence is in conflict or otherwise requires clarification.

5. Off-Premises Injuries. The protection of the FECA is not limited to injuries which occur on the industrial premises. There are many workers who are required to perform some or all of their duties away from the employer's premises. Here we are concerned with coverage for injuries which occur to these off-premises workers.

a. There are four broad classes of off-premises workers:

(1) Messengers, letter carriers, and chauffeurs who, by the nature of their work, perform service away from the employer's premises;

(2) Traveling auditors and inspectors, whose work requires them to be in a travel status;

(3) Workers having a fixed place of employment who are sent on errands or special missions by the employer; and

(4) Workers who perform services at home for their employer.

b. In these cases, the CE must determine whether at the time of the injury the employee:

(1) Was performing assigned duties,

(2) Was engaged in an activity which was a reasonable incident of the assignment, or

(3) Had deviated from the assignment and was engaged in a personal activity which was not related to the work. The general principles for deciding these cases differ because the protection of the premises rule does not exist for off-premises injuries. Furthermore, there is a difference in the application of these principles among the several kinds of off-premises injuries.

c. Workers Such as Messengers, Letter Carriers, and Chauffeurs.

(1) By the nature of their work, employees in this category are on the premises of the employer for only part of each working day and it follows that many of their injuries are sustained away from the industrial premises. Of course, claims for these employees when injured on the premises will be examined and adjudicated in accordance with the principles for all on-premises injuries. The off-premises injuries will require somewhat different consideration.

(2) For the off-premises injuries of these employees, it is neither necessary nor practicable to develop the evidence in all cases as fully as is required for the injuries sustained by other kinds of off-premises workers. No additional evidence is needed if the CE can reasonably conclude from the evidence on the notice of injury combined with other material in the file that the employee was performing assigned duties when the injury occurred.

(3) If it appears questionable that the employee was in the course of employment when injured, the official superior should be asked to submit:

(a) A statement with full explanation showing specifically whether the employee was in the performance of duty when the injury occurred, and whether at the time of injury the employee had deviated from the proper route for personal reasons; and

(b) A diagram showing the location of the accident in relation to the route of travel the employee was to follow to perform the assigned duty.

(4) In most cases, the evidence should be sufficient to adjudicate the claim. If not, supplemental statements should be obtained from the official superior, co-workers, or other possible witnesses, and in disability cases, from the injured employee.

d. Workers in a Travel Status.

(1) For injuries sustained in a travel status the record must contain evidence showing:

(a) When and where the employee last performed official duty;

(b) The distance between the place of injury and the place where official duty was last performed;

(c) Between what points the employee was traveling when injured;

(d) The purpose of the trip;

(e) When and where the employee was next expected to perform official duty;

(f) Whether the injury occurred on the direct or most usually traveled route between the place of last official duty and the place where the employee was expected to next perform official duty and, if not, the nature and extent of the deviation should be given with a full explanation of the reason for such deviation;

(g) Whether at the time of the injury the employee was riding in or driving a Government-owned vehicle; and

(h) Whether the employee's travel expenses were reimbursable.

(2) In injury cases, this information should be supplied by the injured employee, with the official superior confirming or refuting the employee's allegations (see Form CA-1014). In death cases, the information will be supplied by the official superior (see Form CA-1014). In appropriate cases, the CE should request:

(a) A copy of the employee's travel authorization, and

(b) A map or diagram showing the location of the place where official duty was last performed, the place where the employee was next expected to perform official duty, the shortest or most usually traveled route between these points, and the place where the accident occurred.

e. Workers on an Errand or Special Mission. For workers having a fixed place of employment, who are injured while on an errand or special mission, the CE will obtain the same information as for workers in travel status.

f. Workers Who Perform Service at Home.

(1) Ordinarily, the protection of the FECA does not extend to the employee's home, but there is an exception when the injury is sustained while the employee is performing official duties. In situations of this sort, the critical problem is to ascertain whether at the time of injury the employee was in fact doing something for the employer. The official superior should be requested to submit a statement showing:

(a) What directives were given to or what arrangements had been made with the employee for performing work at home or outside usual working hours;

(b) The particular work the employee was performing when injured; and

(c) Whether the official superior is of the opinion the employee was performing official duties at the time of the injury, with appropriate explanation for such opinion.

(2) In disability cases, the injured employee should be required to submit a statement showing:

(a) What directives were received from, or what arrangements had been made with, the employer for performing work at home or outside usual working hours;

(b) The particular work the employee was performing when injured; and

(c) The reasons for the belief that the employee was in the performance of duty at the time the injury occurred.

(3) If the statements are not sufficiently detailed or are otherwise insufficient to permit a proper determination, additional statements should be obtained from others in a position to know the circumstances.

6. To and From Work. Employees do not generally have the protection of the FECA when injured while en route between work and home.

a. Exceptions. There are five well-established exceptions to this general rule. These exceptions are:

- (1) Where the employment requires the employee to travel;
- (2) Where the employer contracts for and furnishes transportation to and from work;
- (3) Where the employee is subject to emergency duty, as in the case of firefighters;
- (4) Where the employee uses the highway or public transportation to do something incidental to employment with the knowledge and approval of the employer; and
- (5) Where the employee is required to travel during a curfew established by local, municipal, county or state authorities because of civil disturbances or for other reasons.

b. Where the Employment Requires the Employee to Travel. This situation will not occur in the case of an employee having a fixed place of employment unless on an errand or special mission. It usually involves an employee who performs all or most of the work away from the industrial premises, such as a chauffeur, truck driver, or messenger. In cases of this type the official superior should be requested to submit a supplemental statement fully describing the employee's assigned duties and showing how and in what manner the work required the employee to travel, whether on the highway or by public transportation. In injury cases a similar statement should be obtained from the injured employee.

c. Where the Employer Contracts for and Furnishes Transportation to and from Work. Where this expectation is claimed, the official superior should be requested to submit a supplemental statement showing, with appropriate explanation, whether the employee's transportation was furnished or otherwise provided by contract by the employer. In injury cases a similar statement should be obtained from the injured employee. Also see Program Memorandum 104 dated October 24, 1969.

The Safe, Accountable, Flexible, Efficient Transportation Equity Act of 2005 (Public Law 109-59) amends Title 31, Section 1344 of the U.S. Code to allow Federal agencies in the National Capitol Region to pay for the costs of shuttle buses or other means of transportation between the place of employment and mass transit facilities. The bill states that for "purpose of any determination under chapter 81 of title 5 ... an individual shall not be considered to be 'in the performance of duty' or 'acting within the scope of his or her employment' by virtue of the fact that such individual is receiving transportation services" under this legislation.

If it is determined that a shuttle bus or other means of transportation to and from mass transit is authorized under this statute, then the injury is not considered to have occurred within the performance of duty. When requesting information from the agency about the employer-provided conveyance, the agency should be asked whether the service in question was provided pursuant to the above statutory authority.

d. Where the Employee is Subject to Emergency Duty.

(1) When it is alleged that the employee was subject to emergency duty, the official superior should be requested to submit:

(a) A copy of the injured employee's official position description, or other document showing that as the occasion arose, the duties did in fact require the performance of emergency duty; and

(b) A specific statement showing that at the time of the injury the employee was in fact traveling to or from work because of emergency duty.

(2) In disability cases, a statement from the injured employee should be requested showing whether at the time of the injury the employee was in fact going to or from work because of emergency duty.

e. Where the Employee Uses the Highway or Public Transportation to Perform a Service for the Employer.

(1) Where this exception is claimed, the official superior should be requested to submit a statement showing:

(a) The precise duty the employee had performed or was expected to perform for the employer during the trip in question; and

(b) Whether this was being done upon directions of the employer and, if not, whether the employer had prior knowledge of and had previously approved the employee's activity.

(2) In disability cases the injured employee should be requested to submit a similar statement.

f. Travel During a Curfew.

(1) When it has been determined that the employee was required to travel during a curfew established by local, municipal, county or state authorities because of civil disturbances or for other reasons, the official superior should be requested to submit:

(a) The reason the employee was requested to report for duty;

(b) Whether other employees were given administrative leave because of the curfew; and

(c) Whether the injury resulted from a specific hazard caused by the imposition of the curfew, such as an attack by rioting citizens.

(2) In disability cases the injured employee should be requested to submit a similar statement.

(3) When all the facts are developed, the case should be referred to the National Office.

7. Diversions from Duty.

a. Emergencies.

(1) Some injuries occur when the employee steps outside the sphere of assigned duties to assist in an emergency, such as to extinguish a fire, assist a person who is injured or in imminent danger, etc. In these cases, it is particularly essential to determine the extent to which the employee diverted from assigned duties to perform the emergency act, and whether the employee was acting in the scope of employment just before the diversion. It is the CE's responsibility to obtain a statement from the official superior, showing:

(a) The precise location of the scene of the accident in relation to the industrial premises, and the place where the employee regularly performed assigned duties;

(b) Whether the employee was performing assigned duties immediately preceding the emergency and, if not, this should be fully explained;

(c) A full description of the particular emergency act performed by the employee; and

(d) The extent of the employee's diversion from duty in terms of time and distance.

(2) In disability cases a statement should be obtained from the injured employee setting forth the same information required of the official superior. Statements from co-workers or other witnesses to the injury should also be obtained, when needed to clarify situations where the evidence submitted by the official superior and the injured employee is unclear or in conflict. The parties should set forth the same information required of the official superior and should show how they acquired the information.

b. Personal Acts.

(1) Injuries sometimes occur while the employee is allegedly engaged in a personal act for the employee's comfort, health, convenience, or relaxation. In these cases, it is particularly essential to determine whether the act was one which is regarded as a normal incident of the work experience, or was one which is foreign or extraneous to the work experience, and the extent to which the employee diverted from duty to perform the act. The evidence appearing on Form CA-1 or CA-2 may, in many cases, contain sufficient information to permit a proper determination. This will be particularly so where the diversion is inconsequential or not excessive and the act is one which is well established to be a normal incident of the work experience. Where clarification is needed, the official superior should be asked to submit a statement showing:

- (a) The precise location of the scene of the accident in relation to the industrial premises, and the place where the employee regularly performed assigned duties;
 - (b) Whether the employee was performing assigned duties immediately preceding the personal act and, if not, this should be fully explained;
 - (c) A description of the personal act in which the employee was engaged;
 - (d) Whether for this purpose the employee was using the nearest available facilities or those intended for such use; and
 - (e) The extent of the employee's diversion from duty in terms of time and distance.
- (2) In disability cases, a similar statement should be obtained from the injured employee. Statements from co-workers and/or other witnesses to the injury should also be obtained when needed to clarify the extent of the employee's diversion and the nature of the personal act.

8. Recreation.

a. An employee is considered to be in the performance of duty while engaged in formal recreation and either the employee is paid for participating or the recreational activity is required and prescribed as a part of the employee's training or assigned duties. The CE may approve injuries occurring under these circumstances if the file contains a statement from the official superior showing that:

- (1) At the time of the injury, the deceased or injured employee was engaged in a recreational activity organized and directed by the employing establishment and the employee was being paid for participating, or
- (2) The activity was required and prescribed as a part of the employee's training or assigned duties.

It is the CE's responsibility to obtain this statement from the official superior.

b. Where injuries are sustained while the employee is engaged in a recreational activity under other circumstances, the determination must be made at an adjudicative level above that of the CE. In these cases, it is necessary to ascertain what benefit, if any, the employer derived from the employee's participation in the activity, the extent to which the employer sponsored or directed the activity, and whether the employee's participation was mandatory or optional. See ECAB decisions in the cases of Donald C. Huebler, 28 ECAB 17, and Stephen H. Greenleigh, 23 ECAB 53. The CE should require the official superior to submit a statement showing:

- (1) Whether the employee was required to participate in the activity and, if so, the reason or authority for such requirement should be given or otherwise explained. If the participation was not mandatory, the official superior should explain fully whether participation was optional or what degree of persuasion was used to influence the employee's participation;

- (2) What specific benefit the employer derived from the employee's participation in the activity (increasing employee morale is not considered a direct benefit);
- (3) Whether other employees were required, persuaded, or permitted to participate in the activity and, if so, this should be explained;
- (4) Whether the employee's participation in the activity violated any rules or regulations of the employer and, if so, these should be explained, including discussion of the manner in which the rule or regulation was enforced;
- (5) Whether the injury occurred on the employer's premises and during the employee's regular working hours and, if not, this should be explained; and
- (6) What leadership, equipment, or facilities the employer provided for the activity.

c. In disability cases, the injured employee should be required to submit a statement showing:

- (1) Whether the employer required or persuaded the employee to participate in the activity and, if so, this should be explained;
- (2) Whether other employees were required or persuaded to participate in the activity; and
- (3) Whether the injury occurred during regular working hours or on the employer's premises and, if not, this should be explained.

d. The need for additional statements from co-workers, witnesses, or other sources will be determined by the circumstances of the case, the discrepancies in the evidence, or other matters requiring clarification.

9. Idiopathic Falls.

- a. The CE should give particular attention to those cases where the injury is due to a fall which may have been caused by a personal and non-occupational pathology, such as a myocardial infarction, fainting spell, or epileptic seizure. Injuries caused by such conditions are excluded from coverage under the FECA unless there is intervention or contribution by some hazard or special condition of the employment, including normal furnishings of an office or other workplace.
- b. In such cases it is the CE's responsibility to obtain appropriate evidence from the injured employee, the immediate superior, the witnesses, and the attending physician, showing whether the fall was due to an idiopathic condition or an unknown cause. If the incident was due to an idiopathic condition, the record must also clearly show whether the fall was to the immediate supporting surface (floor) or whether some special condition, hazard, or instrumentality of the work contributed to or intervened as a cause of the injury. If some factor of the employment intervened or contributed to the injury resulting from the fall, the employee has coverage under the FECA for the results of the injury but not for the idiopathic condition which caused the fall.

c. A distinction must be made between idiopathic falls and those falls which are merely unexplained. If a fall is not shown to be caused by an idiopathic condition, it is simply unexplained and is therefore compensable if it occurred in the performance of duty. An idiopathic fall is one where a personal, non-occupational pathology causes an employee to collapse. An unexplained fall is one where the cause is unknown even to the employee. The ECAB made the distinction between idiopathic and unexplained falls in the following two cases:

(1) Martha G. List, 26 ECAB 200. Employee Joseph G. List's fall at work on December 21, 1972 resulted in his death. There was no evidence that any obstacle or other irregular condition of the workplace caused the fall. The employee had a history of hypertension and episodes of falling but he had not fallen from the end of 1967 until December 21, 1972. An Office medical adviser filed a brief opinion stating that it was "reasonable to assume that the hypertension probably was out of control and that a 'small stroke' occurred on 21 Dec. 72 and was the reason for the fall."

The Board reversed the Office's decision that the employee's injury was caused by an idiopathic fall and neither arose out of nor was causally related to the employment. In support of its finding that the employee's fall was unexplained and his resulting death was compensable, the Board stated:

The question of causal relationship in a case of a fall like that in the present case is a medical one. The only medical evidence in the case record indicating that the employee's fall was idiopathic is the statement of the Office medical adviser. His opinion is speculative and lacking in rationale; it is therefore insufficient to establish that the employee's fall was idiopathic and to prove that it was due to a preexisting physical condition. The 5-year interval between his 1967 fall and the fatal 1972 incident militates against such a conclusion.

(2) Gertrude E. Evans, 26 ECAB 195. Employee Wesley W. Evans' fall at work on May 7, 1973 resulted in his death. There was no indication that anything in the workplace caused him to fall. The employee had a three to five year history of dizziness and fainting spells as well as a series of falls and hospitalizations in the period immediately preceding the May 1973 episode. He had been hospitalized a month before the May 1973 episode, complaining of dizziness and passing out. Although the attending physician could not diagnose the employee's condition, his reports and those of other physicians made it clear that they regarded the May 1973 episode and the previous ones as having as a common cause an abnormal physical condition.

The Board affirmed the Office's finding that the employee's fall was idiopathic in nature but remanded the case for a determination as to whether or not the employee struck an intervening object when he fell on May 7, 1973.

Whether a fall at work is idiopathic or unexplained will usually be determined on the basis of the medical evidence. If the medical evidence shows that the employee's fall was caused by a non-occupational, preexisting physical condition, it is idiopathic and not compensable. Absent such evidence, the fall is unexplained and compensable.

CEs should carefully read the List and Evans decisions, as they illustrate the difference between idiopathic and unexplained falls.

10. Assault Cases. Where the injury or death is caused by the assault of another person, it is necessary to establish to the extent possible whether the assault was accidental, arose out of an activity directly related to the work or work environment, or arose out of a personal matter having no connection with the employment. In the case of a personal matter, the evidence must show whether it was materially and substantially aggravated by the work association. An assault occurring off the agency's premises and outside of work hours may be compensable if it arose for reasons related to the employment.

a. It is the responsibility of the CE to obtain copies of any police reports which may have been made. Statements should also be obtained from the official superior and co-workers or other witnesses showing:

(1) Whether there was any animosity between the injured or deceased employee and the assailant by reason of a personal association away from work and, if so, this should be explained fully; and

(2) A full description of the events and circumstances which immediately preceded, led up to, and resulted in the assault.

b. A similar statement should be obtained from the assailant, if possible, and in disability cases, from the injured employee.

11. Horseplay.

a. An employee injured during horseplay is considered to be in the performance of duty if the horseplay was of a character that could reasonably be expected where a group of workers is thrown into personal association for extended periods of time. In such cases, it is important to determine whether the particular activity was one that was a reasonable incident of the employment or was an isolated, unanticipated event which could not reasonably have been expected to result from the workers' close association.

The CE must also consider whether the horseplay may have constituted a prohibited activity; resulted from the employee's intoxication, willful misconduct, or intention to bring about self-injury or injury to another; or occurred while the employee was so removed from assigned duties in point of time or space as to be removed from the course of employment.

b. If there is sufficient evidence to properly find the injury was sustained in the performance of duty, the CE may approve the case. Otherwise, the CE should ask the official superior to submit a statement which includes:

(1) A full description of the particular horseplay in which the employee was engaged when injured, including the precipitating cause and the number of employees involved;

(2) Whether horseplay of this character had been prohibited previously and, if so, full details of the prohibition should be given, showing when and how the employees were notified and what efforts had been made to enforce prohibition;

(3) The precise location where the injury occurred in relation to (a) the industrial premises, and (b) the place the employee regularly performed assigned duties;

(4) Whether the employee was performing assigned duties immediately preceding the horseplay and, if not, this should be explained fully; and

(5) Whether this was a single, isolated act of horseplay or whether this had occurred on prior occasions and, if so, the frequency of such prior occurrences.

c. In disability cases a similar statement should be obtained from the injured employee. Other workers engaged in the horseplay should be asked to submit statements responsive to the same questions. The need for statements from other coworkers or witnesses should be considered if the evidence conflicts or otherwise requires clarification.

12. Coworker Harassment or Teasing.

a. Harassment or teasing of employees by coworkers is a compensable factor of employment. Employees who are harassed, teased, or called derogatory names by coworkers are considered to be in the performance of duty provided that the reasons for the harassment or teasing are not imported into the employment from the employee's domestic or private life.

The Office had previously taken the position that coworker harassment was a factor of employment only if the employing establishment failed to intervene to moderate or resolve the situation, based on the Board's decision in Joe N. Richards, Docket No. 91-836, issued December 17, 1991. In its remand order the Board stated "if the evidence establishes appellant's supervisor failed to intervene when appellant was harassed by coworkers or, as alleged by appellant, actually instigated such harassment, appellant's emotional reaction to the harassment would arise within the performance of duty." Thus, under the Office's interpretation of Richards, management intervention effectively removed the harassment victim from the performance of duty even if the harassment continued following such intervention.

Board decisions in Gregory J. Meisenberg, Docket No. 92-1098, issued February 24, 1993 (remanded) and David W. Shirey, 42 ECAB 783, issued July 5, 1991 (affirmed because of appellant's inability to prove alleged incidents of harassment actually occurred), were less clear regarding coverage. In both cases the Board stated:

To the extent that disputes and incidents alleged as constituting harassment by coworkers are established as occurring and arising from appellants performance of his regular duties, these could constitute employment factors. (emphasis supplied)

However, in Abe E. Scott, 45 ECAB 164, the Board specifically stated that under a particular fact pattern, coworker harassment is a factor of employment.

b. Another factor to consider in determining the compensability of injuries allegedly due to coworker harassment is the "friction and strain doctrine" (see Larson, The Law of Workmen's Compensation, §11.16[a]) which is followed by the Board. Under this doctrine the fact that employees with their individual characteristics (emotions, temper, etc.) are brought together in the workplace creates situations leading to conflicts which may result in physical or emotional injuries. Because these conflicts have their origin in the employment they arise out of and in the course of employment even though they have no relevance to the employee's tasks. In other words, a conflict between employees involving a nonwork topic may be found to have occurred in the performance of duty because the employment brought the employees together and created the conditions which resulted in the conflict.

However, the "friction and strain doctrine" does not apply to privately motivated quarrels or disputes imported from outside the employment. (see Larson, §11.20).

Although the Board did not use the phrase "imported into the employment" in the case of Sharon R. Bowman, 45 ECAB 187, its decision is based on the same principle. In affirming the Office's decision that appellant had not sustained an emotional condition in the performance of duty the Board found that the gossip of coworkers regarding her ex-husband did not relate to her job duties or requirements and was therefore not compensable.

The Board had previously found in the case of Gracie A. Richardson, 42 ECAB 850, issued August 8, 1991 (footnoted in Bowman) that "Appellants fear of gossip is a personal frustration which is clearly not related to her job duties or requirements and is thus not compensable."

c. If the evidence shows that the alleged incidents of harassment actually occurred, and that they arose out of the employment and did not involve personal matters imported from outside the employment, the CE may find that the employee was in the performance of duty. However, in most cases the initial reports will not provide enough information for the CE to make this determination. Therefore, the CE should develop the evidence by obtaining the following:

- (1) A statement from the employee (if a statement has not been submitted or a submitted statement is inadequate) describing in detail the alleged incidents of harassment, the frequency of their occurrence and their effect on the employee;
- (2) Statements from coworkers allegedly involved in the harassment describing in detail their version of events;
- (3) A statement from the employee's supervisor stating whether he or she was aware of the situation as described by the employee and coworkers, and describing any supervisory action taken; and
- (4) Statements from any other persons who may have knowledge of the alleged harassment stating what they know and how they obtained such knowledge.

After all of the pertinent factual information has been obtained, the CE must determine whether the alleged incidents of harassment actually occurred and, if so, whether they arose out of the

employment or were provoked by something occurring in the employee's private or domestic life; that is, imported into the employment.

If it is established that the harassment arose out of the employment, the question of whether the employee's claimed physical or mental disability is causally related to the harassment must be determined in accordance with the procedures outlined in Chapter 2-805.

13. Prohibited Activities.

a. There may be no right to compensation where the injury occurs while the employee is knowingly engaged in an act which has been prohibited by the employer. The test in such a case is whether the injury was caused by the willful misconduct of the employee as outlined in 5 U.S.C. 8102(a)(1) and as covered in paragraph 13 of this chapter. In these cases it is essential to determine whether the employee was fully aware of the prohibition, whether the prohibition was enforced, the extent to which the employee had diverted from assigned duties, and whether the particular act was within the general scope of the assigned duties. It is the responsibility of the CE to obtain a statement from the official superior which:

- (1) Identifies the full range of the employee's assigned duties;
- (2) Fully describes the prohibited act in which the employee is accused of engaging;
- (3) States how, when, and how often the employee or coworkers were informed of the prohibition (copies of the notice should be obtained if it is asserted that written notification of the prohibition had been given); and
- (4) Describes the manner in which the prohibition had been enforced and what disciplinary action, if any, had been taken against the employee or co-workers for prior violations.

b. In disability cases the injured employee should be asked to submit a statement which:

- (1) Identifies the full range of assigned duties;
- (2) Shows whether the claimant was aware that an act prohibited by the employer was being performed and, if so, states how, when, and how often the employee was informed of the rule;
- (3) Describes the particular act in which the employee was engaged at the time of the injury and whether, in the employee's opinion, this was within the general scope of the duties;
- (4) States whether the employee had previously violated this prohibition and, if so, this should be explained fully, including an opinion as to whether the employee's supervisors were aware of such violations; and
- (5) Includes any explanation which the employee believes would justify the violation of the prohibition.

c. Statements should also be obtained from co-workers or other witnesses which:

(1) Describe what they know about the injury, the manner in which it was sustained, and the particular activity in which the employee was engaged at that time, and also how they acquired this knowledge;

(2) State whether they were aware of the prohibition which was allegedly violated and, if so, they should state how, when, the number of times, and the manner in which they were informed of the prohibition; and

(3) Describe the manner in which the prohibition had been enforced and what disciplinary action had been taken against the injured employee for prior violations.

14. Statutory Exclusions.

a. Willful Misconduct, Intoxication, or Intention to Bring About Injury or Death to Self or Another. Where the questions of "fact of injury" and "performance of duty" are decided affirmatively, consideration must also be given to the question of whether the injury or death was caused by the willful misconduct of the employee, by the employee's intention to bring about the injury or death of self or of another, or if intoxication of the injured employee was the proximate cause of the injury or death (see 5 U.S.C. 8102). The CE has authority to decide these questions when these factors were not the cause of the injury. Otherwise, the CE has no authority to decide these questions adversely to the claim and must not in any way notify or imply to the claimant or the representative that the claim has been or will be denied because of one of these factors.

(1) The claimant enjoys an affirmative defense against these factors. The OWCP must overcome such defense. Adverse decisions must always be made at an adjudicative level above that of the CE.

(2) The official superior's answers to the appropriate items on the Form CA-1, and the particular circumstances of the accident, are the factors which require the CE's attention when considering these questions. In most cases these questions may be determined negatively with ease. In those few cases where it appears that an adverse determination may be indicated or where there is confusion in the facts, it will be the CE's responsibility to obtain all available evidence which may be relevant to the question. Thereafter, the CE should present the case to the next adjudicative level with a written explanation of the factors involved and a reasoned recommendation for approval or disapproval of the claim.

b. Willful Misconduct.

(1) The question of willful misconduct arises where at the time of the injury the employee was violating a safety rule, disobeying other orders of the employer, or violating a law. Safety rules have been promulgated for the protection of the worker--not the employer--and, for this reason, simple negligent disregard of such rules is not enough to deprive a worker or the worker's dependents of any compensation rights. All employees are subject to the orders and directives of their employers in respect to what they may do, how they may do certain things, the place or

places where they may work or go, or when they may or shall do certain things. Disobedience of such orders may destroy the right to compensation only if the disobedience is deliberate and intentional as distinguished from careless and heedless. A distinction is also made in respect to orders which relate to the manner in which assigned tasks are to be done, as distinguished from other activities which are merely incidental to the employment. It is necessary, therefore, that the evidence be unusually well developed before any steps are taken to disallow a claim because of willful misconduct.

(2) Violating a Safety Rule.

(a) In these cases the official superior should be required to submit a statement which: identifies the particular safety regulation which was allegedly violated; states how, when, and how often the employee and co-workers were informed of the rule (copies of the notice should be obtained if written notice of the rule was given); and describes the manner in which the rule had been enforced and what disciplinary action was taken against the employee and coworkers for this or prior violations.

(b) In disability cases, a statement from the injured employee should be required which: shows whether the employee was aware of the safety rule which was allegedly violated and, if so, contains information as to how, when, the number of times, and the manner in which the employee was informed of the rule; the reason, if any, for violating the rule; the particular act in which the employee was engaged at the time of the injury and whether, in the employee's opinion, this was a part of assigned duties; whether the employee had previously violated this rule and, if so, a full explanation therefor, including an opinion whether the supervisors were aware of such violations; and any explanation the employee believes would justify the violation of the rule.

(c) Statements should also be obtained from any co-workers or witnesses which show: what they know about the injury, the manner in which it was sustained, the particular activity in which the employee was engaged at that time, and how they acquired this knowledge; whether they were aware of the existence of the safety rule which was allegedly violated and, if so, how, when, the number of times, and the manner in which they were informed of the rule; and the manner in which the rule had been enforced and what disciplinary action, if any, had been taken against them or the injured employee for prior violations.

(3) Disobeying Other Orders of the Employer.

(a) In these cases the official superior should be required to submit a statement which: identifies the particular order which was allegedly disobeyed; gives the reasons the employer found it desirable and necessary to issue this order; states how, when, the number of times, and the manner in which the employee and co-workers were informed of the order (copies of any written orders should be obtained); and describes how the order had been enforced and what disciplinary action was taken against the employee and co-workers for prior instances of disobedience. 2-0804-14 Statutory Exclusions (cont.)

(b) In disability cases, the injured employee should be required to submit a statement showing: the particular person from whom these orders had been received and what supervisory responsibility that person had; how, when, and how often these orders were received; the particular act in which the employee was engaged at the time of the injury, and whether this was a part of the employee's assigned duty; whether the employee had previously disobeyed these or similar orders and, if so, this should be fully explained, including whether the supervisors were aware of such disobedience; and any explanation which the employee believes would justify such disobedience.

(c) Statements should also be obtained from any co-workers or witnesses which show: what they know about the injury; the manner in which it was sustained; the particular activity in which the employee was engaged at that time, and how they acquired this knowledge; whether they were aware of the existence of the particular order which was allegedly violated and, if so, how, when, and how often they were informed of such order; and the manner in which the order had been enforced and what disciplinary action had been taken against them or the injured employee for prior instances of disobedience.

(4) Violation of a Law.

(a) In these cases the official superior should be required to submit a statement citing the particular law which was allegedly violated, stating what legal action was taken by the authorities to prosecute the employee for this violation, and showing the results of such action.

(b) In disability cases, a statement from the injured employee should be requested, describing the particular act in which the employee was engaged at the time of the injury, with an opinion whether this was a part of the employee's assigned duties and any explanation justifying the violation of the law.

c. Intoxication.

(1) Where intoxication may be the proximate cause of the injury, the record must contain all available evidence showing: (a) the extent to which the employee was intoxicated at the time of the injury, and (b) the particular manner in which the intoxication caused the injury. It is not enough merely to show that the employee was intoxicated. It is also the OWCP's burden to show that the intoxication caused the injury. An intoxicant may be alcohol or any other drug.

(2) The official superior should be required to submit a statement which: describes the employee's activities during the several hours immediately preceding the injury, with particular emphasis on the personal conduct, apparent sobriety, and the extent to which the employee appeared to be inebriated or otherwise not in control of all faculties; states whether the employer is aware of the nature and amount of intoxicant consumed by the employee and, if so, supplies full details; states whether the employer believes the employee's intoxication was the proximate cause of the injury with appropriate explanation for such belief; and shows whether immediately prior to or after the injury any tests were made by the police or others to determine the employee's sobriety (the results of any such tests should be requested).

(3) A statement should be obtained from the physician and the hospital where the employee was examined following the injury which describes as fully as possible the extent to which the employee was intoxicated and the manner in which the intoxication was affecting the employee's activities. The results of any tests made by the physician or hospital to determine the extent of intoxication should be obtained.

(4) In disability cases, the injured employee should be requested to submit a statement which: includes a full account of activities during the several hours immediately preceding the injury; states whether any intoxicants were used or consumed during that time and, if so, the precise nature and amount consumed; and states whether or not the employee feels intoxication was the proximate cause of the injury, with appropriate explanation for the belief.

(5) Statements from coworkers or other witnesses should also be obtained which: describe the employee's activities during the several hours immediately preceding the injury with particular emphasis on personal conduct, apparent sobriety, and the extent to which the employee appeared to be inebriated or otherwise not in control of all faculties; states whether they are aware of the nature and amount of intoxicants consumed by the employee and, if so, full details; and states whether they believe the employee's intoxication was the proximate cause of the injury with appropriate explanation for their belief.

d. Employee's Intention to Bring About Injury or Death to Self or Another.

(1) Where it appears the injury or death was caused by the employee's intention to bring about the injury or death of self or another, it is the responsibility of the CE to obtain a statement from any physician or hospital where the employee was examined following the injury, which states whether it appeared the employee was in full possession of all faculties and, if not, a full description of the situation.

(2) The official superior should also be requested to submit a statement which describes the employee's activities during the several hours immediately preceding the injury and states whether it is believed that the injury or death was caused by the employee's intention to bring about injury or death of self or another, with a fully detailed explanation for the belief.

(3) In disability cases, the injured employee should submit a statement which includes a full account of activities during the several hours immediately preceding the injury, and gives a full description of the manner in which the injury occurred, with a definite statement, including explanation, whether the injury was caused by intention to bring about the injury or death of self or another.

(4) Statements from co-workers or other witnesses should also be requested which describe the employee's activities during the several hours immediately preceding the injury, and state whether they believe the injury or death was caused by the employee's intention to bring about the injury or death of self or another, with a fully detailed explanation for their belief. (See paragraph 14 of this chapter for information on suicide cases.)

15. Suicide. As outlined in paragraph 13 above, section 5 U.S.C. 8102(a)(2) would appear to preclude payment of compensation in all suicide cases. In some such cases, however, compensation can be paid if the job-related injury (or disease) and its consequences directly resulted in the employee's domination by a disturbance of the mind and loss of normal judgment which, in an unbroken chain, result in suicide.

a. Tests. Various tests are applied in different jurisdictions for determining compensability in suicide cases. The different tests are known as: Sponatski's Rule, New York Rule and Chain-of-Causation Test. (For a discussion of these different tests refer to Arthur Larson, The Law of Workmen's Compensation [New York, Matthew Bender, 1979], Volume 1A, Chapter VI, Section 36.) It is OWCP's policy to apply the Chain-of-Causation Test in suicide cases filed under the FECA. All jurisdictions, of course, require that a worker's suicide be caused by some mental derangement arising out of and in the course of the employment to be compensable under workers' compensation law.

b. Chain-of-Causation Test.

(1) For a suicide to be compensable under this test, it is not necessary to establish that the employee's act of suicide occurred immediately or within a short time after the injury, that the suicide was unpremeditated, violent, occurred in a delirium of frenzy, or that the employee was genuinely insane, psychotic, or suffered from physical damage to the brain. Further, whether the employee knew of the purpose and physical consequences of the act of suicide is irrelevant to the question of causation and, therefore, "knowledge-of-the-physical- consequences" is not a factor sufficient to break the chain-of-causation from the injury to the suicide. In discussing the "chain-of-causation" test, Arthur Larson states:

If the sole motivation controlling the will of the employee when he knowingly decides to kill himself is the pain and despair caused by the injury, and if the will itself is deranged and disordered by the consequences of the injury, then it seems wrong to say that this exercise of will is "independent," or that it breaks the chain of causation. Rather, it seems to be in the direct line of causation. [Arthur Larson, The Law of Workmen's Compensation (New York, Matthew Bender, 1979), Volume 1A, Chapter VI, Section 36.30.]

(2) If the injury and its consequences resulted directly in a mental disturbance, or physical condition which produced a compulsion to commit suicide, and disabled the employee from exercising sound discretion or judgment so as to control that compulsion, then the test is satisfied and the suicide is compensable.

c. Development.

(1) It is the CE's responsibility to develop the necessary information to determine whether the "chain-of-causation" test is met if it is asserted, or there is evidence to suggest, that a mental disturbance or physical condition is present and such condition was causally related to the injury or conditions of employment. Statements as to the employee's mental or physical condition prior to the suicide should be requested from the employee's family, supervisor, co-workers, and other associates who might have pertinent knowledge or information concerning the circumstances

surrounding and leading to the suicide. Since almost all, if not all, suicides are investigated by local authorities, a copy of the investigation report should be obtained. Copies of any notes or other communication left by the employee should also be obtained.

(2) A rationalized opinion concerning the relationship between the suicide and the employment-related injury should be obtained from the employee's attending physician or second opinion specialist. The physician should be advised of the test to be met for the death to be compensable (that the suicide was a direct result of the employment injury) and should be asked to describe the employee's mental and physical condition prior to the suicide. If a conflict of medical opinion develops in the case, it should be resolved by referral to a psychiatrist or clinical psychologist.

(3) For the suicide to be compensable, the chain of causation from the injury to the suicide must be unbroken. Therefore, if the evidence indicates or suggests the existence of other factors in the employee's life which may break the chain-of-causation (such as personal or family problems, non-employment-related injuries, etc.), the CE must develop such factors to determine what effect, if any, they had in causing the employee to commit suicide, and whether they constitute independent intervening factors sufficient to break the direct chain of causation from the injury to the suicide.

(4) All development efforts in a suicide case must be documented clearly in the case file, and all reasoning behind the recommended decision (be it approval or denial) must be made a part of the record in the form of a Memorandum to the Director.

(5) A decision either accepting or denying a suicide case must be made by the District Director or higher authority.

16. Representational Functions.

a. In the Civil Service Reform Act of 1978, at 5 U.S.C. 7101, it is held that:

experience in both private and public employment indicated that the statutory protection of the right of employees to organize, bargain collectively, and participate in decisions which affect them--

- (A) safeguards the public interest
- (B) contributes to the effective conduct of public business, and
- (C) facilitates and encourages amicable settlements of disputes between employees and their employers involving conditions of employment.

Thus, the Congress held that certain representational functions performed by employee representatives of exclusive bargaining units benefit both the employee and the agency.

b. OPM defines "representational functions" to mean those authorized activities undertaken by employees on behalf of other employees pursuant to such employees' right to representation under statute, regulation, executive order, or terms of a collective bargaining agreement. It includes activities undertaken by specific, individual designation (such as designation of a

representative in a grievance action or an EEO complaint), as well as those activities authorized by a general collective designation such as the designation of a labor organization recognized as exclusive representative under Chapter 71 of Title 5.

c. Official Time. Official time is defined as time granted to an employee by the agency to perform representational functions, when the employee would otherwise have been in duty status, without charge to leave or loss of pay. Official time is considered hours of work and is distinguished from administrative leave. OPM has stated that this may include scheduled overtime or a period of irregular unscheduled overtime, if an event arises which requires representational capacity.

Official time granted to union representatives under section 7131 of 5 U.S.C. Chapter 71 is authorized for an employee acting as an exclusive representative in the negotiation of a collective bargaining agreement, including attendance at impasse proceedings. In addition, certain executive orders and Government-wide regulations require the use of official time for such functions in connection with health and safety matters, agency administrative grievance procedures, prevailing wage-rate appeals and EEO complaints.

Agency regulations and practice, and collective bargaining agreements, may also provide official time for other representational functions.

The Postal Service National Agreement specifies conditions under which a union representative can provide representational service "on the clock."

d. OWCP Policy. Employees performing representational functions which entitle them to official time are in the performance of duty and entitled to all benefits of the Act if injured in the performance of those functions. Activities relating to the internal business of a labor organization, such as soliciting new members or collecting dues, are not included.

e. Case Development. When an employee claims to have been injured while performing representational functions, an inquiry should be made to the official superior to determine whether the employee had been granted "official time" or, in emergency cases, would have been granted official time if there had been time to request it. If so, the claimant should be considered to have been in the performance of duty. This includes Postal Service employees who are "on the clock" while performing representational activities under the National Agreement.

If the agency states that the employee was not performing an activity for which official time is allowed, the Office should issue a letter warning the claimant that the case will be denied unless additional information is provided, and allowing 60 days for a response. If there is no timely response from the claimant, a formal decision should be issued on the ground that the claimant is not in the performance of duty.

If the claimant provides evidence contradicting the agency's position, the official superior should be asked to reply to this evidence, providing documentation in the form of appropriate regulations, executive order or union agreement covering the specific situation. The Office will

accept the ruling of the agency as to whether a representative was entitled to official time, unless this ruling is later overturned by a duly authorized appellate body.

17. Work-Connected Events Which Are Not Factors of Employment.

a. The Cutler Rule. As the ECAB stated in the case of Lillian Cutler, 28 ECAB 125:

Workers' compensation law does not apply to each and every illness that is somehow related to an employee's employment... Where the disability results from his emotional reaction to his regular or specially assigned work duties or to a requirement imposed by the employment, the disability comes within the coverage of the Act.

This concept has come to be known as the Cutler rule.

When an employee experiences emotional stress in carrying out assigned employment duties, or has fear and anxiety regarding his or her ability to carry out these duties, a resulting disability is considered to have "arisen out of and in the course of employment." Similarly covered is a disability arising from a special assignment or requirement imposed by the employing establishment. The assignment need not have been unusually strenuous, as long as the medical evidence shows that it caused the claimed condition. The Board continues:

On the other hand, the disability is not covered where it results from such frustration from not being permitted to work in a particular environment or to hold a particular position.

In Cutler, where the employee became emotionally upset over not receiving an anticipated promotion, the Board held that:

the resulting disability does not have such a relationship to the employee's assigned duties as to be regarded as arising from the employment. The emotional reaction in such circumstances can be truly described as self-generated and as not arising out of and in the course of employment.

"Self-generated" in this context apparently refers to the employee's voluntary application for a higher position, when to seek promotion was not a requirement of the position she already held.

b. Reassignment. The Board has applied the Cutler standard in other cases largely by example, always seeming to distinguish between the performance (or the results) of actual work duties, and dissatisfaction with the structure of the work or position. Thus, under the standard set forth in Cutler, it is clear that reassignment is not a factor of employment: Dario G. Gonzales, 33 ECAB 119; Clair Stokes, Docket No. 82-508, issued May 24, 1982; John A. Snowberger, Docket No. 85-2076, issued January 31, 1986; Robert C. McKenzie, Docket No. 85-532, issued May 10, 1985; Teresa M. Lacona, Docket No. 88-1262, issued May 8, 1989.

However, the case of Brenda Getz, 39 ECAB 245, presents a different situation. Here the employee alleged that she had an emotional reaction to a detail assignment to another city because of the working conditions involved. The Board concluded that the detail assignment

constituted specially assigned work duty within the meaning of Cutler and therefore any disability arising out of an emotional reaction to the assignment would be covered.

c. Performance Ratings. The Board remanded the case of Lizzie J. McCray, 36 ECAB 419 listing the dispute over the employee's performance rating as a factor of employment and citing Derderian. But in Arthur F. Hougens, 42 ECAB 455, the Board found that the employee's reaction to his rating on his performance evaluation was not covered under the Act. The Board stated:

In view of the fact that appellant's rating was "satisfactory" and was changed to a higher rating on his appeal, his reaction to it can accurately be described as "self-generated." Appellant has presented no evidence to substantiate his contention that a rating of satisfactory was a "bad rating" and "as low as you can go" at his employing establishment.

Although the Board did not state the distinction between Hougens and Derderian and McCray, the Board finding that Hougens' reaction was self-generated apparently is based on the fact that his performance was evaluated as satisfactory and his mere perception of the rating as a "bad" one was not sufficient for his reaction to be covered under the Act.

This interpretation is reinforced by the Board's decision in Thomas D. McEuen, 41 ECAB 387 and 42 ECAB 566. In McEuen the Board stated:

In this case, the medical evidence establishes more than appellant's feeling of job insecurity: It establishes that appellant's episode of severe depression and impaired functioning was directly precipitated by what appellant regarded as an unsatisfactory performance appraisal. The Board finds that appellant's emotional reaction bears a direct relationship to his regular or specially assigned duties and constitutes an injury in the performance of duty within the meaning of the Act.

The Office petitioned for reconsideration on the ground that the Board's January 10, 1990 decision contained legal and factual errors. The petition stated in part:

In the decision on January 10, 1990, the Board concluded that appellant's depression constituted an emotional condition sustained while in the performance of duty because it was "directly precipitated by what appellant regarded as an unsatisfactory performance appraisal." In so doing, the Board departed from longstanding precedent holding that feelings of job insecurity do not constitute an illness sustained while in the performance of duty. Raymond S. Cordova, 32 ECAB 1005 (1981); Lillian Cutler, 28 ECAB 125 (1976). Rather, the Board concluded that "feelings of job insecurity" may be compensable, depending upon the "source" of those feelings.

In an April 3, 1991 decision granting petition for reconsideration and reaffirming its January 10, 1990 decision, the Board noted:

an unsatisfactory performance rating, without more, is insufficient to provide coverage. Although the rating is generally related to the employment, it is an administrative function of the employer, not a duty of the employee. As was held in Cutler, an emotional reaction under such

circumstances would be self-generated. Exceptions will occur, however, in those cases where the evidence discloses error or abuse on the part of the employing establishment. That is what has occurred in this case. An error was committed by the employing establishment that resulted in appellant's emotional reaction. Such a reaction cannot be labeled "self-generated."

In the instant case, appellant felt the employer was out to get his job. He based this "perception" on the fact that, instead of receiving a performance rating when due, the employer deferred it in several particulars for 90 days. He alleged, and the employer conceded, that the proposed performance rating was incorrectly based on standards not derived from his job description and, with these standards removed, his performance was satisfactory. As the Office correctly points out, appellant was never given an 'unsatisfactory' rating. The rating was simply deferred for 90 days. The decision here therefore turns, not on whether the performance rating was unsatisfactory per se, but on the fact the employer took erroneous action that resulted in the employee's emotional condition. Such reaction cannot be deemed self-generated.

The Board has thus made it clear that an unsatisfactory performance ratings, performance assessments and informal discussions of performance, standing alone, are insufficient to provide coverage under the Act. An employee's reaction to an unsatisfactory performance rating, performance assessment or informal discussion of performance, absent any evidence of error or abuse by the employing establishment, is self-generated and therefore not compensable.

d. Fear of Removal. The Board has also distinguished between an employee's reaction to criticism arising from performance of day-to-day duties, or fear of inability to perform, and the fear of losing a job or a particular position, even when a performance evaluation is the sole or principal reason for an employee's actual or possible removal or job change.

In Allen C. Godfrey, 37 ECAB 334, the employee alleged extreme depression due partly to his reaction to a letter received from the employing establishment proposing to remove him from his position for failure to meet certain performance requirements of his job. His performance deficiencies were documented in official performance evaluations. A subsequent letter from an agency official stated he would not sustain the proposal to remove the employee but would assign him to a lower-graded position.

The Board referred to two of its previous decisions where an employee's reaction to a discussion with his supervisor concerning the performance of his work duties, and another employee's emotional reaction to attempting to meet quality and quantity standards for his job, both constituted injury in the performance of duty. In this case, the Board found the facts to lead to the contrary conclusion that, while the employee's disabling reaction had some connection to his employment, it was not a reaction to his day-to-day duties or fear or anxiety concerning his ability to perform his employment duties but to what he perceived as a "sudden loss of his career." The employee's disabling emotional reaction was due to a fear of losing his job and a fear of losing a particular position, which does not constitute a factor of employment.

e. Harassment. Since Stanley Smith, 29 ECAB 652, the Board has consistently held that an employee is not required to show that a supervisor's actions constituted harassment or were improper as long as the employee could show that the disability arose directly from experience

of the supervisor's actions and reaction to them, and that the actions themselves were appropriately related to the employee's assigned duties and position. In Lewis Leo Harms, 33 ECAB 897 (902), the Board stated:

Where an employee asserts that emotionally stressful employment situations or conditions, including actions by the employing establishment described by the employee as constituting harassment or discrimination, caused a disabling condition on his part, the issue, generally speaking is not whether in fact there was harassment or discrimination but instead is whether such disabling reaction was precipitated or aggravated by conditions of employment. The Board's function is not to make a finding on the merits of an employee's charges against the employing establishment; its only function is to determine whether or not the medical evidence supports causal relationship between the employment factors alleged and the physical conditions.

Thus, the Board makes no determination of whether harassment occurred and does not require the Office to make factual determinations of whether an employee was the victim of harassment or discrimination. The Board does, however, rely on the findings of agencies or bodies which have the authority, and whose function it is, to decide the validity of an employee's allegations.

In the case of Norman A. Harris, 42 ECAB 923, the employee alleged that he sustained an emotional condition causally related to his federal employment. The employee was terminated by his employing establishment for falsifying his time records. He appealed the termination to the Merit Systems Protection Board (MSPB) and was restored to his position. The MSPB found:

There was no showing that the appellant intentionally misrepresented his hours or deceived the agency by claiming hours that he did not work.... The charges in this case are predicated upon the appellant reporting late on various dates during the period in question. However, I note that the agency presented no evidence from Paramount officials who could verify [whether or not appellant was] at work.

The MSPB reversed the removal action. Based on the MSPB decision the Board found that the employing establishment had terminated the employee without the proper evidence and that this error was sufficient to bring any emotional reaction by the employee to the termination action within the coverage of the Act. The Office was directed to determine whether the employee had established that he sustained an emotional condition causally related to the termination action.

f. Erroneous Administrative Actions. In Robert E. Green, 37 ECAB 145, the employee alleged an emotional condition stemming from charges that he had falsified lodging costs on his travel vouchers and a finding that he had to reimburse the Government \$24,423.14. He was removed from his position for falsifying official records for monetary gain and for other unrelated charges. The MSPB found no evidence of willful intent to defraud the agency by submitting false travel vouchers and no evidence that the lodging expenses submitted were false, but sustained the employee's removal on the other charges. Citing 5 U.S.C. 5702, which provides a per diem allowance for Federal government employees traveling on official business away from a designated post of duty, the Board found that the employee's emotional reaction to the denial of the reimbursement of his travel expenses constituted an injury sustained in the performance of duty. The circumstances relating to the travel vouchers were part of the employment and related

to the duties the employee was employed to perform. Since the employee had been exonerated of charges that he falsified official records, there was no wrongful misconduct charge which would prevent coverage of his alleged emotional condition under the Act.

In Mary Alice Cannon, claiming as widow of Aubrey B. Cannon, 33 ECAB 1235, the employee received an erroneous personnel action reducing his salary. He suffered cardiac arrest and subsequent total disability leading to his death. Prior to his death the erroneous personnel action was corrected and the employee received a check for the amount by which his salary had been reduced. The claim was denied because the employee's cardiac arrest was not "closely associated with his job duties." The Board found that the employee's cardiac arrest and subsequent disability leading to his demise was an injury sustained in the performance of duty.

The Board noted that Cannon was unlike Cutler because the employee was not aspiring to change his working conditions or status. He was immediately concerned about a direct, unanticipated and erroneous action by the employing establishment affecting the conditions of his employment. His emotional reaction could not be considered self-generated because the action by the employing establishment affected the conditions of his employment; neither could it be considered self-generated because the action by the employing establishment was directed to a particular employee on an official basis, and later found to be erroneous. Therefore, his cardiac arrest and subsequent death constituted an injury within the meaning of the Act.

Where the evidence shows error or abuse by the employing establishment, an employee's reaction cannot be considered self-generated and will come within the coverage of the Act. However, a reversal or modification of a disciplinary or other action taken against an employee does not necessarily establish that the employing agency's actions were in error or abusive. In Nicholas D. Buckley, Docket No. 91-673, issued October 24, 1991 the Board stated:

appellant has submitted medical evidence which attributed the aggravation of his preexisting emotional condition to his termination from the letter carrier position he held at the employing establishment following 60 days of his probationary period. The evidence does not establish, however, that appellant's disability arose within the performance of duty. The record establishes that appellant's separation from the postal service resulted from two letters of warning he received, for failure to obey a direct order and for missing a collection box, and a preventable motor-vehicle accident. Following his separation, appellant filed grievances which resulted in one letter of warning being removed from appellant's record, in order that he could apply for a mailhandler position, and the second letter of warning being reduced to an official discussion, a form of discipline at the employing agency. In taking these administrative actions, appellant has not introduced any evidence which would demonstrate that the employing establishment erred or acted abusively in these matters. There is no evidence of record in this case that the employing establishment did not act reasonably in the administration of these personnel matters. The fact that one disciplinary letter of warning was removed and the second letter of warning was reduced to a discussion does not establish that the disciplinary actions brought against appellant were in error.

g. Personnel Actions. Personnel actions may be canceled or modified through various procedures such as arbitration, grievance, etc., or disputes may be settled without prejudice to the position of

any party. Cancellation or modification of personnel actions and settlements of disputes do not, of themselves, establish that the actions were erroneous or unreasonable and therefore constitute factors of the employment. Affirming the Office's decision in William Cook, Docket No. 90-1343, issued November 30, 1990, the Board stated:

appellant attributes his emotional condition to certain events and circumstances that occurred while he was a postal employee. These events and circumstances, although contemporaneous or coincident with appellant's employment, do not constitute factors of employment giving rise to coverage under the Federal Employees' Compensation Act. Appellant primarily complains that he has been the subject of long-standing harassment and discrimination from superiors and fellow employees, and he notes that he has filed complaints with the NLRB and EEOC, and numerous grievances. Yet, the record discloses no finding by the NLRB or EEOC to support appellant's assertions, and it appears that his grievances have yielded nothing more favorable than settlements without prejudice to the position of any party. The evidence does not establish that appellant was in fact the subject of harassment or discrimination.

Requirements imposed by the employment are not limited to assigned duties as such. Other circumstances relating to assigned duties may become part of the employee's employment and be sufficient to bring an injury or illness within the coverage of the Act.

In Pasquale Frisina, 34 ECAB 1230, the employee claimed that his emotional condition resulted from his receipt of an employing establishment letter criticizing his wife for the method of reporting his illness (telephone request to supervisor for sick leave). The employing establishment had procedures for reporting sick leave and returning to work. The employee's method for reporting sick leave had been questioned in the past. Citing 5 CFR 630.101, which charges agency heads with the responsibility for administering sick leave accounts for employees and provides how employees shall apply for sick leave, the Board found that the procedure for reporting sick leave was a requirement imposed by the employment. According to the Board the circumstances leading to the employee's alleged emotional reaction (wife's request on his behalf for sick leave; receipt of employing establishment letter) were part of the employment and related to the duties the employee was employed to perform and to the requirements imposed by the employment.

The Board reached a different conclusion in Joseph C. DeDonato, 39 ECAB 1260. Appellant contended that his emotional disability was caused by several factors including the employing establishment's refusal to grant his application for sick leave. The Board found that all of the factors cited by appellant, including the denial of sick leave, were factors involving personnel matters which did not have such a relationship to his assigned duties so as to be regarded as arising out of and in the course of the employment. The Board distinguished its holding in Frisina by noting that "Frisina addresses the issue of a duty imposed upon the employee by required reporting instead of the issue in the instant case which addresses the administrative denial of leave, and which is purely a personnel matter."

Since both cases involve procedures which employees must follow in order to obtain sick leave, it was unclear why the Board considered the procedural requirements a "duty imposed upon the employee" in Frisina but "purely a personnel matter" in DeDonato (the Board noted in DeDonato

that, in response to his written request for sick leave, the employee received an immediate response from the employing establishment instructing him to "comply with employing establishment regulations within five days since his current absence had exceeded three days"). The Office took the position that Frisina stood alone among cases of this type and that all circumstances related to the administration of leave were strictly personnel matters and not factors of the employment.

The Board clarified its position in Anthony A. Zarcone, 44 ECAB 751, finding that employment establishment requirements for the use of sick leave were not compensable factors of employment. In affirming the Office's decision that appellant had not met his burden of proof to establish that he sustained an injury in the performance of duty, the Board discussed its previous decisions in Cutler and Raymond H. Schulz, Jr., 23 ECAB 25. The Board stated:

In the case of Pasquale Frisina, the Board stated that the procedure for reporting sick leave was a requirement imposed by the employment. It found, without explanation, that the circumstances presented were a part of the employment and related to the duties that the claimant was employed to perform and to the requirements imposed by the employment. This holding was not explained in light of the Board's prior decisions in Edgar Lloyd Pake, (33 ECAB 872) which found that the disapproval of a request for sick leave was not a compensable factor arising from the employment. Because there was no explanation of how the requirement related to the duties the claimant was hired to perform, Frisina implies that any "requirement" of employment constitutes a compensable factor of employment. Such a holding is too broad, as the above discussion of Lillian Cutler and Raymond H. Schulz, Jr., demonstrates. Accordingly, the Board expressly overrules Pasquale Frisina to the extent that it is inconsistent with Cutler, Pake and the holding herein. The Board notes that Pasquale Frisina was implicitly overruled in subsequent cases, notably Joseph C. DeDonato and Ralph O. Webster, (38 ECAB 521) which held that emotional conditions resulting from actions taken by the employing establishment in personnel matters such as use of leave are not sustained in the performance of duty.

The Board has thus made clear that requirements for use of sick leave are personnel matters, administrative in nature, and have no relationship to the duties the employee was hired to perform

h. Other Factors. The Board reiterates in its decisions the principles set forth in Cutler distinguishing between injuries or illnesses which have some connection with the employee's employment but do not result from the regular or special duties or a requirement imposed by the employment, and those that do. An employing establishment may take action against or relating to an employee because of something the employee did while on the job, or in connection with the employment, or because of his or her activities as a private citizen, which may result in a claim by the employee or dependents. In such cases the CE must determine whether the employee's actions were related to the assigned duties and the requirements of the employment.

In Walter Asberry, Jr. 36 ECAB 686 (1985), the employee claimed that his emotional disability was the result of being terminated from his employment because of discrimination. The evidence showed that the employee's dismissal was properly based on his willful misconduct and the

charges of discrimination were unsupported. The Board found that the employee's emotional upset was self-generated and did not arise out of or in the course of his Federal employment.

In Helen Marrotte, claiming as widow of Walter E. Marrotte, 36 ECAB 670 (1985), the employee accepted stolen military clothing from a co-worker who claimed to have found it in a locker. The employee was found to have had no part in the theft, but he received a written reprimand for having in his possession military clothing not received through regular supply channels. He filed a grievance but died of cardiac arrest before hearing were concluded. The Board found that, regardless of whether the employee knew that the clothing had been stolen, his acceptance of it through other than official channels was unrelated to his regular day-to-day duties, his specifically assigned duties or to a requirement imposed by his employment, and therefore the proceedings instituted against him were not factors of his employment.

In Pauline Phillips 36 ECAB 377 (1984), the employee, a postmaster, signed a petition regarding a community problem, which lead to a complaint filed against her by a local businessman. She received notice from the Postal Service that the complaint would be investigated. She alleged that worry over this caused her to develop an anxiety reaction and congestive heart failure. No investigation was initiated and Postal Service officials assured the employee that no adverse action would be taken against her. In finding that the employee was not entitled to coverage under the Act, the Board noted that her emotional reaction allegedly resulted from a situation which did not involve her ability to perform her day-to-day duties, or a special assignment, or because of a requirement imposed by the employing establishment. The situation arose because she exercised her rights as a private citizen.

The Board noted a similarity to the case of Manuel W. Vetti, 33 ECAB 750 (1982), a postmaster who developed a disabling emotional condition due to his reaction in an investigation involving a sale to the employing establishment of a parcel of land in which he had an interest. The Board found that the fact that the investigation would not have been initiated if Vetti were not a postmaster was "not a sufficient link to employment to consider his emotional reaction to it to have arisen out of the employment."

Ashberry's disability was not compensable because it had its origin in his willful misconduct. Marrotte's failure to conform to official procedures removed him from the coverage of the Act. Phillips' claim stemmed from her actions as a private citizen and the fact that she was the postmaster was insufficient to consider her disability as having arisen out of her employment.

i. Distinguishing Among Factors and Non-Factors of Employment. In George Derderian, 33 ECAB 1910, issued September 16, 1982, the employee alleged numerous causes of his emotional condition, all of which had some connection with his employment but not all of which could be deemed conditions of his employment. In its remand order the Board stated that situations which could be deemed conditions of employment as enunciated in Cutler were the employee's emotional reaction to the circumstances of his performance rating; confrontations with his supervisor involving criticism and other verbal altercations concerning his performance; the employee's assignment to a special project and its subsequent cancellation; legal action taken against the employee by a subordinate for his failure to promote the subordinate; and the employing establishment's failure to arrange for the employee's defense in the ensuing lawsuit

causing him to retain private counsel. Factors which were not compensable under Cutler were distress over reduction-in-force and the appeals process which followed; distress over a newly created position and the national advertisement of that position; and distress over the assignment of one of the employee's subordinates as his acting supervisor.

The Board's finding that Derderian's emotional reaction to the circumstances of his performance rating resulted from his employment preceded the Board's clarification of its McEuen decision that an unsatisfactory performance rating, without more, is insufficient to provide coverage. Therefore, Derderian does not apply to claims which involve an emotional reaction to performance evaluations or assessments or to discussions of performance. McEuen is considered to be the definitive opinion with regard to the compensability of performance evaluations, assessments or discussions and is the basis for Office policy that these are not deemed conditions of employment.

j. Developing Factors of Employment. An employee who claims to have had an emotional reaction to conditions of employment must identify those conditions. The CE must carefully develop and analyze the identified employment incidents to determine whether or not they in fact occurred and if they occurred whether they constitute factors of the employment. When an incident or incidents are the alleged cause of disability, the CE must obtain from the claimant, agency personnel and others, such as witnesses to the incident, a statement relating in detail exactly what was said and done. If any of the statements are vague or lacking detail, the responsible person should be requested to submit a supplemental statement clarifying the meaning or correcting the omission.

When all available evidence has been obtained, the CE must prepare an objective and neutral account of the facts (Statement of Accepted Facts, or SOAF). Where the evidence is in conflict, the CE must decide which is the best supported and most likely version. The CE must distinguish in the SOAF between those activities and circumstances which are factors of employment and those which are not (see PM Chapter 2-809.13c). The evaluating physician will be required to give a rationalized opinion specifying which activities and circumstances, as set forth in the statement of accepted facts, caused or contributed to the condition found on examination.

The determining factor in the types of cases discussed in this section is whether the alleged disability resulted from an incident or incidents which are sufficiently connected to the employment to be considered factors of the employment. To make this determination, the CE must fully develop the circumstances of the alleged injury as well as the employee's duties and working conditions. This will include not only those duties specifically defined (official position description) but also implied (not specifically defined but expected by the employing establishment), if any. Where a claim is filed because of an incident which appears to have no direct relationship to an employee's regular or specially assigned duties, the CE must decide whether a requirement imposed by the employment was involved that, under the circumstances, would be considered part of the employment.

Claims filed for injury or illness allegedly due to employing establishment actions against or relating to an employee solely because of willful misconduct, failure to conform to or violation of official agency procedures, or an employee's actions as a private citizen, do not have the

coverage of the Act because the injury or illness does not result from the employee's regular or special duties or a requirement imposed by the employment. These situations are not the result of work performance, but of a type of behavior which removes the employee from the performance of duty. Claims filed for emotional reactions to personnel actions such as performance evaluations and administration of leave also do not have the coverage of the Act. Where the evidence, after proper development, shows the existence of any of the described situations, and requirements for time, civil employee and fact of injury have been met, the claim will be denied for failure to meet the performance of duty requirement.

CEs must become familiar with significant Board decisions in this area and apply the established precedents to new cases. In addition to the cases cited above, CEs should note Carol Medlinger, 29 ECAB 168, and Kenneth Vreeland, 12 ECAB 281.

k. Rescission. In some claims, factors which were originally accepted as work-related would no longer be considered so in light of the ECAB decisions quoted above. Therefore, it may sometimes be necessary to rescind a claim where the acceptance was based on factors which are no longer considered to fall within performance of duty. Decisions to rescind acceptance of a claim will be made only by journey-level CEs and above.

The Board has upheld the Office's authority to reopen a claim at any time on its own motion under section 8128(a) of the Act and, where supported by the evidence, set aside or modify a prior decision and issue a new decision. (Eli Jacobs, 32 ECAB 1147). To justify rescission of acceptance, the Office must establish that its prior acceptance was erroneous based on a new or different evidence or through new legal argument and/or rationale as was done in the case of Curtis Hall, Docket No. 92-683, issued January 11, 1994.

In that case, appellant claimed an employment-related disabling emotional condition which he attributed to a confrontation with a coworker who objected to his bible reading during work breaks. He also alleged a previous incident when a toxic substance had been placed in his chair causing contact dermatitis, diabetes mellitus and hypertension. The Office accepted appellant's claim for a depressive reaction based solely upon medical opinion evidence without determining whether his allegations were supported by the factual evidence of record.

After appellant's claim was accepted, the employing establishment physician submitted a report to the Office which stated that appellant had sat on his own super glue pen container, which was not issued and used in his job, and that the incident would not cause hypertension or diabetes mellitus. On further review, the Office found that appellant's emotional condition did not arise out of factors of his federal employment, and that the medical opinion evidence on causal relationship was unrationalized.

An office hearing representative found that the alleged incidents of confrontation and placement of super glue on appellant's chair were not established as factual; that the medical reports of appellant's attending physician were based on an inaccurate history and therefore of little probative value; and that the reports of the physicians of record did not find appellant disabled for his position.

The Board found that the Office met its burden of proof to rescind its acceptance of this claim based on new medical evidence and the provision of new legal rationale that the implicated work related incidents were not established as factual.

When it has been determined that only correct and proper application of personnel and administrative matters were involved in a case accepted for emotional disability, the acceptance may be rescinded based on new legal argument that no employment factors were involved, without the need for new evidence. In those cases the CE will prepare a Memorandum to the Director which will include:

- (1) A summary of the development and adjudication of the claim, noting that the Office had not previously considered whether the employment circumstances which caused the claimant's emotional reaction were factors of the employment.
- (2) A description of the employment circumstances which caused the claimant's emotional reaction with an explanation of why they do not constitute employment factors, citing pertinent Board decisions.
- (3) A recommendation to rescind acceptance of the claim based on new legal argument that, since the circumstances to which the claimant attributes emotional problems do not constitute factors of employment, disability did not arise out of the employment or in the performance of duty, and the employee has not sustained an injury within the meaning of the Act.

If the claimant does not respond to the pre-termination notice, or if the claimant's response is not sufficient to change the Office's position or to require further development of the record by the Office, a formal decision will be issued rescinding acceptance of the claim and terminating benefits on the ground that acceptance of the claim was incorrect because the circumstances to which the claimant attributes his or her emotional disability are not factors of the employment within the meaning of the Act and the claimant's disability did not arise out of in the course of his or her employment and he or she was not injured in the performance of duty.

18. Employing Agency Physical Fitness Programs. A number of employing agencies have instituted structured Physical Fitness Programs (PFPs), which typically include agency-appointed fitness coordinators, physical assessment tests and structured exercise while off duty. If the employee's position requires that a certain level of fitness be maintained, work time may be allocated for exercise. Employees enrolled in PFPs maintain logs of their program exercises and report to fitness coordinators, who have been trained by the agency to monitor progress and to give advice on matters related to physical fitness. Considering the degree of agency management, support and encouragement of PFPs, and the expressed benefits to the government anticipated from employee participation, employees enrolled in a PFP are in the performance of duty for FECA purposes while doing authorized PFP exercise, including off-duty exercises performed under the auspices of the fitness program.

a. Injuries and occupational diseases arising from participation in an employing agency's PFP are compensable under the FECA. Participation will not always occur during regular work hours, and not always on the employing establishment's premises.

b. Employees who are injured while exercising or participating in a recreational activity during authorized lunch or break periods in a designated area of the employing establishment premises have the coverage of the Act whether or not the exercise or recreation was part of a structured PFP. Injuries which occur during the use of fitness and recreational facilities furnished by the employing establishment outside of official work hours, on or off the premises, are not compensable if the employee was not participating in a structured PFP. The mere fact that the employing establishment allows employees to use its facilities on their own time does not create a sufficient connection to the employment to bring any resulting injury within the coverage of the Act.

c. All Forms CA-1 which attribute an injury to PFP activity must be accompanied by a statement from the employee's supervisor indicating that the employee was enrolled in the PFP, and that the injury was sustained while the employee was performing authorized exercises under the program. An assessment test provided as a part of the program or in a related screening process is considered a program-authorized exercise. The employee's supervisor must verify that the facts are as described on Form CA-1. If the statement from the supervisor is not submitted with Form CA-1 it must be requested. The supervisor must obtain this information from the fitness coordinator.

d. Where a Form CA-2 is filed claiming that an occupational disease is causally related to the PFP participation, the employee is required to state specifically what activities caused the condition. A statement must be obtained from the supervisor showing what exercises were approved to ensure that the activities performed were authorized under the program.

e. All employees in a PFP must receive medical clearance to participate. CEs must request a copy of the medical examination report in every case.

19. Deleterious Effects of Medical Services Furnished by the Employing Establishment. Public Law No. 79-658, approved August 8, 1946, authorized Federal agencies and government-owned and controlled corporations to establish, by contract or otherwise, health service programs to provide health services for employees under their respective jurisdictions. These services are limited to (1) treatments on-the-job illness and dental conditions requiring emergency attention; (2) pre-employment and other examinations; (3) referral of employees to private physicians and dentists; and (4) preventive programs relating to health.

a. An employee who participates voluntarily in the health service program is considered in the performance of duty on those occasions when such participation causes absence from regular duties for the specific purpose of obtaining the medical service offered by the employer. Deleterious effects such as injury while undergoing periodic medical examination, reaction to agency-sponsored inoculation, or disease contracted from instrumentation are compensable.

b. Coverage for the deleterious effects of employer provided medical services is limited to employees who are voluntary participants in the employer's sponsored health service program and, only for the effects of treatment for on-the-job illness and dental conditions requiring emergency attention. Coverage for deleterious effects does not extend beyond the immediate

service contemplated by P.L.-658; therefore it does not follow the employee who is referred for, or obtains, outside medical services.

c. The medical procedures involved in a pre-employment medical examination come within the rule for coverage provided the person has already been appointed or hired when the examination is performed. A prospective employee is not covered for compensation benefits.

d. Deleterious effects of medical services may be unavoidable or may occur because of error or agency failure to report examination results to the employee or to the employee's physician in time to alter the course of a disease. They may also result from an act such as inadvertently administering the wrong drug, or failure to inform an employee of positive test results.

e. Following appropriate development, all cases of this type should be referred to a District Medical Adviser for an opinion on whether the condition claimed was causally related to the agency medical service or was adversely affected by the failure to promptly alert the employee or the employee's physician.

f. This matter was initially addressed in FECA Program Memorandum No. 42 dated March 3, 1966 and was supplemented by Program Memorandum No. 186 dated December 23, 1974 which the Office interpreted as expanding coverage from on-the-job illness and dental conditions requiring emergency attention to any medical treatment given by the employing establishment for a non-employment related condition. The Employee's Compensation Appeals Board criticized this interpretation in Beverly Sweeney, 37 ECAB 651, noting that it exceeded "any authority given under the Act or any other statute as regulations." The Board also stated that "Neither the Office nor the Board has the authority to enlarge the terms of the Act nor to make an award of benefits under any terms other than those specified by law." The Office's interpretation was also contrary to previous Board decisions, several of which were cited in Sweeney. The procedures set forth in this section conform to the Board's decision in Sweeney.

Chapter 2-0805, Causal Relationship

1. Purpose and Scope. This chapter contains guidelines for determining the question of causal relationship as it relates to both traumatic injury and occupational illness claims. It discusses causal relationship as one of the five basic components for acceptance of an initial claim and also discusses the information necessary to establish causal relationship for claimed consequential conditions later in the life of a case.

The CE should refer to the FECA PM Chapter 2-0800 (Initial Development of Claims) for specific information regarding how to properly develop claims.

2. Types of Causal Relationship. An injury or disease may be related to employment factors in any of four ways, as follows:

a. Direct Causation. This type of relationship is demonstrated when the injury or factors of employment, through a natural and unbroken sequence, result in the condition claimed. A fractured arm sustained in a fall would be considered a direct result of the fall, and a sensorineural hearing loss might likewise be caused directly by occupational noise exposure over a period of time.

In occupational disease claims, however, the medical evidence needed to support the relationship will likely require greater rationale than in traumatic injury claims. The phrase "proximately caused" is also used to designate this kind of relationship.

b. Aggravation. This kind of relationship occurs if a pre-existing condition is worsened, either temporarily or permanently, by an injury arising in the course of employment. For instance, a traumatic back injury may aggravate a claimant's pre-existing degenerative disc disease, and compensation would be payable for the duration of the aggravation as medically determined. An aggravation must be diagnosed by a physician to be compensable.

A claim may be accepted for a lesser established diagnosis if the aggravation issue requires further development. For example, if a physician diagnoses degenerative arthritis of the right knee and a right knee strain as causally related to a traumatic injury, but does not address aggravation, the CE may accept the right knee strain and concurrently develop the claim to determine whether the arthritis was aggravated by the injury.

If the medical evidence establishes an aggravation of a condition as causally related to a work injury, but the evidence is unclear as to whether the aggravation is temporary or permanent, the case may be accepted for a temporary aggravation and concurrently developed to determine the nature and extent of the aggravation.

(1) Temporary aggravation involves a limited period of medical treatment and/or disability, after which the employee returns to his or her previous physical status (i.e. baseline). Compensation is payable only for the period of aggravation established by the weight of the medical evidence, and not for any disability caused by the underlying disease. This is true even if the claimant cannot return to the job held at time of injury because the pre-existing condition will worsen if he or she does so (see *James L. Hearn*, 29 ECAB 278).

If the medical evidence establishes that a temporary aggravation has ceased at the time of acceptance, the acceptance letter should note the end date of the accepted temporary aggravation. The specific dates of the temporary aggravation or the date the temporary aggravation ceased should also be included in any Statement of Accepted Facts (SOAF) that is prepared.

(2) Permanent aggravation occurs when a condition will persist indefinitely due to the effects of the work-related injury or when a condition is materially worsened such that it will not revert to its previous level of severity. For instance, an allergy in a severely asthmatic employee which would have persisted in any event may be permanently aggravated by exposure to construction dust and fumes in the workplace such that subsequent episodes are more severe than they otherwise would have been.

A case should be accepted for permanent aggravation only after careful evaluation of all medical evidence of record. The CE should usually refer the claimant for a second opinion examination (depending upon the complexity of the claimed condition and the medical rationale in the file) before accepting the claim for a permanent aggravation.

c. Acceleration. A work-related injury or condition may hasten the development of an underlying condition, and acceleration is said to occur when the ordinary course of the disease does not account for the speed with which a condition develops. For example, a claimant's knee arthritis may have been accelerated by activities such as continuous walking, stooping and squatting in his/her job over a 15 year career that involved these activities for a majority of each day. An acceptance for acceleration of a condition carries the same force as an acceptance for direct causation. That is, the condition has been accepted with no set limitation on its duration or severity.

d. Precipitation. A latent condition which would not have become manifest but for the employment is said to have been precipitated by factors of the employment. For instance, tuberculosis may be latent for a number of years, and then become manifest due to renewed exposure in the workplace. The claim would be accepted for precipitation, but the acceptance would be limited to the period of work-related tuberculosis and OWCP's responsibility for the condition would cease once the person recovered.

Any ensuing episode of the disease would be considered work-related only if medical evidence supported such a continued relationship. In this way acceptance for precipitation may resemble acceptance for temporary aggravation. A claim can also be accepted for precipitation of a condition with no limit on the duration of the acceptance.

3. Evidence Needed. The question of causal relationship is a medical issue which usually requires reasoned medical opinion for resolution. This evidence should be obtained from a physician who has examined or treated the claimant for the condition for which compensation is claimed.

a. Physicians Qualified to Provide Opinions. As defined by 5 U.S.C. 8101 (2), the term "physician" includes surgeons, osteopathic practitioners, podiatrists, dentists, clinical psychologists, optometrists and chiropractors within the scope of their practice as defined by state law. Registered nurses (RNs), licensed practical nurses (LPNs), physician assistants, nurse practitioners, certified nursing assistants, social workers and physical therapists are not physicians under the Act and, therefore, are not qualified to provide medical opinion to establish causal relationship.

(1) A report of a physician assistant or a certified nurse practitioner will be considered medical evidence if countersigned by a qualified physician.

(2) A clinical psychologist may serve as a treating physician for a work-related emotional condition. See 20 C.F.R. 10.312.

(3) A chiropractor's opinion constitutes medical evidence only if a diagnosis of subluxation of the spine is made and supported by x-rays (*Loras C. Digmann*, 34 ECAB 1049). See 20 C.F.R. 10.311.

b. Sources of Medical Evidence. A medical report from the claimant's physician is required to consider the issue of causal relationship, though in some instances OWCP may refer the claimant for a second opinion examination (e.g. hearing loss claims). This report should include the physician's diagnosis of the condition found, the objective examination findings that establish that diagnosis, and opinion concerning the relationship, if any, between the condition and the injury or factors of employment claimed. The opinion may appear on a Form CA-16, Form CA-20, Form CA-5 or 5b (death claims), or in other medical forms or narrative reports.

c. When No Medical Report is Required. If all of the following criteria are satisfied, a claim may be accepted without a medical report:

(1) The condition reported is a minor one which can be identified on visual inspection by a lay person (e.g., burn, laceration, insect sting or animal bite); and

(2) The injury was witnessed or reported promptly, and no dispute exists as to the fact of injury.

d. When Medical Opinion is Required. If the circumstances noted above in 3c do not apply, the CE should determine whether a medical report addressing causal relationship is contained in the file. If no such report is present, the CE should request it from the claimant.

(1) In clear-cut traumatic injury claims, where the fact of injury is established and is clearly competent to cause the condition described (for instance, a worker falls from a scaffold and breaks an arm), a fully rationalized medical opinion is not needed. The physician's diagnosis and an affirmative statement are sufficient to accept the claim.

(2) In all other traumatic injury claims, and in occupational illness claims, rationalized medical opinion supporting causal relationship is required.

(3) Certain cases require directed development and specialized medical opinions.

(a) Claims for hearing loss require an opinion from a Board-certified specialist in otolaryngology. See PM 3-600.

(b) Claims for pulmonary conditions (e.g., exposure to asbestos) require an opinion from a Board-certified pulmonary specialist prior to acceptance. See PM 3-600.

(c) An extended occupational disease claim for an emotional condition must be supported by an opinion from a psychiatrist or clinical psychologist before the condition can be accepted. Because clinical psychologists are not licensed to treat physical disorders or prescribe medication, an opinion from a psychiatrist must be obtained where a non-mental component is present, a functional overlay is implicated, and/or medication is used. See PM 2-800-9.

e. Evidence Needed if an Underlying Condition Exists. In any case where a pre-existing condition involving the same part of the body is present and the issue of causal relationship therefore involves aggravation, acceleration or precipitation, the physician must provide rationalized medical opinion which differentiates between the effects of the work-related injury or disease and the pre-existing condition. Such evidence will permit the proper kind of acceptance (e.g., temporary vs. permanent aggravation).

Depending on the circumstances of the case, the CE may request the following:

(1) From the claimant:

(a) Full details of the pre-existing condition, including the approximate date it first appeared, the names and addresses of all physicians who examined or treated the claimant for this condition, and the approximate dates of such examinations and treatment.

(b) Reports from all physicians who examined or treated the claimant for the pre-existing condition, including surgical and hospital records.

(2) From the employing agency:

(a) A copy of the pre-employment physical examination, if one was performed.

(b) Copies of any other pertinent medical records maintained by the employing agency.

(c) A statement from the claimant's immediate superior describing the nature of any complaints made by the claimant, and any disability the claimant may have from performing his or her duties because of this condition.

4. Evaluating Medical Opinions.

a. Determining Causal Relationship. The degree of difficulty in determining causal relationship depends mainly on:

(1) The precise employment factors accepted as occurring within the performance of duty or the nature of the injury which is implicated;

(2) The nature of the disability or the cause of death for which compensation is claimed;

(3) The time which elapsed between the injury and the onset of the condition causing disability or death; and

(4) The employee's medical history.

b. When no opinion regarding causal relationship is provided by the attending physician, the claim generally can be denied provided appropriate development has been completed.

Exceptions to this rule are where no medical opinion or medical report is required (see paragraph 3c above).

c. When the attending physician negates causal relationship between the condition and the employment factors, and no medical evidence to the contrary appears in the file, the case may be disallowed, provided appropriate development has been completed. No other medical opinion is required to support the denial.

d. The influence of the factors noted in 4a is shown by the following examples:

(1) An employee is hit by a truck while in the performance of duty and is immediately taken to a hospital, where a fracture of the right femur is found. It is clear that the fracture was caused by the truck accident, and the report from the attending physician supporting causal relationship would need no elaborate medical rationale.

Ninety days after the injury, symptoms of thrombophlebitis appear in the right leg and compensation is claimed for this condition. The passage of this amount of time between the injury and the development of the thrombophlebitis would create uncertainties regarding causal relationship. The report from the attending physician would need to include medical rationale to justify an opinion in support of causal relationship.

Six months later, the employee suffers a stroke while sitting quietly in an easy chair at home. The employee claims additional benefits for the stroke, alleging it was caused by the original injury of being struck by a truck. Two reasons now exist for questioning causal relationship: (a) nine months elapsed between the injury and the stroke, and (b) the original injury involved the leg, whereas the stroke may have resulted from a blood clot implicating the thrombophlebitis. Or the stroke may have resulted from a lesion in the brain, and no apparent physiological connection exists between the two. Any medical opinion in support of causal relationship would have to be based on a complete factual and medical background and justified by detailed medical rationale within a reasonable degree of medical certainty. Otherwise, the claimant's burden of proof would likely not be met.

(2) A nurse becomes disabled by pulmonary tuberculosis after a year of continuous employment on a ward where active tuberculosis patients were housed. If all other factors were negative, any medical opinion supporting causal relationship would require little or no rationale, as it would be apparent that the most probable source of the infection was in the employment.

If, however, investigation had revealed that the employee lived with a spouse in whom an advanced case of active pulmonary tuberculosis had been discovered 60 days before, two probable sources of the infection exist: the hospital where the employee was exposed for 40 hours per week in an atmosphere where the hazard was known and appropriate precautions were taken; and the home, where the hazard was unknown and no precautions were taken and where the contact was much more intimate and far exceeded 40 hours per week.

Under these circumstances, it would be more difficult to find that the employment was a proximate cause of the disease and any medical opinion in support of causal relationship would require a full description of the medical reasons justifying such an opinion.

Another variation involves the supposition of massive exposure at work and no exposure in private life, but with a positive skin test for tuberculosis prior to Federal employment. The major question then would be whether the current illness is a new disease process or a reactivation of an old one. This issue would require careful consideration, and any opinion which did not discuss all relevant factors and contain detailed rationale would not be sufficient to serve as the basis for acceptance.

5. Obtaining Additional Medical Opinion. If the CE determines that additional medical opinion is necessary, he/she may request an additional report from the claimant's physician or seek a second opinion. This may occur if medical evidence exists in the case file which indicates there is a causal relationship between the condition and employment factors, but the opinion is not fully rationalized. This, however, does not mean that the Office must accept a claim or that it must directly obtain further evidence.

a. Attending Physician. A list of questions may be sent to the attending physician, and a SOAF may be provided as the background for the case, if needed, based on the complexity of the case. See FECA PM 2-0809 for further discussion of SOAFs.

b. Second Opinion Specialist. In cases that cannot be adjudicated on the basis of the opinion provided by the claimant's physician, a SOAF should be prepared and an opinion should be requested from a physician who specializes in the pertinent field of medicine that pertains to the condition being claimed. FECA PM 3-0500.3 discusses such referrals. Also, see paragraph 3d(3) above and 5 U.S.C. 8123(a).

c. Referee Specialist. A conflict of medical opinion may be created when opinions of the attending physician and the second opinion are of approximately equal weight. When this occurs, the entire case file should be referred to a board-certified specialist in the pertinent field of medicine that is appropriate for the issue in conflict. FECA PM 3-0500.4 addresses these referrals. See also 5 U.S.C. 8123 (a).

d. Questions to the Physician. Questions should be as precise as possible, and they should be tailored to the particular circumstances of the case and the particular issue at hand. The CE should ask case-specific questions and avoid asking general questions, those which can be interpreted in more than one way, and those which suggest a certain answer. For instance, the question, "If there was an aggravation, was it temporary or permanent?" is preferable to, "When did the temporary aggravation cease?"

To prevent unnecessary delays in adjudication, the CE should identify and address all medical issues which need resolution before requesting the additional opinion. For example, if acceptance of causal relationship will entail a further decision about the extent of disability, the claimant's fitness for duty, or the appropriateness of medical care, these issues should be formulated in precise questions to the physician. However, the CE should avoid asking questions unnecessary

to the issue at hand. For instance, any questions regarding any related permanent partial impairment would be premature if causal relationship had yet to be established.

6. High-Risk Employment. Certain kinds of employment routinely present situations which may lead to infection by contact with animals, human blood, bodily secretions, and other substances. Conditions such as HIV infection and hepatitis B more commonly represent a work hazard in health care facilities, correctional institutions, and drug treatment centers, among others, than in Federal workplaces as a whole. Likewise, claims for brucellosis, anthrax, and similar diseases will most often arise among veterinarians and others who regularly work with livestock.

Establishing causal relationship in these types of complex cases usually requires an in-depth discussion of causal relationship by an appropriate specialist (whether it is the claimant's physician or a second opinion specialist). When writing to a specialist, the CE should include a SOAF to provide a complete and accurate factual background for the specialist to render his/her opinion.

The CE can accept the claim for a physical injury where one exists while developing the claim for a more serious condition (e.g., a puncture wound may be accepted while any claimed hepatitis is developed).

Note: OWCP does not authorize payment for preventive measures such as vaccines and inoculations, and in general, preventive treatment may be a responsibility of the employing agency under the provisions of 5 U.S.C. 7901; however, OWCP can authorize treatment in specific circumstances. See 20 C.F.R. § 10.313.

a. Physical Injury and Prophylactic Treatment. For claims based on transmission of a communicable disease where the means of transmission and the incubation period are medically feasible, the CE should do the following:

(1) If the source of infection is a known or probable carrier of the disease, the CE should accept the case for the physical injury involved and authorize prophylactic treatment (see FECA PM 3-0400).

(2) If the source of infection is unidentified or the source's status is unknown, the CE should accept the claim for the physical injury involved. Prophylactic treatment for the underlying disease will not be an issue, since a known carrier is not involved.

b. Testing for Presence of Disease. Incubation periods often last for several weeks or months (e.g., it is around 120 days for hepatitis B). Therefore, testing for the presence of the disease following a specific, known exposure may be delayed. Employees in occupations with high risks of exposure to specific diseases are often tested for these diseases at fixed intervals (e.g., a phlebotomist may be tested every three months for HIV infection). If the test results are positive, the CE may accept the case if:

(1) A known carrier is involved, and the claimant had neither a prior history of the disease nor exposure outside of employment; or

(2) A prior test was negative and a physical injury (such as a sexual assault) has been accepted, even if a known carrier is not involved, if the claimant's occupation puts him or her at continuous risk for contracting the disease in question and factors unrelated to work have not been identified as a source of infection. If such factors are present, the CE must carefully consider the medical probability of infection both outside and within the sphere of employment, as well as the incubation period of the disease.

7. Consequential and Intervening Injuries. After the original acceptance of a claim, an injury occurring outside the performance of duty may affect the compensability of an existing accepted injury.

a. Consequential Injury. This kind of injury occurs because of weakness or impairment caused by a work-related injury, and it may affect the same part of the body as the original injury or a different area altogether. For instance, a claimant with an accepted knee injury may fall at home because the weakened knee buckled. This incident will constitute a consequential injury whether the affected part of the body is the knee or some other area, such as the back or arm. Or, a claimant with an injured eye may compensate for loss of functioning by overuse of the other eye, which may result in a consequential injury.

ECAB has held that, when the primary injury is shown to have arisen in performance of duty, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause which is attributable to the employee's own intentional conduct. The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury. Sandra Dixon-Mills, 44 ECAB 882 (1993).

If such an injury is claimed, the CE should:

(1) Ask the claimant to provide a factual statement. Depending on the circumstances of the case, this statement should include the following:

(a) Why he/she believes the claimed consequential condition (and resulting disability, if any) is related to the already accepted work-related conditions.

(b) A detailed factual statement describing the claimed consequential condition from the date of last medical care through the present, including a description of whether symptoms were occasional or constant, and what made any symptoms worse or better.

(c) A description of the medical care received, and all periods of disability from work, from the date he/she returned to work.

(d) A description of the claimant's work activities since returning to work.

(e) A statement regarding whether the claimant has sustained any other injuries/illnesses, either on or off the job, since the original injury/illness.

(f) A description of any hobbies or activities, such as sports, volunteering, or another job, which may have affected the accepted work-related conditions and serve as an independent intervening cause that would break the chain of causation.

(2) Ask the claimant to furnish medical evidence. Though the request will vary depending on the circumstances in the case, this request should typically include the following:

(a) Copies of all medical records for the work-related condition from the date of discharge or date of last medical care through the present, including office visit notes, treatment notes, diagnostic test results, etc., if these are not already on file and/or a significant period of time has passed since receipt of any medical evidence.

(b) A comprehensive medical report from the claimant's physician that addresses the following:

(1) A description of the original mechanism of injury/work exposure and summary of the medical care received.

(2) A description of the current symptoms.

(3) Current objective findings upon examination.

(4) Results of all current diagnostic studies.

(5) Current diagnosis.

(6) The physician's opinion supported by a medical explanation as to the relationship between the accepted work-related condition(s) and the claimed consequential condition, if any.

(7) If disability is claimed as result of the consequential condition, a description of the work duties that the claimant cannot perform and the objective medical findings that form the basis of renewed disability for work.

(8) The recommended course of treatment.

(3) The CE should allow a reasonable time period for submission of the evidence (usually 30 days). After the time period has passed, the CE should adjudicate the claim for a consequential condition, and issue an acceptance letter or formal denial with appeal rights.

The CE may also seek further clarification from the claimant's physician if needed, or refer the case for review by the District Medical Advisor or to a second opinion examiner, prior to adjudicating the claim for a consequential condition.

b. Intervening Injury. An injury occurring outside the performance of duty to the same part of the body originally injured is referred to as an intervening injury if compensation is claimed subsequent to the second injury. In this case the CE must determine whether the disability is due to the second injury alone, or whether the effects of the first injury still contribute to the disability. Unless the second injury breaks the chain of causation between the original injury and the disability claimed, the disability will be considered related to the original incident.

For instance, if the claimant is recovering from rotator cuff surgery and slips on ice leaving the house and lands on the same shoulder and reinjures it, this would be considered an intervening injury. But since the claimant had not fully recovered from the approved shoulder surgery, the effects of the original shoulder injury and subsequent surgery would still be contributing to the disability, therefore the chain of causation was not completely broken.

(1) When an intervening injury has occurred and a subsequent period of disability has been claimed, the CE should obtain the following information from the claimant to resolve the issue of causal relationship:

- (a) A statement giving full details of the second incident.
- (b) Copies of all medical reports pertaining to treatment of this injury.
- (c) A medical report containing a reasoned opinion concerning the relationship between the disability currently claimed and both the original injury and the intervening injury.
- (d) Other information as described above for consequential injuries may also be requested, as needed.

(2) As with consequential injuries, additional medical development may be necessary to confirm or deny the alleged causal relationship.

Chapter 2-0806, Initial Acceptances

1. Purpose and Scope. This chapter contains procedures for the initial acceptance of claims. It supplements information about developing claims (FECA PM 2-0800), the five basic requirements of a claim (FECA PM 2-0801 through 2-0805), weighing medical evidence (FECA PM 2-0810), and disability management (FECA PM 2-0600). Also, see FECA PM 2-1400 for a detailed discussion of disallowances.

2. Accepting the Claim. In adjudicating the case, the CE must review and evaluate all material submitted to determine whether the case meets the five basic requirements for a claim under the FECA (timeliness, civil employee, fact of injury, performance of duty, causal relationship). If the evidence is sufficient to establish that the five basic requirements have been met, the CE should take the following actions:

a. Determine what diagnosis or diagnoses to accept based on the medical documentation of record, and identify the corresponding International Classification of Diseases (ICD) codes.

(1) The CE should accept each diagnosis that is causally related to the work injury, regardless of severity or impact on disability. Cases with multiple medical conditions are further addressed in paragraph 4 of this chapter.

(2) If the medical evidence establishes that a pre-existing condition was aggravated, an aggravation should be accepted, not the underlying condition itself.

b. In traumatic injury cases, determine if Continuation of Pay (COP) is payable. If COP has been claimed but is not payable, the CE should release a formal decision with appeal rights denying COP. In occupational disease cases, and in those cases where the claimant is not entitled to COP but has lost wages as identified by the receipt of Form CA-7, the CE should determine if compensation is payable in accordance with timely payment procedures. See FECA PM 2-0807 for further discussion of COP and PM 2-0901 for further discussion of initial payment of compensation.

c. Enter the accepted condition(s) (i.e., ICD code(s)) and the correct case status and adjudication status codes into the Integrated Federal Employees' Compensation System (iFECS). See FECA PM 2-0401 for details about case status and adjudication status codes.

d. Advise the claimant by letter of the condition(s) accepted. A letter should be issued in all formally adjudicated and accepted cases, without exception. The letter should include the date of injury, name of the employer, accepted work-related condition(s), information regarding entitlement to COP (if applicable), and instructions for filing a wage-loss claim (if applicable). A copy of the letter should be sent to the employing agency, and to the claimant's representative, if applicable.

e. If the employing agency has challenged the claim and/or controverted COP, and such challenge or controversion is not upheld, the CE must acknowledge and respond to the challenge either in the acceptance letter or by separate correspondence. Responding to challenges is further discussed in paragraph 7 of this chapter.

f. Review the case to determine if the potential for third party liability exists. If third party potential exists, the CE should initiate third party subrogation procedures in accordance with FECA PM 2-1100.

g. Review the case to determine if Disability Management actions are needed. See paragraph 3 of this chapter.

3. Disability Management Upon Acceptance. At the time the claim is accepted, the CE should ascertain the claimant's current work status if it is not clear in the file.

If the claimant is losing time from work, the CE should initiate disability management actions in accordance with FECA PM 2-0600. If the claimant is working in a limited duty capacity without wage loss because of the accepted work injury, disability management actions may also begin.

If upon acceptance, it is clear that disability management is needed because the claimant has not returned to work, the CE should advise the claimant in the acceptance letter that OWCP is evaluating the case to determine what steps are necessary to facilitate medical recovery and sustainable return to work; such notice will prepare the claimant for the upcoming disability intervention actions.

4. Multiple Medical Conditions. In many cases, the claimant will claim multiple conditions on the CA-1 or CA-2. The CE should ensure that all claimed conditions are addressed at the time of initial adjudication. The action taken by the CE will depend on whether each claimed condition has been properly developed.

a. If all claimed conditions have been developed, and the evidence of record supports acceptance of some but not all of the conditions claimed, the CE should issue an acceptance letter for the compensable conditions and issue a formal decision with appeal rights denying the remaining claimed conditions. Like any other formal denial, this decision must make findings of fact and include appeal rights.

b. If multiple conditions have been claimed, the evidence submitted supports acceptance of some but not all of the conditions, and the remaining conditions have not been developed, the CE should issue an acceptance letter for the compensable conditions and concurrently issue a development letter for the remaining claimed conditions. The development may be undertaken in either the acceptance letter itself or by separate correspondence.

c. In some instances, the claimant may claim only one medical condition, while the medical evidence indicates that multiple diagnosed conditions are work-related. The CE should accept each diagnosis related to the work injury, regardless of severity or impact on disability. For example, a claimant slips and falls on ice in the course of employment, and a left hip contusion and left knee medial meniscus tear are diagnosed by a physician in the emergency room. Even if the left knee condition becomes the predominant cause for disability and need for further treatment, the CE should also accept the left hip contusion, assuming the five basic requirements are met.

5. Resolved Conditions. In some instances the medical evidence will support that a condition being accepted at the time of adjudication has already resolved. In these situations, a determination regarding ongoing entitlement may be addressed in the acceptance letter. This is particularly important if there is evidence of ongoing treatment for another non-work related, but similar, condition.

In this instance, the CE cannot state that the work-related condition has resolved and close the case without providing the claimant the opportunity to exercise appeal rights. For this reason, the CE must cite the evidence that demonstrates the condition has resolved in the acceptance letter, attach a copy of the medical evidence to the acceptance letter, and include appeal rights. For

medical bill processing purposes, the case should first be adjudicated for the acceptance with appropriate case status and adjudication codes, before updating iFECS with the final coding of C3/D5.

Where multiple conditions have been accepted, the medical evidence may support that one or more condition has resolved while residuals are ongoing for remaining accepted conditions. Such cases should be open for benefits related to the ongoing accepted conditions while finding no further entitlement for those conditions which have resolved.

The following sample language may be used when an accepted condition has clearly resolved: Your claim has been accepted for a cervical strain, resolved by April 1, 2011. In a report dated April 1, 2011, your treating physician stated that your examination resulted in normal findings and the cervical strain had completely resolved. A copy of this April 1, 2011 report is enclosed. Therefore, no further benefits for a cervical strain will be covered after the date of this letter. If you disagree, please refer to the attached appeal rights.

6. Accepting and Simultaneously Closing a Case. The Office should administratively close a case at the time of adjudication if the treating physician has released the claimant from care and/or advised the claimant to return only on an as-needed, or "prn," basis. This often occurs with minor conditions such as sprains/strains and contusions.

The CE should properly notify the claimant in the acceptance letter that the case has been closed. Appeal rights need not be attached, as such a closure is not a termination of benefits and would still allow the claimant to pursue reopening his or her claim (e.g. by filing Form CA-2a, Notice of Recurrence). For medical bill processing purposes, the case should first be adjudicated with appropriate case status and adjudication status codes and saved before updating the final coding to C5/AM.

Sample language: On April 16, 2011, your physician released you from care to return on an as-needed (prn) basis. Therefore, your case has been administratively closed with no need for further medical care anticipated. This will allow authorized medical bills submitted for payment to be processed for a period of 120 days from the date of this letter. Form CA-2a, Notice of Recurrence, may be filed in the event further medical care is needed.

7. Addressing Employing Agency Challenges/Controversions. A controversy is an employing agency's dispute, challenge, or denial of the validity of a claim for COP. An employing agency may controvert COP based on one of nine statutory exclusions (see FECA PM 2-0807) or challenge the claim as a whole based on other objections associated with the five basic requirements for FECA coverage. The term "controversion" applies specifically to the issue of COP. The agency may pay COP but challenge the claim itself; controvert COP (based on a statutory exclusion) but not challenge the claim; or controvert COP and challenge the claim.

The CE must be mindful of the nature, strength and logic of the employing agency's objection and thoroughly develop the controversion or challenge if necessary. A controversion or challenge can be addressed in the development letter or acceptance letter with a copy to the employing agency or in a separate narrative letter to the agency.

The CE must provide a response to the employing agency's challenge or controversion if the claim is accepted and COP is approved. This would also include situations where no specific reason or argument is provided by the agency in support of its objection. The CE should provide such notification within the body of the acceptance letter or by separate letter. In some instances it will be more appropriate to notify the agency by separate letter or by using Form Letter CA-1038; however, notification should be provided at the time of acceptance. The CE should sufficiently explain the basis for approving COP or the claim by specifically referencing each challenge and explaining how the evidence of record was used to support the acceptance of the case. The facts or dates of medical reports which led to the determination should be clearly stated.

Sample language to Employing Agency addressing a challenge of a claim: It is noted that you challenged this claim due to a lack of medical evidence establishing causal relationship. The evidence, however, supports that this employee is a Federal employee who sustained a traumatic injury in the performance of duty; therefore, the case has been accepted. Even though you indicated that there was a lack of medical evidence, we have received a report from Dr. John Smith dated March 31, 2011 supporting causal relationship in this case. The injury was clearly established (the claimant fell on ice) and the attending physician diagnosed a right knee meniscus tear as a result of the injury.

8. Aggravation of a Medical Condition. A claimant may sustain an aggravation of a pre-existing condition due to an injury arising in the course of employment. This could result from a traumatic event or exposure to hazardous conditions.

In determining whether a pre-existing medical condition has been aggravated by an injury or by job duties, causal relationship can only be established by medical evidence. Where medical evidence establishes that a pre-existing condition was aggravated, an aggravation should be accepted, not the underlying condition. The CE should accept either a temporary or permanent aggravation, depending on the medical evidence of record. A permanent aggravation should only be accepted after careful evaluation of the weight of the medical evidence of record, as discussed in FECA PM 2-0805.

A CE can neither diagnose nor medically determine the extent and duration of an aggravation or any disability associated with the aggravation. This determination must be made based on the medical evidence. The extent and duration of work-related aggravation is one of the critical areas that should always be developed when an aggravation is diagnosed.

The CE should define in the acceptance letter exactly what type of aggravation is being accepted, whether temporary or permanent. If the accepted aggravation has ceased, the acceptance letter should state the date that the accepted aggravation is considered to have ended by citing the specific medical evidence used to make that determination. The CE should also consider whether the case is in posture for termination of ongoing benefits at the time of acceptance, in which case appeal rights must be attached (see paragraph 5 of the chapter). If it remains unclear whether the temporary aggravation has resolved, the CE should include questions to the attending physician (or write to the physician directly) at the time of acceptance in order to develop when the temporary aggravation is expected to subside or return to baseline, or pre-injury, status.

If the aggravation is temporary and leaves no permanent residuals, the claimant is entitled to compensation only for the period of disability related to the aggravation. This is true even when the claimant is found medically disqualified to continue in his or her regular job because of the effect which the employment factors might have on the pre-existing condition. When the claimant's inability to continue working is due to the underlying condition, without any contribution from the employment, compensation is no longer payable.

The Employees' Compensation Appeals Board (ECAB) has held that where an employee claims an aggravation of a preexisting condition, the employee must provide a rationalized medical opinion discussing the nature of the condition, including its natural or traditional course, and how the underlying condition was affected by the employment. See Newton Ky Chung (39 ECAB 919___ (1988) and Raquel Navedo-Cruz, Docket No. 96-1558; Issued May 1, 1998).

9. Risk of Future Exposure. Generally speaking, a wage-loss claim due to the risk of future exposure or prevention of future injury (prophylactic measures) is not compensable.

When an employee cannot work due to risk of future exposure, the CE must determine whether the susceptibility is due to the employee's exposure on the job site, or if it pre-existed such exposure. Such disability is compensable only if it is due to exposure on the job.

As ECAB held in Dennis L. O'Neill (29 ECAB 151) and clarified in James L. Hearn (29 ECAB 278), when an employee has suffered a work-related injury which results in permanent residuals, disability for work may result when additional exposure to the implicated employment conditions would further endanger the employee's health, although the residuals of the injury alone might not be disabling.

For instance, since exposure to asbestos dust generally results in permanent and irreversible changes in the pulmonary system, medical evidence may state that continued employment in a certain job or work environment is contraindicated due to the dangers of continued exposure. If the employing agency cannot provide employment in an environment that conforms to the medically allowed level, the claimant will be entitled to compensation. If the impairment is sufficient to disable the individual for his or her customary employment, the CE should refer the claimant for vocational rehabilitation services.

On the other hand, if employment factors aggravate a pre-existing condition, the claimant is entitled only to compensation for the period of disability related to the aggravation, if the aggravation is temporary and leaves no permanent residuals. This is true even if the claimant is found medically disqualified to continue in his or her regular job because of the effect which the employment factors might have on the pre-existing condition. The claimant's inability to continue working is due to the underlying condition, without any contribution from the employment, and therefore compensation is not payable.

Chapter 2-0807, Continuation of Pay and Initial Claims for Compensation

1. Purpose and Scope. This chapter furnishes the information and instructions necessary for the Claims Examiner (CE) to understand and implement the provisions of the Federal Employees' Compensation Act (FECA) pertaining to continuation of pay (COP), which are found at 5 U.S.C. 8118, and to process initial claims for compensation in a timely manner.

2. Statutory Authority. Effective September 7, 1974, the FECA was amended to authorize the employing agency to continue an employee's pay for a period not to exceed 45 days, pending the OWCP's adjudication of the employee's claim for compensation. COP applies only to traumatic injuries occurring on or after November 6, 1974 and reported on an OWCP claim form within 30 days. The intent of the COP provision is to eliminate interruption in the employee's income for the period immediately following a job-related traumatic injury. The COP provision eliminates interruption of pay for the great majority of employees injured on or after November 6, 1974. See 5 U.S.C. 8118.

Effective December 20, 2006, the FECA was amended by Title IX of the Postal Service Accountability and Enhancement Act to establish a three-day waiting period before COP may be granted to employees of the United States Postal Service.

3. COP Defined. COP is the continuance of the employee's regular pay for a period not to exceed 45 calendar days of disability. See 20 C.F.R. §10.200.

a. Disability. The employee is entitled to continued pay when he or she is totally disabled for work or partially disabled for work, including reassignment by personnel action to a lower grade or position with lower rate of pay.

b. Medical Care. The employee is entitled to continued pay when he or she loses time from work due to the need for medical examination and treatment for the work injury.

c. Lost Elements of Pay. If the effects of the injury require that an employee lose elements of pay (e.g., the assignment of a night shift worker to a day shift in order to perform prescribed light duty), COP should be granted for the lost elements of pay (e.g., the night differential).

d. Light Duty. Informal assignment of light or restricted duties, without a personnel action and without loss of pay, is not counted as continued pay under 5 U.S.C. 8118 and does not decrease the number of days available to the claimant. See 20 C.F.R. §10.217.

e. Relationship to Compensation. COP during the 45-day period is not considered compensation as defined by 5 U.S.C. 8101(12) and therefore is subject to income tax, retirement and other deductions. See 20 C.F.R. §10.200(a).

4. Employee Status. The policies and procedures for determining whether the injured or deceased individual was a civil employee of the United States within the meaning of 5 U.S.C. 8101(1) are found in FECA PM 2-0802. The eligibility of certain groups of these civil employees to receive COP is determined by statute and regulation.

a. Statutory Exclusions. Persons appointed to serve on the office staff of a former President are considered to be Federal employees, but they are specifically excluded from entitlement to COP. Persons listed in subsections "i" through "iv" of 5 U.S.C. 8101(1)(E) are expressly excluded from COP because they are not employees within the meaning of the FECA.

b. Separate Legislation. Persons whose entitlement to FECA benefits depends upon separate legislation are also excluded from COP. In many of these cases, entitlement to compensation begins from the date such persons are discharged from the programs in which they are enrolled, such as the Peace Corps, Job Corps, and Youth Conservation Corps. In other instances, the employment status and/or pay rate is too uncertain to make specific determinations (e.g., Work Study students, Civil Air Patrol Volunteers, and non-Federal law enforcement officers). See 20 C.F.R. §10.200(d).

c. Individuals Serving Without Pay or for Nominal Pay. Persons whose employment status for compensation purposes is determined under 5 U.S.C. 8101(1)(B) (e.g., consultants and volunteers) work without pay or for nominal pay, and they are generally not carried in a regular, continuing-pay status. While these individuals render personal service to the United States similar to civil officers and employees, they are not entitled to COP, per 20 C.F.R. §10.200(d).

d. Non-Citizens and Non-Residents. Persons who are not citizens or residents of the United States or Canada, and who are injured while working outside the continental United States or Canada, are covered under the provisions of 5 U.S.C. 8137 and are excluded from COP, per 20 C.F.R. §10.220(b).

Panamanian nationals employed by any agency of the U. S. government, including the Panama Canal Commission, before October 1, 1979 are entitled to COP. Those hired on or after that date, however, are not entitled to COP.

e. Jurors. Any person serving as a petit or grand juror subject to Chapter 121 of Title 28 is entitled to coverage under the FECA, whether or not he/she is also a Federal employee. In order to be entitled to COP, however, the juror must be a Federal employee, per 20 C.F.R. §10.200(d). If the juror is not a Federal employee, he/she is not entitled to COP.

f. Temporary Employees. Persons in this category are civil employees of the Federal government and are included under the provisions of 5 U.S.C. 8118. The fact that their employment would not have continued is not considered sufficient reason to exclude them from coverage, subject to the conditions noted in paragraph 10b below. Like any other employee, however, a temporary employee who first reports a traumatic injury after the employment is terminated is not entitled to COP, per 20 C.F.R. §10.220(d).

5. Employee Responsibilities. Per 20 C.F.R §10.205, to be eligible for COP, the injured employee must meet three requirements: 1) sustain a traumatic injury which is job-related and the cause of the disability and/or the cause of lost time due to the need for medical examination and treatment; 2) provide timely written notice of such injury on Form CA-1 or other OWCP-approved form; and 3) begin losing time from work due to the traumatic injury within 45 days of the injury. In addition to those three requirements, the employee must also present medical evidence in support of any claimed disability. The injured employee is also responsible for advising his or her physician of any available modified duties and for returning to duty upon release to any available work, whether regular or modified.

a. Traumatic Injury. A traumatic injury is defined as a condition of the body caused by a specific event or incident, or series of events or incidents, within a single workday or shift. Such condition must be caused by external force, including stress or strain, which is identifiable as to time and place of occurrence and member or function of the body affected. See 20 C.F.R. §10.5(ee). Such an injury is distinguishable from an occupational disease or illness in that the latter is a condition produced by the work environment over a period longer than a single work day or shift. See 20 C.F.R. §10.5(q).

b. Timely Notice of Injury. The injured employee, or someone acting on his or her behalf, must provide a written report on Form CA-1 (Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation) to the employing agency within 30 days of the injury. See 20 C.F.R. §10.210(a). Another OWCP-approved form, such as Form CA-2 (Notice of Occupational Disease and Claim for Compensation), CA-2a (Notice of Recurrence), or CA-7 (Claim for Compensation on Account of Traumatic Injury or Occupational Disease), which contains words of claim, can be used to satisfy timely filing requirements.

(1) The employee's submission of a sick leave slip or any form of leave request other than Form CA-1 or CA-2 to the employing agency may not be construed as an election of personal leave over COP for disability resulting from a traumatic injury.

(2) The Employees' Compensation Appeals Board (ECAB) held in the case of *William E. Ostertag*, 33 ECAB 1925 (1982), that 5 U.S.C. 8122(d)(3), which provides that failure to file claim in a timely fashion may be excused for exceptional circumstances, does not apply to claims for COP. See, P.L., Docket No. 11-493 (issued September 22, 2011) (ECAB stated: "Because the FECA makes no provision for an exception to the time limitation in section 8118(a), no exceptional or mitigating circumstance, including error by the employing establishment, can entitle a claimant to continuation of pay who has not filed a written claim within 30 days of the date of injury.")

c. The employee's first work stoppage must occur within 45 days of the date of injury in order for the employee to be entitled to continued pay. If the employee's work stoppage occurs more than 45 days after the injury, the employee may claim compensation for leave without pay or leave buy back on Form CA-7.

d. Medical Evidence. The employee must present the employing agency with medical evidence supporting disability resulting from the claimed traumatic injury within 10 calendar days after

filing a claim for COP. See 20 C.F.R. §10.210(b). The employing agency may continue the employee's pay absent such evidence if the nature and severity of the injury warrant the continuation. COP may be reinstated retroactively if payment was not initially authorized but supporting medical evidence is received later, as noted in 20 C.F.R. §10.222(a)(1).

e. Advising the Physician. Where the agency has advised the employee that a specific alternative position exists, the employee must furnish a description of the position to the physician and inquire whether and when he or she will be able to perform such duties. Likewise, where the agency has advised that it is willing to accommodate the employee's work limitations, the employee must so advise the attending physician and ask the physician to specify the limitations imposed by the injury. In both instances, the employee must provide the agency with a copy of the physician's response. See 20 C.F.R. §10.210(e).

f. Return to Duty. The injured employee must return to work upon notification by the attending physician that the employee is able to perform regular work or light duty, and the agency has advised that work within those restrictions is available. If the employee refuses to do so, the continued absence from work may result in an overpayment. COP may also be terminated if the employee refuses to respond to the agency's offer of work within five work days of receipt of the offer. The agency may make the offer to the employee over the telephone, but must confirm the offer in writing as soon as possible thereafter. The OWCP cannot evaluate the position to determine whether the position meets the claimant's physical restrictions until the position is offered in writing.

6. Employing Agency Responsibilities. When an employee has suffered an employment-related traumatic injury, the employing agency should take action with respect to the following:

a. Authorizing Medical Care. The agency should promptly authorize medical care on Form CA-16 (Authorization for Examination and/or Treatment) and give the form to the claimant (or to someone acting on his or her behalf) to present to initial medical providers. See 20 C.F.R. §10.211(a). If the supervisor is not certain that the injury occurred in the performance of duty, item 6B on Form CA-16 should be checked.

b. Providing Notice of Injury. The supervisor should furnish Form CA-1 to the employee, or to someone acting on his or her behalf, for completion of the employee's portion of the form. See 20 C.F.R. §10.211(a).

c. Right of Election. The agency will notify the employee of the right to elect COP or to use annual or sick leave or LWOP if the injury is disabling, and advise the employee that leave used counts against the 45-day COP period, per 20 C.F.R. §10.211(b).

d. Need for Medical Evidence. The agency will notify the employee of the need to submit medical evidence of a disabling traumatic injury within 10 calendar days of the date disability begins, or pay may be terminated. The agency should also supply the employee with a Form CA-17 (Duty Status Report) for completion by the physician providing medical care.

e. Controversion. The agency will inform the employee whether COP will be controverted and, if so, whether pay will be terminated, and the basis for such action. The reasons must conform to those indicated in paragraph 7 below. The agency will also explain the basis for controversion (if any) on Form CA-1 or by separate narrative report, per 20 C.F.R. §10.211(c). See paragraph 7 in this chapter for information pertaining to the controversion of COP.

f. Submission of Information. Form CA-1, fully completed by both the employee and employing agency, together with all other pertinent information and documents, must be submitted to the OWCP by the employing agency within 10 working days following the agency's receipt of the completed form from the employee. See 20 C.F.R. §10.211(d). In addition, the official superior shall submit any additional reports which the OWCP requires.

g. Return to Duty. The agency is responsible for advising the claimant of his or her obligation to return to work as soon as possible in accordance with the medical evidence.

h. Termination of COP. The agency will terminate COP when disability ends, the 45-day period expires, or the employee returns to work. See 20 C.F.R. §10.222. See paragraph 10 in this chapter for information pertaining to the termination of COP.

7. Controversion of COP. As stated in 20.C.F.R. §10.221, the employing agency may controvert a claim on the basis of the information submitted by the employee or secured on investigation. ("Controvert" means to dispute, challenge, or deny the validity of the claim.)

To controvert the claim, the agency must complete the indicated portion of Form CA-1 and submit detailed information in support of the controversion to the OWCP. Even though a claim is controverted, the employing agency must continue the employee's regular pay unless one of the conditions set forth below is met, in which case the employing agency shall not pay COP. In all other cases, the employing agency may controvert an employee's right to COP, but the employee's regular pay shall not be interrupted during the 45-day period unless the controversion is sustained by the OWCP and the employing agency is so notified.

a. As outlined in 20 C.F.R. §10.200(d) and based on the employee's status (see paragraph 4 in this chapter), COP is not payable in the following instances:

(1) The claimant's status as an employee is defined by 5 U.S.C. 8101(1)(B) or (E), which refers to persons serving without pay or nominal pay, and to persons appointed to the staff of a former President; or

(2) The employee is enrolled in the Civil Air Patrol, Peace Corps, Job Corps, Youth Conservation Corps, a Work Study Program, or a similar program.

b. As outlined in 20 C.F.R. §10.220, the employer can controvert COP in the following instances:

(1) The disability is a result of an occupational disease or illness, not the result of a traumatic injury.

(2) The employee is neither a citizen nor a resident of the United States or Canada (i.e., a foreign national employed outside the United States or Canada).

(3) The injury was not reported on a form approved by the OWCP within 30 days following the injury.

(4) The employee initially reported the injury after employment was terminated.

(5) The injury occurred off the employing agency's premises, and the employee was not engaged in official "off-premises" duties.

(6) The injury resulted from the employee's willful misconduct, the employee's intention to bring about the injury or death of himself or herself or of another person, or the employee's intoxication by alcohol or illegal drugs. See generally 5 U.S.C. 8102 (a) (1)-(3). Intoxication includes any controlled substance obtained or used without proper medical prescription.

(7) Work stoppage first occurred 45 days or more following the injury.

8. Counting COP Days. 20 C.F.R. §10.215 outlines how the OWCP computes the number of COP days that have been used.

a. The 45 days during which pay may be continued are counted as calendar days, not work days.

b. The period begins with the first day the claimant begins to lose time from work after the date of injury, provided that it begins within 45 days of the traumatic injury, unless the injury occurs before the beginning of the work day. The employing agency will keep the employee in a pay status or grant administrative leave for any fraction of a day or shift lost on the date of injury, with no charge to the 45-day period. If the injury occurs before the work shift begins, the date of injury may be charged as the first day of the 45-day period of COP.

c. If the employee stops work for a portion of a day or shift other than the date of injury, such day or shift will be counted as one full calendar day for purposes of counting the 45 days of COP.

(1) The employee is only entitled to COP for the hours lost due to the work injury (and not the entire day or shift) if work is available for the remaining partial shift.

(2) If the employing agency does not allow the employee to work a partial shift, the employee is entitled to COP for the entire shift.

d. Regular days off are included if COP has been used on the regular work days immediately preceding or following the regular day(s) off and medical evidence supports disability.

e. Leave used during a period when COP is otherwise payable is counted toward the 45-day COP maximum as if the employee had been in a COP status.

f. Delayed Disability. An injury which does not immediately disable the employee or require medical care may later cause disability and/or require medical treatment. Provided that the claimant reported the injury on a form approved by OWCP within 30 days following the injury, his or her entitlement to COP must begin within 45 days of the date of injury, whether its use results from disability due to the original injury or the need for medical care. However, where continuing days of COP bridge the 45th day, pay may be continued until entitlement is exhausted or the claimant returns to work.

In cases where the claimant is not immediately disabled, the employee should complete Form CA-1 in the same manner as if the injury were immediately disabling and indicate on the form that he or she is continuing to work. The supervisor should complete the employing agency's portion of Form CA-1, except items which concern work stoppage. If no medical expense has been incurred or is expected, the supervisor should place the CA-1 in the employee's personnel folder. If disability subsequently occurs or medical care becomes necessary, the supervisor will retrieve the Form CA-1 and complete items concerning work stoppage, noting on the form the date these items were completed to clarify the reason for the delay in submitting the form. The form should be transmitted to the OWCP in the usual manner, and pay should be continued as described above, as long as 45 days have not elapsed from the date of injury.

g. Recurrence of Disability. If an employee returns to work following a work stoppage without using all 45 days of COP and then suffers a recurrence of disability within 45 days of the first return to duty, he or she should submit a completed Form CA-2a and may elect to use the remaining days of COP. See 20 C.F.R. §10.207.

(1) Time lost on the day of injury that is charged to administrative leave is considered a work stoppage, whether the time is used to obtain medical treatment or for disability. If the time away from work is so minimal that no administrative leave is charged, such as a brief visit to the health unit, this is not considered a work stoppage for the purpose of counting time.

(2) If the 45-day entitlement has been exhausted, or the recurrence begins more than 45 days after the employee first returned to work, the employing agency may not pay COP. Rather, the employee should claim compensation for wage loss on Form CA-7.

(3) COP is paid for the entire period of any continuous disability which extends beyond the 45-day limit as long as the 45 days have not been used. Any valid period of entitlement to COP for the injury must begin, however, within 45 days of the injury or of the first return to work after the injury.

For example, an employee is injured on January 1. The employing agency provides several hours of administrative leave, enabling the employee to obtain medical attention. On January 2, the employee works a full day. The employee is not disabled due to the injury until February 10, but is disabled and off work February 10, 11, and 12 and receives COP for those three days. The employee returns to work on February 13 and does not lose any further time from work due to the injury until March 17. On March 17, 18 and 19, he again loses time from work due to the disability. The 45-day period begins to run when the employee returned to work on January 2, because work stoppage occurred at the time of injury, even though it was covered by

administrative leave. The employee is entitled to COP for the time lost in February, but is not entitled to COP for time lost in March, as it is more than 45 days since the first return to work.

9. Interruption and Suspension of COP. Once COP is initiated, certain criteria must be met before COP may be interrupted or suspended.

a. Interruption of COP. The employing agency may interrupt COP, or refuse to retroactively convert previously-used leave to COP, if the claimant fails to submit medical evidence supporting disability within 10 calendar days after the claim is submitted (unless the employer's own investigation shows disability to exist).

(1) If COP is discontinued on the basis that insufficient medical evidence is received within 10 calendar days to support disability, and such evidence is later provided for the period in question, the CE should send a copy of the evidence to the agency with instructions to reinstate COP retroactive to the date of cessation, or to convert and restore previously used leave. See 20 C.F.R. §10.222(a)(1).

(2) A supervisor may have particular knowledge of the circumstances of the injury and choose not to terminate COP even if medical evidence has not been submitted. Therefore, the CE should not direct the agency to terminate COP 10 calendar days after the employee claimed COP. However, the CE is still responsible for advising the employee to submit supporting medical evidence and for denying the claim if the evidence is not submitted in a timely manner.

b. Suspension of COP. COP may be suspended based on refusal or obstruction of an OWCP-directed scheduled medical examination. If an employee refuses to submit to or obstructs an examination required by the Office under the provisions of 5 U.S.C. 8123(a), COP paid or payable during the period of the refusal is forfeited and is subject to recovery by the employing agency. Action to deny payment of COP (and any subsequent compensation) may be taken only if the claimant was advised of the provisions of 20 CFR §10.323 and 5 U.S.C. 8123(d) when the appointment was arranged. If a suspension occurs during the COP period, the CE must notify the agency immediately of the suspension and its effective date, per 20 C.F.R. §10.223.

10. Termination of COP. COP should not be terminated until one of the following circumstances occurs:

a. Permanent Workers. Permanent workers are entitled to 45 calendar days of COP unless the employee is scheduled to be separated and suffers a traumatic injury on or before the date of separation. In this event, the employee will be separated regardless of the injury, and the employee is not entitled to COP after the date of separation, provided the date of termination is in writing prior to the date of injury.

b. Temporary Workers. Temporary workers are often provided with a notice of appointment which indicates the date on which the appointment is scheduled to expire. The employee is not entitled to COP after the date of expiration. If a temporary worker's term of employment is changed, written notice of the change is necessary to support termination of COP at an earlier date than the original expiration of appointment date.

c. Specific Occupations. Where termination of COP in a specific case depends upon the termination date of temporary or seasonal employment, the CE should determine the ending date of employment in accordance with the following:

(1) Seasonal Firefighters. The end date of employment corresponds with the end of the fire season in the geographical area as determined by the U.S. Forest Service.

(2) Emergency Firefighters. The end date of employment occurs the date on which other emergency firefighters in the employee's work group would be terminated due to cessation of activities.

(3) Census Enumerators. The end date of employment occurs on the date on which the employee's assignment was completed. This is usually the date of completion of the short-term enumerating project or survey for which the employee was hired.

(4) Temporary Postal Workers. Temporary postal workers are usually hired for a specific appointment. The end date of employment corresponds with the date the assignment would have ended were it not for the injury.

(5) Other seasonal or temporary workers. The end date of employment corresponds with the date the assignment would have ended were it not for the injury.

d. Claimant can return to Date of Injury job without restrictions based on medical evidence. COP is discontinued when the claimant returns to regular duty. COP is also terminated when the medical evidence supports the claimant is medically capable of returning to the date of injury job without restrictions based on the work-related medical condition.

e. Claimant can return to modified duty, and a modified duty assignment is provided to the claimant within the established work restrictions. COP should be terminated when a partially disabled employee returns to a full-time time modified position without official reassignment and without pay loss. The employee is also expected to accept any reasonable modified assignment which accommodates the established work restrictions as defined by his or her treating physician. Failure to accept the work offered will result in termination of COP. See paragraph 11 in this chapter.

f. Proximate Cause of Injury is Due to Intoxication. In order to uphold the termination of COP on the basis of intoxication by alcohol or illegal drugs, it must be established that the use of the substance was the proximate cause of the injury. Where use of an illegal drug is alleged, it must be shown that the substance was controlled and that it was obtained or used illegally. If these conditions are not met, the CE should advise the agency to pay COP on a retroactive basis.

g. Disciplinary Action. COP may be terminated when a preliminary notice of disciplinary action is issued before the injury and becomes final during the COP period. See 20 C.F.R. §10.222(b). The CE must ensure that the case record contains documentation that the preliminary notice of termination was in fact issued prior to the date of injury. Where these conditions are not met, the CE must advise the agency to continue pay.

11. COP and Modified-Duty Assignments. Employing agencies are expected to provide their injured employees with modified alternative-duty assignments during COP whenever possible, and claimants are expected to accept such offers of work.

a. Acceptance of Modified Duty. If a modified duty assignment is accepted, the following considerations apply:

(1) COP is chargeable only when the claimant has been formally assigned to an established job which is normally paid at a lower salary and would otherwise result in loss of income to the employee. COP must be charged against the employee's 45-day entitlement if personnel action has been taken to:

(a) Assign or detail the employee to an identified position which is classified at a lower salary level than that earned by the employee when injured; or

(b) Change the employee to a lower grade, or to a lower rate of basic pay. See paragraph 12 below.

(2) The employing agency should promptly report an employee's return to modified duty. If the employee worked at a lower paying job but received the full pay of his or her normal job, the difference between the employee's regular pay and the pay for the light duty job represents COP paid.

b. Refusal of a Modified-Duty Assignment. Where the claimant refuses or fails to respond to an offer of work, the CE must determine whether the modified duty assignment is within the claimant's established work restrictions and provide the employee an opportunity to submit his or her reasons for the refusal. When the employing agency's modified-duty offer (including the description and physical requirements of the job) is received prior to or with the form CA-7, the CE must take the following actions:

(1) If the duties and physical restrictions of the modified assignment are found not to be within the claimant's medical restrictions as established by the employee's attending physician, the employing agency should be advised and instructed to reinstate COP retroactive to the date of termination. Compensation should be initiated, if appropriate, at the expiration of the COP period. If the work restrictions established by the attending physician are not on file, the employing agency should be asked to submit the medical documentation as soon as possible.

(2) If the duties and physical restrictions of the modified assignment are found to be compatible with the claimant's medical restrictions as established by the employee's attending physician, the employee must be provided with the opportunity to submit his or her reasons for the refusal within 30 days. Payment of compensation at the end of the COP period should be deferred pending the resolution of the issue, even if the claimant's response indicates the need for further development by the CE.

- (a) If the claimant responds and the refusal is found to be justified, the agency should be instructed to reinstate COP retroactive to the date of termination, and compensation should be paid for any period of disability after COP ended.
- (b) If the refusal is not found to be reasonable or justified (or the claimant does not respond within the 30-day period), a formal decision terminating entitlement to both COP and compensation is to be issued. Termination of entitlement is effective the date the agency terminated COP, rather than the date of the formal decision. The date of the agency's termination of COP should be the date the job was available to the employee.
- (3) If the employing agency has terminated COP based on the employee's refusal of a modified-duty assignment, but the written offer (including the description and physical requirements of the job) is not received prior to or with Form CA-7, compensation should be initiated as claimed. Once initiated, compensation should continue, as appropriate, until a final determination is made concerning the refusal of the offered work.
- (4) If it is subsequently determined that the refusal was not reasonable, a formal decision should be issued which denies COP as of the date the agency terminated pay (since the agency's action was proper) and terminates compensation as of the date of the final decision.

If payment was made on the supplemental roll, the date of termination should be the date of the employee's refusal (or, if the employee did not respond, the end of the 30-day period allowed for response), provided compensation has not been paid beyond that date. If compensation has been paid beyond that date, it should be terminated as of the end of the last period for which payment was made.

12. Payment of COP. An employee is entitled to payment of COP at his or her regular pay rate, which is the average weekly earnings, including premium, night or shift differential, holiday pay, Sunday premium pay except to the extent prohibited by law, or other extra pay, including FLSA pay for firefighters, emergency medical technicians, and others who earn and use leave on the basis of their entire tour of duty. See 20.C.F.R. §10.216(a).

a. Overtime Pay. Overtime pay may not be included in computing the pay rate for COP purposes. See 20 C.F.R. §10.216(a)(1).

b. Within-Grade Increases and Promotions. Since COP is payment of salary and not compensation, additional money which the employee would have received but for the injury is included. 20 C.F.R. §10.216(a)(2).

c. Regular Work Schedules. For an employee in the regular work force who works the same number of hours per week, the weekly pay rate equals the number of hours regularly worked each week times the hourly pay rate on the date of injury, in accordance with the following formula: Weekly Hours x Hourly Rate = Employee's average weekly earnings. This applies to both full-time and part-time employees working on either a permanent or temporary basis, per 20 C.F.R. §10.216(b)(1).

d. Irregular Work Schedules. For a part-time employee, whether permanent or temporary, who does not work the same number of hours per week, the weekly pay rate is the average of the weekly earnings for the year prior to the date of injury, in accordance with the following formula: Total pay earned during one-year period prior to injury (excluding overtime), divided by 52 weeks for the year prior to the injury (or prorated if employee worked less than a year). For purposes of this computation, a partial-work week is counted as an entire week. See 20 C.F.R. §10.216(b)(2).

e. Intermittent and Seasonal Workers. For intermittent and seasonal workers, whether permanent or temporary, who do not work either the same number of hours or every week of the year, the weekly pay rate is the average of the employee's earnings in Federal employment, excluding overtime, during the year prior to the injury. The average annual earnings, however, must not be less than 150 times the average daily wage earned within one year prior to the date of injury. The pay rate should be computed using both the year prior and average weekly earnings formulas. The higher result should be accepted as the pay rate for COP. See 20 C.F.R. §10.216(b)(3).

(1) Year Prior Calculation: The employee's weekly earnings during the year prior to the injury is calculated by dividing total pay in Federal employment (excluding overtime) by total number of weeks worked.

(2) Average Weekly Earnings Calculation: To determine the average weekly earnings, multiply 150 times the average daily wage earned during the year prior to the injury, divided by 52 weeks.

f. National Guard and Military Reserve Members. Where membership in the National Guard or the military reserve is a condition of employment, COP includes military drill and field training pay only in the limited circumstances where there is an actual loss of military pay. For example, an individual who at the end of the year has not completed the physical training requirements sustains an injury and loses military pay, such loss of military pay must be included in the pay rate for COP purposes. On the other hand, if the agency is able to provide alternative military training activities to injured Federal employees such that no loss of military pay occurs during the 45-day COP period, the military pay component is not included in the COP pay rate.

g. Postal Service. Postal Service employees have a three-day waiting period before COP will be granted. They may use annual leave, sick leave, or leave without pay during that period, except that if the disability exceeds 14 days or is followed by permanent disability, the Postal Service employee may have that leave restored. See 20. C.F.R. §10.200(c). The three waiting days count toward the 45 calendar-day COP entitlement period. Time lost for medical treatment only does not count as work disability and does not count as a waiting period day, and the employee must elect COP on the front of Form CA-1 to request that any previously-used leave be changed to COP.

13. COP and Leave Election. An employee may use annual or sick leave to cover all or part of an absence due to a work injury, but the employee's compensation for disability does not begin, and the waiting period specified by 5 U.S.C. 8117(1) does not begin, until COP terminates and any use of leave ends.

a. An employee may elect COP by checking the appropriate box on the front of the CA-1 form. A CA-1 without an election between COP and leave should be construed as an election for COP.

b. Entitlement to COP may not be delayed or extended beyond the 45-day period by the use of sick or annual leave. Any leave used during the period of eligibility counts towards the 45-day maximum entitlement to COP.

c. If OWCP denies a claim for COP (or denies the claim in its entirety), the amount paid will be charged to sick or annual leave at the option of the employee, or shall be deemed an overpayment within the meaning of 5 U.S.C. 5584. See 20 C.F.R. §10.224.

d. If a third-party credit has been established, the OWCP should be contacted before paying COP.

e. Leave Restoration. A sick or annual leave election during the 45-day COP period is not considered irrevocable. A leave request slip is not considered a selection of leave when determining COP eligibility. If an employee has elected sick or annual leave for the period and then wishes to elect COP, the agency is required to make such a change on a prospective basis (from the date of the employee's request). If the employee makes a request to change sick or annual leave to COP, the request must be made no later than one year from the date the leave was used or the date the claim was approved, whichever is later. The claimant must provide medical evidence of disability due to the injury. Upon receipt of a timely request, the employing agency is to convert the sick or annual leave to COP and restore the leave to the employee.

If the leave balance of an employee who elects leave is not sufficient to cover all disability during the 45-day COP period, COP may be elected retroactive to the leave exhaustion date and continued wage loss began. When leave is exhausted, the agency is required to convert the employee to COP status immediately without the employee's written election.

14. Formal Adjudication of COP. The CE should give priority to cases in which COP has been terminated to determine whether the employing agency's action is correct, taking the following steps:

a. COP Entitlement Development. If the employing agency improperly controverted COP, with or without stopping the employee's pay, the CE will send Form Letter CA-1038 (or equivalent) to the agency, or include an explanation in the development letter, indicating that the agency should continue payment of the COP pending formal adjudication of the claim.

If additional information is needed prior to adjudicating the claim for COP, the CE shall release an appropriate letter requesting additional information.

b. COP Approval. If the claimant meets the requirements for COP, and if the employing agency did not controvert the claim, a formal approval of COP is not needed, as the claimant is already receiving COP.

If COP was controverted by the employing agency but COP is in fact payable, the CE should release an acceptance letter which specifically includes a provision for approval of COP, indicating the accepted condition(s) and notifying the claimant of the procedures to follow for claiming compensation following the period of COP. The CE must notify the employing agency when a controverted claim is accepted and COP is approved and must provide a sufficient explanation as to why the employing agency's controversion of the claim was not upheld. This requirement applies both to controversions erroneously based on one of the nine regulatory exclusions and to those founded on other objections. This also applies to situations where the agency fails to provide a specific reason or argument for the controversion.

c. COP Denial. If COP is denied, the CE will release a formal decision denying COP with appeal rights.

(1) If the entire case is denied, a formal Notice of Decision is issued to the claimant, with a copy to the employing agency. COP paid may then be charged, at the employee's option, to sick or annual leave, or be deemed an overpayment subject to collection by the agency. This matter will be resolved by the employing agency without further input from the OWCP.

(2) If the case is accepted but COP must be denied, a formal denial of COP that includes appeal rights, Form Letter CA-1050 (or equivalent), should be sent to the claimant and employing agency.

If only a portion of the period of COP can be approved because the employee did not meet his or her responsibilities for eligibility, this decision may be used to deny the remaining portion. The formal decision should state the dates for which COP is approved, and explain why the other dates claimed are denied.

d. COP Approval for Jurors. In a case where a juror who is also a Federal employee is eligible for COP, the CE should forward a copy of Form CA-1 to the employing agency, advising it to continue the employee's pay beginning the day after the date of the employee's termination of service as a juror.

15. Initial Claims for Compensation Following COP. If medical evidence demonstrates that disability is expected to continue beyond 45 days, the employer should give Form CA-7 to the employee by the 30th day of the COP period and submit the completed form to the OWCP by the 40th day of the COP period (if a completed form is returned by the employee). See 20 C.F.R. §10.111(b).

In order to ensure that claimants are not without income during the period immediately following payment of COP, the CE must advise the claimant and employing agency promptly of any necessary information needed in order to pay the claim. Note though that the claimant is primarily responsible for submitting CA-7 forms to the employing agency and furnishing medical evidence that substantiates disability for the period claimed. See 20 C.F.R. §10.102.

a. If an initial CA-7 is received immediately following the COP period, the CE may use the authority provided by the FECA to approve a payment for a period not to exceed 15 days into the

future (15 days post termination of COP), if disability for the period is medically supported and the employing agency verifies that the claimant has not returned to work at the time the payment is processed.

This authority does not extend to occupational disease claims and applies only to the initial 15-day period following COP in cases of traumatic injury.

(1) The CE should call the employing agency to obtain or verify the information needed to approve payment, and should request written confirmation of the information provided verbally. The employee and the agency should be advised that further payment requires a formal claim and appropriate supporting evidence, as the Office is not obligated to continue paying compensation without such submission.

(2) Payment may be approved even if the Form CA-7 received was signed prior to the period claimed. If the claim was submitted in advance, however, the CE should verify by telephone that the employee has not returned to work at the time of processing the payment.

(3) If a payment is processed with future dates, the CE should advise the claimant in writing of his/her obligation to advise the OWCP immediately if he/she returns to work, since an overpayment could be created.

(4) The three-day waiting period stipulated by 5 U.S.C. 8117(1) must be considered when payments are approved. When the period ends on the date the CE is setting up payment, and medical evidence clearly establishes that disability will extend 15 days or more after the beginning of wage loss, the CE may extend the period approved for payment through the 15th day if such an extension will eliminate the need to withhold waiting days.

(5) Payment should not be authorized if the attending physician states that the employee can return to duty, but the employee does not return, makes an unauthorized change in physicians, and subsequently submits medical evidence of disability from the second physician.

b. Subsequent Claims for Compensation. The discretion to process a payment for dates into the future applies only to initial claims for compensation following COP in traumatic injury cases, as outlined above.

Consistent with the FECA regulations at 20 CFR §10.102(b), Form CA-7 should be used to claim compensation for any additional periods of disability. If disability continues, the claimant should submit a Form CA-7 each two weeks until otherwise instructed by the OWCP. The employing agency must verify work/leave status when submitting these forms, and this can only be done once the period has passed.

See FECA PM 2-901 for more detailed information on processing compensation payments.

Chapter 2-0808, Schedule Awards and Permanent Disability Claims

1. Purpose and Scope. This chapter outlines the difference between impairment and disability, and focuses primarily on the procedures for the development, adjudication and payment of schedule award claims.

PM 3-0700 should also be consulted for further information on schedule awards.

2. Impairment and Disability. Impairment is a medical concept, and any evaluation of impairment must rest upon medical evidence. Disability, on the other hand, is an economic concept which reflects a claimant's inability to earn wages comparable to those received before the injury. The degree of impairment is a major factor in evaluating disability, but it is not the only one; others include age, education, and work history. The kinds of permanent disability and impairment are as follows:

a. Permanent Total Disability (PTD). Claimants are rarely considered to have disability which is permanent and total in nature. Only in catastrophic injuries or long-standing chronic conditions should this course be considered, and then only after all attempts to reemploy and/or rehabilitate the claimant have been exhausted. See 5 U.S.C. 8105.

b. Permanent Partial Disability (PPD). In disability which is permanent in nature but only partial, compensation is based on the difference between the wages earned at the time of injury, disability, or recurrence, and the wages the claimant is capable of earning after the injury. This difference is called loss of wage-earning capacity (LWEC). See 5 U.S.C. 8106.

c. Permanent Impairment. This term is defined as the loss or loss of use of a part of the body, whether total or partial. See 5 U.S.C. 8107 and 20 C.F.R. §10.404.

The degree of impairment is established by medical evidence and expressed as a percentage of loss of the member involved. Permanent impairment may originate either within the affected member or in another part of the body. For instance, a back injury may result in impairment to a leg, for which a schedule award would be payable. See, Veronica Williams, 56 ECAB 367 (2005) (ECAB noted that the members and functions listed in the schedule award provision and the regulation do not include impairments of the back or the body as a whole. A claimant, though, may be entitled to a schedule award for a permanent impairment to the leg if the cause of the impairment originated in the spine citing: John Litwinka, 41 ECAB 956 (1990), which noted that Section 8107(a)(1) of the FECA states a schedule award is "payable regardless of whether the cause of the disability originates in a part of the body other than that member."). A claimant may also receive an award for more than one part of the body in connection with a single injury.

3. Permanent Total Disability. The FECA provides that loss of both hands, arms, feet, or legs, or the loss of sight of both eyes is prima facie evidence of permanent total disability. See 5 U.S.C. 8105(b). It does not mean, however, that a claimant in this medical condition should be automatically declared permanently and totally disabled. Some individuals may be able to work

despite such severe medical conditions, and the possibility of rehabilitation and/or reemployment should be explored before any declaration is made.

In very few other cases is it necessary or desirable to make a determination of permanent and total disability. Such a determination confers no additional benefit on the claimant, and it could result in forfeiture of other rights that a claimant may possess under other Federal laws. Therefore, it is usually sufficient to continue payments for temporary total disability (TTD), even where efforts to reemploy and/or rehabilitate the claimant have failed.

In the rare instance where such a determination is appropriate, it should be based on the evaluations of the attending physician or other physicians who have examined the claimant. Such a determination does not supersede any award which may be payable for a schedule impairment. Whenever a case involves both permanent total disability and schedule impairment, the CE should pay the schedule award and then continue compensation for permanent and total disability at the expiration of the schedule award. It may be necessary to first obtain an election if the claimant is also receiving an annuity from the Office of Personnel Management (OPM).

Note - There is no specific case status to differentiate or classify a claimant as permanently, totally disabled as defined by 5 U.S.C. 8105(b).

4. Entitlement to Schedule Awards. Permanent impairment to certain parts of the body will entitle the claimant to an award of compensation payable for a set number of weeks. The Claims Examiner (CE) should monitor medical reports for the possibility of eventual impairment to a schedule member and the date by which maximum medical improvement (MMI) is expected. If it appears that a schedule award may be payable, the CE should advise the claimant via Form CA-1053, or the equivalent, of his or her possible entitlement to such an award.

a. General Considerations.

(1) The length of the award is determined by the provisions of 5 U.S.C. 8107, which also lists the parts of the body which may be considered for such an award. Additional parts of the body which may be considered are listed in 20 CFR §10.404.

(2) In some instances a schedule award may be payable even if the claimant had a pre-existing loss or loss of use of 100 percent of a member or function of the body. Cases of this type should be developed to determine the prior usefulness of the member or function and whether the injury in Federal employment has diminished any such usefulness, in whole or in part.

(3) A schedule award is payable consecutively but not concurrently with an award for wage loss for disability for the same injury. See, e.g., S.W., Docket No. 10-2071 (issued July 11, 2011). However, a schedule award may be paid concurrently with salary reimbursement under the Assisted Reemployment Program. If the injury occurred on or after September 13, 1957, the schedule award may be paid concurrently with benefits under the U. S. Civil Service Retirement Act.

(4) If a claimant loses wages to obtain medical treatment during the period of a schedule award (e.g. claims hours due to a medical appointment with the treating physician), compensation for the hours lost may be paid concurrently with a schedule award, as time lost for medical appointments is not considered disability. As noted above, however, time lost for disability surrounding the appointment (if any) cannot be paid concurrently with a schedule award.

(5) A schedule award for one injury may be paid concurrently with compensation for wage loss paid for another injury, as long as the two injuries do not involve the same part of the body and/or extremity. For example, a claimant is currently receiving a schedule award for 10% permanent partial impairment of the right arm due to a work-related right rotator cuff tear. The claimant files for total disability under another claim for the same period due to undergoing right carpal tunnel surgery. Compensation claimed for total disability cannot be paid since compensation involves the same extremity, the right arm. See J.B., Docket No. 08-1178 issued December 22, 2008; and V.P., Docket No. 07-1158 issued December 17, 2007.

(6) Lump sum schedule awards. In certain situations, a claimant may be entitled to receive a lump sum payment of his or her schedule award. Lump sum schedule awards are discussed in FECA PM 2-1300.

(7) Schedule awards unpaid at death. Under 5 U.S.C. 8109, if an individual has sustained impairment compensable under section 8107(a) of this title; has filed a valid claim in his lifetime; and dies from a cause other than the injury before the end of the period specified by the schedule, the compensation specified by the schedule that is unpaid at his death, whether or not accrued or due at his death, shall be paid in accordance with the order of precedence specified by the statute. See Sandra Henley, Docket No. 00-1619 issued April 4, 2002. (The ECAB affirmed the denial of a schedule award benefit to a widow where her husband who was injured in a terrorist bombing had not filed a claim for a schedule award during his lifetime. The ECAB found a valid claim, in writing and with words of claim, filed by the employee or someone on his behalf must be made during the employee's lifetime.)

b. History of Entitlement. Entitlement to schedule awards has been affected by various legislative changes over the years. Following is a description of coverage afforded by the FECA during various periods according to date of injury:

(1) Prior to December 7, 1940. No provision for schedule award.

(2) December 7, 1940 to September 12, 1957. Schedule award for 100 percent loss or loss of use of major members only; injury must be to schedule member itself. No entitlement to compensation for loss of wage-earning capacity (LWEC) after expiration of the award. (On October 14, 1949, the law was amended such that schedule awards were payable retroactively to October 14, 1948 for "minor" impairments, such as simple fractures, and retroactive to January 1, 1940 for "major" impairments, such as amputations of hands or feet or loss of vision.)

(3) September 13, 1957 to July 3, 1966. Broadened coverage such that schedule impairment did not have to be the only residual of the injury. Permanent impairment had to be confined to the schedule member, however, so that if any other "significant disability" existed (i.e., any which

would require treatment or cause loss of wage-earning capacity), no schedule award was payable. However, an employee who had a significant permanent impairment of a portion of the body not covered by the schedule provisions (i.e. back) in addition to the loss or loss of use of a schedule member (i.e. arm) could not receive both a schedule award for the schedule member in addition to compensation for the LWEC of the non-schedule member. In such a case, compensation could only be paid on the basis of LWEC.

(4) July 4, 1966 to September 6, 1974. Increased coverage to compensate for LWEC after schedule award ended; schedule was payable regardless of location of other "significant disability." Schedule award available regardless of whether the injury resulted in impairment to a non-scheduled member (i.e. back) in addition to the loss or loss of use of a schedule member (i.e. arm). Provision explicitly permitted payment of both schedule award and disability compensation in such circumstances. (Provision was not made retroactive to any injuries sustained prior to July 4, 1966.)

(5) September 7, 1974 to present. The FECA amended to provide for schedule awards payable for internal organs specified by the Secretary, in addition to those indicated in the FECA. See 5 U.S.C. 8107(22). The Secretary has added by regulation the following organs: the breast, kidney, larynx, lung, penis, testicle, tongue, ovary, uterus/cervix and vulva/vagina. 20 C.F.R. §10.404.

(6) Effective August 29, 2011, the Secretary added by regulation the skin as a new schedule member, for up to 205 weeks of compensation, for injuries sustained on or after September 11, 2001. 20 C.F.R. §10.404(b).

5. Evaluation of Schedule Awards.

a. Method of Evaluation. For impairment ratings calculated on and after May 1, 2009, the American Medical Association's (AMA) Guides to the Evaluation of Permanent Impairment, Sixth Edition, should be used to report findings except as noted below. (Also, see FECA PM 3-0700.)

b. Evidence Required. To support a schedule award, the file must contain competent medical evidence which:

(1) Shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred ("date of maximum medical improvement" or MMI);

(2) Describes the impairment in sufficient detail for the CE to visualize the character and degree of disability; and

(3) Gives a percentage of impairment based on a specific diagnosis, not the body as a whole (except for impairment to the lungs). In members with dual functions, the physician should address both functions according to the AMA Guides.

c. Special Considerations.

(1) Impairment to the lungs should be evaluated in accordance with the Guides insofar as possible. The percentage of "whole man" impairment will be multiplied by 312 weeks (twice the award for loss of function of one lung) to obtain the number of weeks payable; all such awards will be based on the loss of use of both lungs.

In cases involving anatomical loss by traumatic injury or surgery, the evaluation will also be based on loss of lung tissue by weight or volume, and the award will be based on these factors if it results in a greater percentage of loss than one based on loss of respiratory function. Anatomical loss awards will be made for one or both lungs as appropriate.

(2) Impairment due to pain. Impairment applicable to pain is inclusive as a component of the medical condition (diagnosis) and not measured separately unless the pain does not correlate with objective findings or body part dysfunction. Chapter 3 of the Guides discusses evaluation of pain if it is not classifiable in the diagnosis based impairment. An example would be fibromyalgia, or pain due to a sprain where no objective findings or identifiable abnormalities are noted. In no circumstances, though, should the pain-related impairment developed under Chapter 3 be considered as an add-on to impairment determinations based on the criteria listed in Chapters 4 – 17. When pain is the sole impairment, the physician should have the claimant complete Appendix 3-1 of the AMA Guidelines, Sixth Edition - Pain Disability Questionnaire (PDQ), or obtain the necessary information in some other format.

(3) Impairment resulting from an injury to the spine. While the FECA does not allow payment for impairment to the spine, a schedule award can be paid for the extremities if a spinal injury leads to impairment of the arms or legs. Impairment to the upper or lower extremities that is caused by a spinal injury should be rated consistent with the article "Rating Spinal Nerve Extremity Impairment Using the Sixth Edition" in the July/August 2009 edition of the The Guides Newsletter published by the AMA. This newsletter, which has been reproduced with the permission of the AMA, is Exhibit 4 in PM 3-0700.

(4) Impairment of the skin. With the most recent regulatory update at 20 C.F.R. §10.404, effective August 29, 2011, a schedule award can be paid for impairment to the skin, for up to 205 weeks of compensation, for injuries sustained on or after September 11, 2001. According to the AMA 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.

Chapter 8 in the AMA Guides outlines specific criteria to be considered when calculating permanent impairment of the skin. 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. 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; and attending phototherapy sessions on a routine basis.

A schedule award for the skin can be paid in addition to any disfigurement award.

d. Rated impairment should reflect the total loss as evaluated for the scheduled member (i.e. arm, leg, etc.) at the time of the rating examination. See Raymond E. Gwynn, 35 ECAB 247, 253 (1983). There are no provisions for apportionment under the FECA. As such, schedule awards include permanent impairment resulting from conditions accepted by the OWCP as job-related as well as and any non-industrial permanent impairment present in the same scheduled member at the time of the rating examination.

As long as the work-related injury has affected any residual usefulness, in whole or in part, of a scheduled member, a schedule award may be appropriate. Similarly, an increase in schedule award may be appropriate as long as a material change in the work-related injury is at least in part contributory to an increase in impairment of the scheduled member.

For example, if an aggravation of left hip osteoarthritis is accepted as work-related but the claimant also suffers from non-industrial left knee osteoarthritis, both of which have resulted in permanent impairment, an assessment of impairment should reflect the total loss of the left leg, to include both the industrial and non-industrial injuries.

e. Adjoining Members. In general, loss of less than one digit should be computed in terms of impairment to the digit itself (thumb, finger, etc.), and loss of two or more digits should be computed in terms of impairment to the whole hand or foot. Where the residuals of an injury to a member of the body specified in the schedule extend into an adjoining area of a member also enumerated in the schedule, such as an injury of a finger into the hand, of a hand into the arm or of a foot into the leg, the schedule award should be made on the basis of the percentage loss of use of the larger member. See Charles B. Carey, 49 ECAB 528 (1998) (ECAB remanded the case, so that the OWCP could consider the physician's report and disability rating sheet to determine whether the impairment in appellant's right finger resulting from his accepted employment injury extended into his right hand, resulting in an impairment of the right hand).

6. Obtaining Medical Evidence. The CE should review the case file to determine if medical evidence meeting the criteria in paragraph 5(b) above has been submitted. The attending physician should perform the evaluation whenever possible; however, the claimant may submit an examination from another physician if the regular attending physician does not wish to or cannot provide an impairment rating.

a. If the claimant requests a schedule award but has not submitted such evidence, the claimant should be requested to submit it. The report of the impairment evaluation should provide the evidence cited in paragraph 5(b) above and include the following:

(1) A detailed report that includes history of clinical presentation, physical findings, functional history, clinical studies or objective tests, analysis of findings, and the appropriate impairment based on the most significant diagnosis, as well as a discussion of how the impairment rating was calculated.

(2) Impairment due to amputation is based on the level of the amputation. The physician's report must include functional history, physical examination and clinical studies. Impairment based on proximal diagnosis or range of motion may be combined with the amputation impairment. However, the physician must explain the reasoning for combining the additional impairment.

b. If the claimant has not reached MMI, but evidence establishes that there may be impairment, the CE should advise the claimant in writing that once MMI is established he/she should submit the medical evidence establishing MMI and request that the claim for the schedule award be re-reviewed.

c. If the claimant does not provide an impairment evaluation from his/her physician when requested, and there is no indication of permanent impairment in the medical evidence of file, the CE may proceed with a formal denial of the award. If in doubt, the CE should obtain an opinion from the DMA prior to such a denial.

d. If the claimant does not provide an impairment evaluation from his/her physician when requested, and there is an indication of permanent impairment in the medical evidence of file, the CE should refer the claimant for a second opinion evaluation. The CE may also refer the case to the DMA prior to scheduling a second opinion examination to determine if the evidence in the file is sufficient for the DMA to provide an impairment rating.

If the case is referred for a second opinion, the report should contain the information described in 6a above. If it does not contain this information, clarification with the second opinion should be sought.

e. If the claimant's physician provides an impairment report, or after the second opinion is received, the case should be referred to the DMA for review.

f. District Medical Advisor (DMA) Review. After obtaining all necessary medical evidence, the file should be routed to the DMA for opinion concerning the nature and percentage of impairment.

(1) When referring the case to the DMA, the CE should ask the DMA to verify the calculations of the attending physician or second opinion examiner and determine the percentage of permanent impairment based on the standards outlined in the AMA Guides, Sixth Edition. The DMA should also be asked to provide the date MMI was reached. The DMA should provide rationale for the percentage of impairment specified. When more than one evaluation of the impairment is present, it is especially important for the DMA to provide such medical reasoning.

(2) The CE should review the DMA's findings and take follow-up action.

(a) If the DMA neglects to provide rationale for the percentage of impairment specified, the CE should request a clarification or a supplemental report from the DMA.

(b) If the DMA selects a retroactive MMI date (i.e. one preceding the date of the impairment evaluation), medical rationale should be provided. Usually MMI dates selected based solely on

criteria such as "one year post surgery or return to full duty status" should not be considered sufficiently rationalized unless the DMA uses the findings of examination from such a date to calculate the impairment. If sufficient rationale is not present, the CE should request a supplemental report from the DMA.

(c) If the DMA believes that the impairment has not been correctly described by the claimant's physician or the second opinion examiner, the DMA should specify the missing information so that it can be requested. The response should then be routed back to the DMA for further opinion concerning impairment. If the missing information cannot be secured, a new or supplemental evaluation should be obtained.

(d) If the DMA and examining physician are in agreement as to the work-related permanent impairment, the schedule award should be processed.

(e) If the DMA provides a detailed and rationalized opinion in accordance with the AMA Guides but does not concur with the claimant's physician's impairment rating, and the claimant has been provided an opportunity to submit the necessary evidence, the CE should weigh the medical opinions to determine if a conflict exists or whether the award can be paid based on the weight of medical evidence. See FECA PM 2-810 for a complete discussion on weighing medical evidence.

If there was a second opinion examination, and the DMA provides a detailed and rationalized opinion in accordance with the AMA Guides but does not concur with the second opinion doctor's impairment rating, the CE should seek clarification or a supplemental report from the second opinion examiner. After receiving clarification, the CE should refer the case back to the DMA for review.

(f) The CE should not attempt to assign a different percentage of impairment than assigned by the DMA without the benefit of further medical clarification.

(g) If after reviewing the reports it is determined a conflict of medical opinion exists between the DMA and the claimant's physician regarding work-related impairment, the CE should refer the claimant for an independent medical examination with a referee examiner to resolve the conflict. See FECA PM 2-0810 and 3-0500.

g. If a case has been referred for a referee evaluation to resolve the issue of permanent impairment, it is not necessary to route the file to another DMA to review the referee calculations as long as the referee's report fully resolves the conflict and provides a thorough explanation of impairment, citing to the applicable tables and charts in the AMA Guides. If the CE feels the opinion of a DMA is necessary to clarify or verify findings of the referee examiner, a referral can be made so long as the file is not reviewed by a DMA that was a party to the conflict in medical opinion. Otherwise, the CE may process the schedule award based on the report of the referee examiner.

(1) The ECAB has held that while a DMA may review the opinion of a referee specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility. The DMA

cannot resolve a conflict in medical opinion. If necessary, clarification to the referee examiner may be needed. See Richard R. Lemay, 56 ECAB 341 (2005).

(2) In reviewing a referee report, the DMA should not:

(a) Resolve the conflict of medical opinion or attempt to clarify or expand the opinion of the medical referee. See K.O., Docket No. 10-745 (issued November 19, 2010).

(b) Telephone the specialist for clarification or elaboration of the report, as information obtained in this manner cannot be considered probative medical evidence, and inference of bias may result. See Carlton L. Owens, 36 ECAB 608 (1985).

(c) Comment that the facts on which the opinion is based are not in the Statement of Accepted Facts (SOAF), or that the report fails to address or resolve the issue, or that the opinion is speculative. All of these assessments are the CE's responsibility.

7. Schedule Award Payments.

a. General Considerations.

(1) Any previous impairment to the member under consideration is included in calculating the percentage of loss except when:

(a) The prior impairment is due to a previous work-related injury and a schedule award has been granted for such prior impairment, in which case the percentage already paid is subtracted from the total percentage of impairment; or

(b) The VA has already paid a claimant for a previous impairment to the same member, in which case an election will be required if the VA has increased the percentage payable due to the injury in civilian employment. In this instance, an election will be required between the entire schedule award and all VA benefits prior to any increase and all VA benefits subsequent to the increase. Such an election should be offered only for the period of the schedule award, as any determination of LWEC will involve different entitlement and require a separate election. See PM 2-1000.

(2) The impairment computed for loss of two or more digits occasionally exceeds the percentage for the hand or foot; in such instances, the award should reflect the computation most favorable to the claimant. Similarly, the impairment computed for monaural loss of each ear occasionally exceeds the percentage for the binaural loss, and in such instances the award should reflect the computation most favorable to the claimant.

(3) If a recurrence is accepted for a period which overlaps a schedule award, it will be necessary to interrupt the schedule award in order to pay for the period of recurrence. If a recurrent pay rate is established, the claimant will be entitled to that rate for the balance of the schedule award after the period of disability attributable to the recurrence has ceased.

(4) A claimant who enters a vocational rehabilitation program during the course of a schedule award is entitled to receive compensation at the rate for TTD. This entitlement is satisfied by schedule award payments as well as those for TTD. It is therefore not necessary to interrupt a schedule award for payment of TTD unless the claimant is also receiving an annuity from OPM. In this case, the payments must be converted to TTD and an election must be obtained, as vocational rehabilitation services cannot be provided to an individual in receipt of such an annuity.

(5) If payment for TTD is interrupted to pay a schedule award, such TTD payments must be resumed at the end of the schedule if the claimant has not been reemployed or rated for LWEC at the time the award ends (see Goldie Washington, 31 ECAB 239 (1979)). Therefore, it is extremely important to establish the claimant's earning capacity before the award ends. It may also be necessary to obtain an election if the claimant is also receiving an annuity from OPM.

(6) If a schedule award extends for more than one year into the future, a periodic entitlement review should be conducted annually. At a minimum, this review should consist of releasing Form CA-1032 to determine the status of any dependents.

(7) If a claimant dies during the course of a schedule award from a cause other than the injury, payment for the remainder of the award may be made to his or her dependents as specified in 5 U.S.C. 8109. Such payment must be made at the 66 2/3 percent rate, rather than 75%, for the portion of the award that runs after the date of death. If no eligible dependents remain, the balance of the award may not be paid to the estate. If the claimant dies of a cause related to the injury, death benefits may be paid in accordance with 5 U.S.C. 8133, but the balance of the award is not payable to the survivors.

If at the time of the claimant's death a schedule award claim is being developed but has not yet been paid, the claimant's dependent(s) would be entitled to the entire payment of the award. (See Cheryl R. Holloway (Wryland R. Holloway), 54 ECAB 443 (Docket No. 02-2153, issued February 28, 2003). Such payment must be made at the 66 2/3 percent rate, rather than 75%, for the portion of the award that runs after the date of death (it is made at 75% from the date of MMI through the date of death).

b. Beginning Date of the Award. Schedule awards begin on the date of MMI, unless circumstances show a later date should be used.

(1) The ECAB has held that the determination of whether MMI has been reached is based on the probative medical evidence of record, and is usually considered to be the date of the evaluation by the attending physician which is accepted as definitive by the OWCP. See Mark A. Holloway, 55 ECAB 321 (2004).

(2) The MMI date is determined solely on the basis of the medical evidence; however, a subsequent date may be chosen to start the award if the MMI date falls within a period of compensable disability such that converting disability payments into a schedule award would be disadvantageous to the claimant. See Franklin L. Armfield, 28 ECAB 445 (1977).

(3) A retroactive determination of the date of MMI is not *per se* erroneous. When the medical evidence establishes that the employee did in fact reach maximum improvement by such date, the determination is proper. Rationale for a retroactive MMI date such as "one year post surgery or return to full duty status" should not usually be considered sufficient unless the findings of examination from such a date are used to calculate the impairment.

(a) If a date in the past will result in conversion of a period paid for TTD into payment for schedule award, it may not be chosen unless the record contains persuasive proof that MMI had in fact been reached on that date. The claimant must be informed of the right to receive benefits from the Office of Personnel Management (OPM) during the period. See J.C., 58 ECAB 258 (2007); Marie J. Born, 27 ECAB 623 (1976).

(b) If the date of MMI is in the past and the CE converts a period of TTD to schedule award payments, the calculation of the period of TTD being converted should be based on monetary values rather than number of days, and the file should be documented to show this calculation.

(c) See sub-paragraph e. in this section for information on the effective pay rate date to use in this instance.

c. Percentage of Loss. This percentage is applied to the number of weeks specified in section 8107 of the FECA or in 20 CFR §10.404. The resulting number of weeks is multiplied by the weekly wage and the compensation rate. For example,

10% (the actual percentage of impairment) X 244 weeks (100% loss of use of the hand) = 24.4 weeks.

24.4 weeks x \$400 (weekly pay rate) x 75% (compensation rate) = \$7320.

See Exhibit 1 (Percentage Table for Schedule Awards), which lists the number of weeks and days by percentage and schedule member.

d. Period of Award. Given a starting date and the percentage of loss (the number of days of entitlement), the compensation system will automatically compute the ending date of an award and terminate payments accordingly at the end of that period. The period of the award often includes a fraction of a day expressed as a decimal, and this is paid at the end of the award period.

e. Pay rate. Pay rates are discussed in detail in FECA PM 2-0900, and Exhibit 1 of FECA PM 2-0900 provides specific guidance on determining pay rate effective dates for schedule awards.

If the MMI date is established to be a date in the past [see 7b(3)], the "date of injury" for pay rate purposes is the date of last exposure to the work factors that caused the condition prior to the MMI date, since the "injury" must have occurred prior to the date of MMI associated with the accepted impairment. Any additional impairment sustained after that date of MMI can be claimed in accordance with 2-808-9.

f. Compensation Rate. Schedule awards are paid at either the basic rate (66 2/3%) or the augmented rate (75%) of the pay rate for compensation purposes, depending on whether the claimant has an eligible dependent. Eligibility for the augmented compensation rate is discussed in FECA PM 2-0901-12.

g. Minimum (MIN) and Maximum (MAX) rates. While the MIN provision applies to compensation payments for disability, it does not apply for schedule awards. Instead, schedule awards are paid based on the actual pay rate and applicable 75% or 66 2/3% compensation rate. However, the MAX rate does apply to schedule awards. MIN and MAX rates are discussed in more detail in FECA PM 2-0901-13 and 2-0901-14.

h. Consumer Price Index Adjustments (CPIs). Where the schedule award represents the first payment for compensable disability, the claimant's entitlement to CPIs does not begin until one year after the award begins. See Franklin J. Armfield, 29 ECAB 500 (1978) (holding that the claimant was not eligible for a cost-of-living increase, as provided by section 8146a, unless the date of his entitlement to compensation occurred more than a year before the effective date of the cost-of-living increase). CPIs are discussed in more detail in FECA PM 2-0901-16.

8. Schedule Award Decisions. After the payment has been certified, the CE should promptly issue a formal decision outlining the award details. Form CA-181 Award of Compensation (or equivalent) should be used.

a. The CE should provide all relevant payment information based upon the payment output, including the percentage of impairment, the schedule member, date of MMI, the period and length of the award, the weekly pay rate, the compensation rate, and the effective date of the pay rate. Where the award includes a fraction of a day, line 3 of Form CA-181, Schedule Award Decision, should include the phrase "fraction of a day."

For example: An award for 15 percent loss of use of a foot is 30.75 weeks of compensation. The two-place decimal is retained, and the partial day it represents is called "fraction of a day," or FOD. The dates of payment might be shown as, "March 2, 2011 to October 4, 2011, fraction of a day."

The decision should also include the amount of weekly compensation after CPI adjustments, if applicable.

b. If the award percentage was reduced due to payment of a prior award for the same member, the decision should clearly explain the reduction.

c. The decision should outline, in narrative form, the significant development actions with regard to the determination of the percentage of permanent impairment. The CE should explain how the weight of medical evidence was afforded, especially if the decision awarded a percentage of impairment different than that recommended by the claimant's physician. The decision should clearly outline how the decision was reached.

d. The medical report used for the final determination should be included with the decision.

e. Formal Schedule Award Denial. After appropriate development, if it is determined that the schedule award is not payable, a formal denial with appeal rights should be issued.

(1) When the medical evidence indicates the claimant has reached a fixed-and stable status, and there is no permanent impairment to the injured body part, the formal denial should include a full discussion of the weight of medical evidence used to deny impairment entitlement. Formal denials may also be issued when the medical evidence substantiates the claimant has not reached MMI, the claim is for a non-schedule member, etc.

(2) When the medical evidence indicates the claimant has reached a fixed-and stable status, the claim is for a schedule member, and the claimant has some permanent impairment but not enough to be ratable using the AMA Guides, Sixth Edition, the formal denial should include a full discussion of the weight of medical evidence used to determine that the impairment is 0% and, therefore, an award is not payable.

9. Claims for Increased Schedule Award.

a. A disagreement with a previous award should not be considered a claim for an increased schedule award. Instead, if the claimant is requesting review of a prior award, the case should be processed as an appeal and the claimant should be referred to their appeal rights that accompanied the prior decision.

If the claimant's request is unclear, the claims examiner should ask them to clarify whether the request is for review of the award or for additional impairment subsequent to the prior award. If the former, the claimant should be referred to their appeal rights that accompanied the prior decision.

b. If the claimant sustains increased impairment at a later date which is due to work-related factors, a claim for increased schedule award is appropriate. In this case, the original award is undisturbed and the new award has its own date of MMI, percent of impairment, and period of award.

c. In some instances, particularly in hearing loss cases, a claim for an additional schedule award will be based on an additional period of exposure to the same work factors. This constitutes a new claim and should be handled as such.

d. Claims for increased schedule award should follow the same medical development as claims for initial schedule award. See paragraph 6 of this chapter. However, following any appropriate development, all claims for increased schedule award should be referred for a second opinion medical evaluation. Once findings are reconciled with any medical evidence submitted by the claimant, the impairment evaluation carrying the weight of the medical evidence should be submitted to the District Medical Advisor (DMA) for review. Note that DMA review is not mandatory if the report carrying the weight of the medical evidence is from a referee physician. See paragraph 6(g) of this chapter.

Claims for increased schedule award where the prior decision found no ratable impairment do not require a second opinion if sufficient medical evidence is submitted by the claimant to proceed directly to DMA review.

e. If a claimant who has received a schedule award calculated under a previous edition of the AMA Guides is entitled to additional benefits, the increased award will be calculated according to the Sixth Edition. It is not appropriate to recalculate using a prior edition of the Guides.

f. Should any claim for increased scheduled award yield a percentage of impairment lower than the original award, a finding should be made that the claimant has no more than the percentage of impairment originally awarded and that the evidence does not establish an increased impairment. An overpayment should not be declared.

Note that this paragraph applies specifically to claims for an increased award. Claims are still subject to overpayment if a schedule award decision is set aside as a part of the appellate process and a new schedule award decision is issued yielding a lower percentage of impairment. See PM 2-1601.8(c).

10. Disfigurement. If an injury causes serious disfigurement of the face, head or neck of a character likely to handicap a claimant in securing or maintaining employment, a schedule award is payable under 5 U.S.C. 8107(c) (21) if the claimant is employed or employable. (A claimant who is permanently and totally disabled because of an employment-related injury is not entitled to a disfigurement award.) Cases of this type should remain open until it is clearly established whether or not permanent disfigurement of the face, head or neck has occurred.

Where the evidence shows that the employment injury has caused a permanent scar, blemish or some other type of deformity or defect, the CE will notify the claimant of the right to apply for an award.

A claimant who expresses a desire or intent to claim an award for disfigurement will be sent the proper forms and instructions, even if the evidence of record seems to indicate no permanent disfigurement has occurred.

a. When to Consider a Disfigurement Award. Disfiguring marks on the body tend to heal slowly, and scars and blemishes that remain after healing tend to fade and become less prominent with time. Therefore, an award for disfigurement should not be considered until at least six (and preferably 12) months after the last medical treatment. If a claimant chooses to undergo additional surgery or other treatment, consideration of an award will be deferred until the additional treatment is completed.

b. Notification to Claimant. When the evidence shows disfigurement after healing, the claimant should be notified by Form CA-1094 (or equivalent) of the right to apply for an award. The claimant must complete the front of the form, while the attending physician should complete the lower portion of the reverse side of the form. A new application is required in any instance where the claimant files for an award prematurely.

c. Other Information Required. Form CA-7 should be submitted if one has not been filed previously. Only the front of the form need be completed if a disfigurement award is the only benefit claimed. With the CA-1094, the claimant must submit two photographs taken within five days of the date of the application, each showing different views of the disfigurement fairly and accurately portrayed. The claimant may be reimbursed for the cost of the photographs.

d. OWCP Medical Evaluation. After the CE has gathered the required evidence, the case will be referred to the DMA. The DMA will review the photographs submitted along with the medical evidence of record and place a memorandum in the file describing the disfigurement and stating whether MMI has occurred. If not, final action on the application for disfigurement will be deferred.

If the DMA finds MMI has occurred, the concurrence of the Assistant District Director (ADD) or the District Director (DD) must be obtained. The parties evaluating the disfigurement will place a memorandum in the file which states their findings and decision with supporting rationale. The case will then be returned to the CE for payment of the award not to exceed \$3500, or denial of the application.

e. Payment of Award. An award for disfigurement may be paid concurrently with compensation for TTD.

f. A schedule award for the skin may be payable in addition to an award paid for serious disfigurement of the face, head or neck.

11. Schedule Awards after Termination of Compensation and Medical Benefits. The ECAB has held that termination of a claim for all benefits due to a finding of no residuals of the accepted condition(s) does not bar a subsequent schedule award; rather, the CE should consider the schedule award matter separately from the termination of benefits.

a. If a claimant applies for a schedule award after termination, and submits prima facie medical evidence reflecting permanent impairment as a result of the work-related injury or exposure, the CE should develop the claim further, even if a finding of no residuals has previously been made.

b. If medical evidence establishes that impairment to the schedule member exists, the claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment.

c. A separate decision from the termination decision needs to be made as to schedule award entitlement. See B.K., 59 ECAB 228 (Docket No. 07-1545, issued December 3, 2007); A.A., 59 ECAB 726 (Docket No. 08-951, issued September 22, 2008); W.J., Docket No. 08-2409 (issued September 11, 2009).

12. Schedule Awards and Refusal of Suitable Work. Section 5 U.S.C. 8106(c) provides a penalty against employees who refuse offers of suitable employment, or who abandon suitable work without good cause. If a claimant refuses to accept a suitable offer of employment,

the CE should follow the sanction procedures as discussed in FECA PM 2-0814. Once a §8106(c) sanction decision has been issued, the claimant has no ongoing entitlement to compensation for continuing TTD or schedule award payments.

However, the commencement of the schedule award begins on the date of MMI. If MMI was obtained prior to invoking the §8106(c) sanction, then the claimant would be entitled to schedule award payments from the date of MMI through the date of the §8106(c) sanction decision. See K.H., Docket No. 07-2022 (issued February 25, 2008) (The ECAB held that the OWCP properly denied appellant's entitlement to schedule award compensation as section 8106(c) of the FECA served as a bar to further compensation for disability arising from the accepted employment injuries); Alfred R. Anderson, 54 ECAB 179 (2002); Stephen R. Lubin, 43 ECAB 564 (1992) (where the ECAB found that the penalty provision of section 8106(c) may serve as a bar to compensation pursuant to appellant's claim for a schedule award for the period after the termination of compensation based on a refusal to accept a suitable offer of employment).

Claims for Schedule Award received after the date of the §8106(c) sanction decision should not be adjudicated such that new appeal rights are afforded. Rather, the CE should refer the claimant to the appeal rights provided with the original sanction.

Exhibit 1: Percentage Table for Schedule Awards

Member	W/D	01%	02%	03%	04%	05%	10%	15%	20%
Arm	W	3.12	6.24	9.66	12.48	15.60	31.20	46.80	62.40
	D	21.84	43.68	65.52	87.36	109.20	218.40	327.60	436.80
Leg	W	2.88	5.76	8.64	11.52	14.40	28.80	43.20	57.60
	D	20.16	40.32	60.48	80.64	100.50	201.60	302.40	403.20
Hand	W	2.44	4.88	7.32	9.76	12.20	24.40	36.60	48.80
	D	17.08	34.16	51.24	68.32	85.40	170.80	256.20	341.60
Foot	W	2.05	4.10	6.15	8.20	10.25	20.50	30.75	41.00
	D	14.35	28.70	43.05	57.40	71.75	143.50	215.25	287.00
Penis	W	2.05	4.10	6.15	8.20	10.25	20.50	30.75	41.00
	D	14.35	28.70	43.05	57.40	71.75	143.50	215.25	287.00
Vulva/Vagina Uterus/Cervix	W	2.05	4.10	6.15	8.20	10.25	20.50	30.75	41.00
	D	14.35	28.70	43.05	57.40	71.75	143.50	215.25	287.00
Larynx/Tongue	W	1.60	3.20	4.80	6.40	8.00	16.00	24.00	32.00
	D	11.20	22.40	33.60	44.80	56.00	112.00	168.00	224.00
Eye	W	1.60	3.20	4.80	6.40	8.00	16.00	24.00	32.00
	D	11.20	22.40	33.60	44.80	56.00	112.00	168.00	224.00
Kidney/Lung	W	1.56	3.12	4.68	6.24	7.80	15.60	23.40	31.20
	D	10.92	21.84	32.76	43.68	54.60	109.20	163.80	218.40
Thumb	W	.75	1.50	2.25	3.00	3.75	7.50	11.25	15.00
	D	5.25	10.50	15.75	21.00	26.25	52.50	78.75	105.00
1 st Finger	W	.46	.92	1.38	1.84	2.30	4.60	6.90	9.20
	D	3.22	6.44	9.66	12.88	16.10	32.20	48.30	64.40

Great Toe	W	.38	.76	1.14	1.52	1.90	3.80	5.70	7.60
	D	2.66	5.32	7.98	10.64	13.30	26.60	39.90	53.20
2 nd Finger	W	.30	.60	.90	1.20	1.50	3.00	4.50	6.00
	D	2.10	4.20	6.30	8.40	10.50	21.00	31.50	42.00
3 rd Finger	W	.25	.50	.75	1.00	1.25	2.50	3.75	5.00
	D	1.75	3.50	5.25	7.00	8.75	17.50	26.25	35.00
Toe (other than great toe)	W	.16	.32	.48	.64	.80	1.60	2.40	3.20
	D	1.12	2.24	3.36	4.48	5.60	11.20	16.80	22.40
4 th Finger	W	.15	.30	.45	.60	.75	1.50	2.25	3.00
	D	1.05	2.10	3.15	4.20	5.25	10.50	15.75	21.00
Hearing (1 ear)	W	.52	1.04	1.56	2.08	2.60	5.20	7.80	10.40
	D	3.64	7.28	10.92	14.56	18.20	36.40	54.60	72.80
Hearing (Both ears)	W	2.00	4.00	6.00	8.00	10.00	20.00	30.00	40.00
	D	14.00	28.00	42.00	56.00	70.00	140.00	210.00	280.00
Testicle	W	.52	1.04	1.56	2.08	2.60	5.20	7.80	10.40
	D	3.64	7.28	10.92	14.56	18.20	36.40	54.60	72.80
Breast	W	.52	1.04	1.56	2.08	2.60	5.20	7.80	10.40
	D	3.64	7.28	10.92	14.56	18.20	36.40	54.60	72.80
Ovary (includes fallopian tubes)	W	.52	1.04	1.56	2.08	2.60	5.20	7.80	10.40
	D	3.64	7.28	10.92	14.56	18.20	36.40	54.60	72.80
Skin	W	2.05	4.10	6.15	8.20	10.25	20.50	30.75	41.00
	D	14.35	28.70	43.05	57.40	71.75	143.50	215.25	287.00

W = Weeks and D=Days

Exhibit 1 (continued): Percentage Table for Schedule Awards

Member	W/D	25%	30%	35%	40%	45%	50%	55%	60%
Arm	W	78.00	93.60	109.20	124.80	140.40	156.00	171.00	187.20
	D	546.00	655.20	764.40	873.60	982.80	1092.00	1201.20	1310.40
Leg	W	72.00	86.40	100.80	115.20	129.60	144.00	158.40	172.80
	D	504.00	604.80	705.60	806.40	907.20	1008.00	1108.00	1209.60
Hand	W	61.00	73.20	85.40	97.60	109.80	122.00	134.20	146.40
	D	427.00	512.40	597.80	683.20	768.60	854.00	939.40	1024.80
Foot	W	51.25	61.50	71.75	82.00	92.25	102.50	112.75	123.00
	D	358.75	430.50	502.25	574.00	645.75	717.50	789.25	861.00
Penis	W	51.25	61.50	71.75	82.00	92.25	102.50	112.75	123.00
	D	358.75	430.50	502.25	574.00	645.75	717.50	789.25	861.00
	W	51.25	61.50	71.75	82.00	92.25	102.50	112.75	123.00

Vulva/Vagina Uterus/Cervix	D	358.75	430.50	502.25	574.00	645.75	717.50	789.25	861.00
Larynx/Tongue	W	40.00	48.00	56.00	64.00	72.00	80.00	88.00	96.00
	D	280.00	336.00	392.00	448.00	504.00	560.00	616.00	672.00
Eye	W	40.00	48.00	56.00	64.00	72.00	80.00	88.00	96.00
	D	280.00	336.00	392.00	448.00	504.00	560.00	616.00	672.00
Kidney/Lung	W	39.00	46.80	54.60	62.40	70.20	78.00	85.80	93.60
	D	273.00	327.60	382.20	436.80	491.40	546.00	600.60	655.20
Thumb	W	18.75	22.50	26.25	30.00	33.75	37.50	41.25	45.00
	D	131.25	157.50	183.75	210.00	236.25	262.50	288.75	315.00
1 st Finger	W	11.50	13.80	16.10	18.40	20.70	23.00	25.30	27.60
	D	80.50	96.60	112.70	128.80	144.90	161.00	177.10	193.20
Great Toe	W	9.50	11.40	13.30	15.20	17.10	19.00	20.90	22.80
	D	66.50	79.80	93.10	106.40	119.70	133.00	146.30	159.60
2 nd Finger	W	7.50	9.00	10.50	12.00	13.50	15.00	16.50	18.00
	D	52.50	63.00	73.50	84.00	94.50	105.00	115.50	126.00
3 rd Finger	W	6.25	7.50	8.75	10.00	11.25	12.50	13.75	15.00
	D	43.75	52.50	61.25	70.00	78.75	87.50	96.25	105.00
Toe (other than great toe)	W	4.00	4.80	5.60	6.40	7.20	8.00	8.80	9.60
	D	28.00	33.60	39.20	44.80	50.40	56.00	61.60	67.20
4 th Finger	W	3.75	4.50	5.25	6.00	6.75	7.50	8.25	9.00
	D	26.25	31.50	36.75	42.00	47.25	52.50	57.75	63.00
Hearing (1 ear)	W	13.00	15.60	18.20	20.80	23.40	26.00	28.60	31.20
	D	91.00	109.20	127.40	145.60	163.80	182.00	200.20	218.40
Hearing (Both ears)	W	50.00	60.00	70.00	80.00	90.00	100.00	110.00	120.00
	D	350.00	420.00	490.00	560.00	630.00	700.00	770.00	840.00
Testicle	W	13.00	15.60	18.20	20.80	23.40	26.00	28.60	31.20
	D	91.00	109.20	127.40	145.60	163.80	182.00	200.20	218.40
Breast	W	13.00	15.60	18.20	20.80	23.40	26.00	28.60	31.20
	D	91.00	109.20	127.40	145.60	163.80	182.00	200.20	218.40
Ovary (includes fallopian tubes)	W	13.00	15.60	18.20	20.80	23.40	26.00	28.60	31.20
	D	91.00	109.20	127.40	145.60	163.80	182.00	200.20	218.40
Skin	W	51.25	61.50	71.75	82.00	92.25	102.50	112.75	123.00
	D	358.75	430.50	502.25	574.00	645.75	717.50	789.25	861.00

W = Weeks and D=Days

Exhibit 1 (continued): Percentage Table for Schedule Awards

Member	W/D	65%	70%	75%	80%	85%	90%	95%	100%
Arm	W	202.80	218.40	234.00	249.60	265.20	280.80	296.40	312.00
	D	1419.60	1528.80	1638.00	1747.20	1856.40	1965.60	2074.80	2184.00
Leg	W	187.20	201.60	216.00	230.40	244.80	259.20	273.60	288.00
	D	1310.40	1411.20	1512.00	1612.80	1713.60	1814.40	1915.20	2016.00
Hand	W	158.60	170.80	183.00	195.20	207.40	219.60	231.80	244.00
	D	1110.20	1195.60	1281.00	1366.40	1451.80	1537.20	1622.60	1708.00
Foot	W	133.25	143.50	153.75	164.00	174.25	184.50	194.75	205.00
	D	932.75	1004.50	1076.25	1148.00	1219.75	1291.50	1363.25	1435.00
Penis	W	133.25	143.50	153.75	164.00	174.25	184.50	194.75	205.00
	D	932.75	1004.50	1076.25	1148.00	1219.75	1291.50	1363.25	1435.00
Vulva/Vagina Uterus/Cervix	W	133.25	143.50	153.75	164.00	174.25	184.50	194.75	205.00
	D	932.75	1004.50	1076.25	1148.00	1219.75	1291.50	1363.25	1435.00
Larynx/Tongue	W	104.00	112.00	120.00	128.00	136.00	144.00	152.00	160.00
	D	728.00	784.00	840.00	896.00	952.00	1008.00	1064.00	1120.00
Eye	W	104.00	112.00	120.00	128.00	136.00	144.00	152.00	160.00
	D	728.00	784.00	840.00	896.00	952.00	1008.00	1064.00	1120.00
Kidney/Lung	W	101.40	109.20	117.00	124.80	132.60	140.40	148.20	156.00
	D	709.80	764.40	819.00	873.60	928.20	982.80	1037.40	1092.00
Thumb	W	48.75	52.50	56.25	60.00	63.75	67.50	71.25	75.00
	D	341.25	367.50	393.75	420.00	446.25	472.50	498.75	525.00
1 st Finger	W	29.90	32.20	34.50	36.80	39.10	41.40	43.70	46.00
	D	209.30	225.40	241.50	257.60	273.70	289.80	305.90	322.00
Great Toe	W	24.70	26.60	28.50	30.40	32.30	34.20	36.10	38.00
	D	172.90	186.20	199.50	212.80	226.10	239.10	252.70	266.00
2 nd Finger	W	19.50	21.00	22.50	24.00	25.50	27.00	28.50	30.00
	D	136.50	147.00	157.50	168.00	178.50	189.00	199.50	210.00
3 rd Finger	W	16.25	17.50	18.75	20.00	21.25	22.50	23.75	25.00
	D	113.75	122.50	131.25	140.00	148.75	157.50	166.25	175.00
Toe (other than great toe)	W	10.40	11.20	12.00	12.80	13.60	14.40	15.20	16.00
	D	72.80	78.40	84.00	89.60	95.20	100.80	106.40	112.00
4 th Finger	W	9.75	10.50	11.25	12.00	12.75	13.50	14.25	15.00
	D	68.25	73.50	78.75	84.00	89.25	94.50	99.75	105.00
Hearing (1 ear)	W	33.80	36.40	39.00	41.60	44.20	46.80	49.40	52.00
	D	236.60	254.80	273.00	291.00	309.40	327.60	345.80	364.00
Hearing (Both ears)	W	130.00	140.00	150.00	160.00	170.00	180.00	190.00	200.00
	D	910.00	980.00	1050.00	1120.00	1190.00	1260.00	1330.00	1400.00
Testicle	W	33.80	36.40	39.00	41.60	44.20	46.80	49.40	52.00
	D	236.60	254.80	273.00	291.00	309.40	327.60	345.80	364.00
Breast	W	33.80	36.40	39.00	41.60	44.20	46.80	49.40	52.00
	D	236.60	254.80	273.00	291.00	309.40	327.60	345.80	364.00
	W	33.80	36.40	39.00	41.60	44.20	46.80	49.40	52.00

Ovary (includes fallopian tubes)	D	236.60	254.80	273.00	291.00	309.40	327.60	345.80	364.00
Skin	W	133.25	143.50	153.75	164.00	174.25	184.50	194.75	205.00
	D	932.75	1004.50	1076.25	1148.00	1219.75	1291.50	1363.25	1435.00

W = Weeks and D=Days

Chapter 2-0809, Statements of Accepted Facts

1. Purpose and Scope. This chapter contains guidelines for the preparation of statements of accepted facts (SOAFs). The SOAF is a concise summary of the relevant facts that will allow a physician to resolve a particular medical issue. The SOAF can be useful to assist the attending physician, a second opinion examiner, a referee medical examiner, the District Medical Advisor, Rehabilitation Counselors, Nurse Case Managers, employing agencies, and others interested in the facts used by the Office to make determinations about a case.

An accurate and complete SOAF requires that the factual issues pertinent to the claim be properly developed, weighed and resolved in advance. For information about the development of particular issues, refer to FECA PM 2-0800, Development of Claims, and the ensuing chapters addressing the five basic requirements, or to FECA PM 2-0700, Death Claims.

For a discussion of formulating medical questions and forwarding cases for medical opinion when the SOAF is completed, refer to FECA PM 2-0810, Developing and Weighing Medical Evidence and FECA PM Part 3, Medical.

2. Introduction. The SOAF is one of the most important documents a Claims Examiner (CE) prepares. It is the written summary of the CE's findings of facts. It serves as a factual frame of reference for the medical specialist, the CE or other case reviewer. When it is used by physicians who base their medical opinions solely on the information presented in the SOAF, the outcome of a claim may depend on its completeness and accuracy. Therefore, the SOAF must clearly and accurately address the relevant information.

a. The SOAF represents what the OWCP in its capacity as fact finder has accepted as factual in a particular case. In Leopold J. Gunston, 15 ECAB 83 (1963), the ECAB stated:

A statement of accepted facts is not a counterpart of a "stipulation of facts" between adversarial parties in court procedure. In the determination of facts in a claim for compensation, the [OWCP] is acting in its adjudicatory function as a trier of the facts.

Given the variation in the factual events which occur in some compensation claims, the number of issues to be resolved, and the differing courses of medical development, the CE will need to assess the relevance and validity of factual evidence and how it should be presented in the SOAF. While some elements will be common to all SOAFs, inclusion of others will depend on the issue to be resolved and the history of the injury. The SOAFs prepared in psychological/emotional stress claims are inherently different from all other types.

b. The SOAF provides the physician a framework from which to formulate an opinion regarding a particular medical issue or question. It allows the physician to place the medical questions posed in the larger context of the mechanism of injury, the requirements of the claimant's job, or the conditions which prevailed in the workplace. It may also provide the physician with a chronology of events after the injury.

c. The SOAF is also the means by which factual findings are separated from medical findings and opinions. This separation of functions is aimed at seeing that the CE does not inadvertently make medical decisions. Similarly, properly written SOAFs demonstrate to physicians what OWCP has accepted as factual; clear factual findings are aimed at preventing physicians from making erroneous factual assumptions about the case, which could undermine their medical conclusions.

d. In certain circumstances SOAFs are required, and in other situations the CE may elect to prepare them:

(1) All issues requiring a medical opinion for resolution, except for those which do not depend on the facts of the claim, should have SOAFs. For example, a request for surgery for repair of a broken bone where causal relationship is not an issue would not necessarily require a SOAF. Issues commonly referred for medical opinion where a SOAF may be required or useful include causal relationship, extent and duration of disability, percentage of impairment, and appropriateness of care.

(2) To assist an attending physician in formulating a well-founded medical opinion, the CE may provide the physician with a SOAF and relevant questions. A SOAF would be particularly indicated in a situation where the facts as related to or by the physician differ from those accepted by OWCP. A CE should provide a SOAF when OWCP has evidence such as exposure data not readily available to or verifiable by the physician.

(3) Due to the complex nature of psychological/emotional stress claims, this type of claim must have a SOAF written before adjudication. In psychological/emotional stress claims, the SOAF is particularly important since the physician's opinion on causal relationship must be based on an accurate identification of the implicated work factors. The SOAF is required in these claims even if the CE decides not to send the claimant for a second opinion medical examination at the time

of adjudication. The complex nature of the issues inherent in this type of claim necessitates that the facts be established and documented in a SOAF.

3. Responsibilities of the Claims Examiner. The CE has certain obligations both before and during preparation of the SOAF. In making findings, the CE is obliged to apply principles of logic and evidence. These guidelines for fact-finding may be based on legal principles of evidence, Larson's Workmen's Compensation Law, OWCP policies, and ECAB decisions. For more information on fact-finding, see FECA PM 2-0803, Fact of Injury.

- a. The CE should first recognize that a medical issue(s) needs resolution and concisely define that issue. Issues may vary during the life of any claim, and a case may need multiple referrals for medical opinion.
- b. The CE must thoroughly review the case to determine if there is sufficient evidence to establish the facts of the case. If the facts cannot be established, the CE is responsible for gathering all the information through development of the case. (See FECA PM 2-0800.)
- c. The CE should define the information needed to form a complete frame of reference for the physician(s) who will review the medical evidence. Evidence which may be pertinent to the resolution of one issue may not have any bearing on the resolution of another. For example, a description of the physical requirements of the date of injury job would be relevant to the question of whether a claimant may return to regular duty work but has no relevance with regard to whether surgery is medically necessary.
- d. If there is an apparent disagreement on the factual evidence, the CE may wish to provide the interested parties an opportunity to comment on the evidence, statements and documentation submitted as well as a meaningful opportunity to rebut when allegations are made or conflicting evidence is received. In addition to seeing that the facts are known to the parties, this process is also a useful vehicle for developing the claim, refining the issues for the CE, and assisting in the resolution of conflicts prior to making findings of fact.
- e. The CE must determine the facts in a case by weighing the evidence which has been developed and drawing conclusions based on that evidence. When the relevant information has been received and the parties to the claim have had a chance to refute any disputed evidence, the CE is ready to evaluate the evidence for credibility and validity.

Evidence can be classified as direct or indirect. The value of each varies and is not fixed for all circumstances. Because direct evidence represents a first-hand account (such as a witness statement), it is ordinarily assigned greater weight than indirect evidence, or second-hand knowledge of an event. However, while direct evidence is generally regarded as superior, it may be overridden by indirect evidence which is more plausible or internally consistent with all the other facts in a case. For this reason the CE must exercise discretion and logic in drawing conclusions or making inferences based on the factual information in a claim.

f. The CE must reach decisions based on the evidence which is received. As the adjudicator of the claim, the CE may not abdicate this responsibility to others, either within or outside the OWCP.

g. The CE must present a description of the employment injury or exposure as a definitive statement of fact without mention of the source from which the information was derived. In essence, the SOAF contains only what the CE has determined as factual. For example, in describing an event as fact, the statement would read that the claimant twisted his right ankle descending stairs, rather than the claimant "states," "claims" or "alleges" that he twisted his right ankle descending stairs.

h. The CE must set forth his or her findings in a clear, concise and orderly statement which is complete with respect to essential details and free of extraneous material. This is usually best accomplished by describing the facts in chronological order. The CE must consider all relevant evidence to ensure that the SOAF is complete and accurate. ECAB has remanded cases even when the omission of evidence from the SOAF may not materially affect the outcome. See Richard A. Sroka, 35 ECAB 209 (1983).

4. **Composition of the SOAF.** The CE must take several factors into consideration in constructing a thorough, accurate and complete SOAF. The SOAF is typically written in a narrative format, with facts presented in an orderly and logical manner. An orderly flow will ensure that readers are able to quickly understand the case's critical components.

For some types of claims, such as hearing loss and asbestosis, specific reporting forms have been developed. In psychological/emotional cases, a SOAF addressing specific elements is necessary (see Paragraph 5 below). Wherever possible, exposure data, job descriptions or duties, and other records should be condensed to essential information and incorporated into the body of the SOAF.

a. SOAF Writing Method and Style.

(1) All evidence on which the SOAF is based must be in the case record. The CE may not make findings based on an undocumented conversation or an investigative report which is not subject to examination or rebuttal. The CE must also avoid making findings based on similar evidence found in other case files (e.g., position descriptions).

(2) The SOAF should include a complete record of all pertinent facts related to the injury or medical condition. The omission of a critical fact diminishes the validity of a medical opinion or decision as much as an incorrect statement. Avoiding selective inclusion of facts in the SOAF prevents a perception of bias and maintains neutrality and objectivity in the management of the case.

(3) Facts should be presented in a chronological order so the reviewer can visualize the sequence of events.

(4) Whenever possible, workplace factors should be quantified so the physician can correlate the exposure with medical or scientific data on causality. Examples of quantifiable factual elements include:

- (a) Period and length of exposure
- (b) Decibel levels of exposure
- (c) Concentration of asbestos fibers and other noxious substances in the air
- (d) Weight and size of objects lifted
- (e) Number of times a repetitive task is performed
- (f) Frequency and type of workplace confrontations or encounters

A medical opinion based on an accurate SOAF has enhanced probative value, whereas an opinion based on incorrect or incomplete facts is of diminished value.

See T.G., Docket No. 07-2231 (issued June 2, 2008). ECAB held that the physician's report was not entitled to the special weight of the medical opinion evidence because it was based on an inaccurate statement of accepted facts.

See also A.C., Docket No. 07-2423 (issued May 15, 2008). ECAB held that the statement of accepted facts did not accurately reflect the conditions the OWCP accepted as employment related and, therefore, the physician's report was of diminished probative value and insufficient to resolve the conflict in medical opinion.

Vague or generic terms such as light, heavy, undue, severe, irregular and abnormal are to be avoided, since they are subject to great differences of interpretation.

(5) Facts should be clearly stated. Simple words and direct statements reduce the potential for ambiguity or misinterpretation. Use of legal terms and Government jargon should be avoided, since they are unfamiliar to external case reviewers. The SOAF should present a vivid picture of the circumstances of a claim so the reader will clearly understand them.

(6) Facts should be stated in a positive voice whenever possible. The CE should identify facts in terms of what can be verified, rather than what has not been, or cannot be, determined. For example, a SOAF should include specific language indicating "The employee lifted ten widgets," rather than "The employee lifted less than twenty widgets."

b. Length of SOAF. The length will vary depending on the issues to be resolved and the facts of the case. The test is whether the SOAF covers all material facts in sufficient detail to provide the physician with a complete picture of the claim without including superfluous information. There is no minimum length requirement except to include the items addressed under paragraph 5 below, "Essential Elements."

(1) In simple cases, a brief SOAF will usually suffice. For instance, where the only outstanding issue is determining a schedule award, the impairment is clearly related to the accepted injury, and there is no dispute concerning the medical evaluations for calculating the rating, the SOAF may be quite brief.

Note: In the case of a schedule award, all medical conditions or impairments to the schedule member should be listed and the instructions to the medical examiner should state that all impairments (preexisting, non-employment related and subsequently developed impairments) must be considered in calculating the award.

(2) In more complex cases, the SOAF will generally need to be longer so that the CE can fully address the pertinent facts. The SOAF may be multiple pages in length, although most issues can be adequately addressed in one page. SOAFs in a psychological/emotional claim are frequently longer due to the number and complexity of the issues raised in that type of claim.

c. SOAF Header. The header is centered at the top of the first page of the SOAF. The first line should state "Statement of Accepted Facts." The second line should include the claimant's name. The third line should identify the claimant's case number. The header font should be in all capital letters and in bold text.

If a SOAF is modified, the header should include, in bold, the additional line "This SOAF supersedes all prior SOAFs." (See paragraph 8 below regarding SOAF modifications.)

d. SOAF Footer. The footer comes at the end of the SOAF body and consists of the author's name, title, and the date the SOAF was created or modified.

5. Essential Elements. For a physician to form a general impression of the individual or evidence to be evaluated, the CE must provide the following information in the SOAF:

a. Date of Injury -- allows the physician to estimate elapsed time and recovery.

b. Claimant's Date of Birth -- permits the physician to factor in any additional healing time if necessary.

c. Job Held on Date of Injury -- permits the physician to visualize the setting of the injury if it occurred during normal duties and possibly to make judgments about the claimant's potential for returning to duty.

d. Name of Employing Agency -- supplements information about the position held.

e. Employment history, including periods of wage loss and returns to full or light duty for the present claim -- helps put the employee's injury and work history in perspective. If the employee did not stop work, that should be reported.

f. Mechanism of Injury -- helps the physician to form an opinion on the relationship of the condition(s) diagnosed to the alleged injury and the severity or extent of the injury. In occupational illness cases, this information would include factors of employment and exposure data.

g. Condition(s) Claimed or Accepted -- allows the physician to assess whether the diagnoses provided in the medical evidence to be reviewed are consistent with the conditions for which the claim is filed or has been accepted.

h. In psychological/emotional stress claims, the CE will need to distinguish between those workplace activities and circumstances which are factors of employment and those which are outside the scope of employment for purposes of compensation. The CE must determine whether the situations alleged actually existed or occurred.

The CE should divide any SOAF containing both work-related and non-work-related elements into three parts, labeled as follows:

- (1) Accepted Events that are Factors of Employment.
- (2) Accepted Events that are Not Factors of Employment.
- (3) Incidents Alleged which the Office Finds Did Not Occur.

Each incident should be numbered consecutively within the section to which it belongs.

ECAB has stated that such findings provide a proper frame of reference for the physician offering an opinion on causal relationship. See Abe E. Scott, 45 ECAB 164, 174 (1993), in which ECAB remanded the case for preparation of a SOAF addressing these factors.

6. Optional Elements.

a. Other elements may be included in the SOAF as described below, depending on the nature of the condition claimed and the issues to be resolved. Virtually all of them should be included when adjudicating an occupational illness claim, particularly where psychological/emotional stress is implicated.

- (1) Prior medical history, including prior workers' compensation claims as appropriate.
- (2) Medical treatment received, including initial medical treatment, surgeries, diagnostic testing and other relevant medical procedures, but the CE should not give a recitation of medical opinions or findings.
- (3) Personal habits such as smoking or drinking, as relevant to the claim. While a smoking history would be particularly pertinent in an asbestosis claim, tobacco or alcohol use can affect many medical conditions.
- (4) Concurrent medical condition(s), as potentially relevant to the claim. Pregnancy would be a relevant factor in a claim for carpal tunnel syndrome.
- (5) Off-duty activities, employment and hobbies.

(6) Family circumstances and potential off-duty stress factors, as relevant to the claim, such as claims for psychological/emotional stress.

(7) A description of the claimant's work (mental, physical and environmental). However, a copy of the position description should not be used verbatim, since at best it will provide only general information or may be inaccurate or incomplete.

7. Exclusions from SOAFs. Not all information contained in a case file bears on the issues to be resolved in connection with the SOAF. Some information is irrelevant, while other material is inappropriate, prejudicial, or better discussed elsewhere. The following items should not be included in the SOAF:

a. Evidence. Raw evidence, such as a police report or time card, should be not be attached or described verbatim in the SOAF. The CE is responsible for making decisions on raw evidence and incorporating the findings into the SOAF.

b. Justifications or Reasons for Conclusions Reached. The CE's findings should be supported by the evidence of record. Any explanation of the findings should be made in a memorandum to the file, not in the SOAF.

c. Medical Opinions. Such opinions should not, however, be confused with the medical history of the claim, which may properly be included. Chronologies of care and nature of treatment received are facts surrounding the medical aspects of a claim, but are not themselves medical opinions.

d. Payment of OWCP Compensation and OPM Annuities. An exception to this rule can be made in a psychological/emotional stress claim where the claimant has alleged to physicians that he or she is not receiving any income. Here the CE should state when benefits began and whether they continue or were terminated.

e. Issues for Determination. The SOAF is not used to outline the factual issues to be resolved. Factual issues belong in memoranda to the file. Medical issues to be resolved are properly addressed in a memorandum to the file or a letter to the physician.

f. Definitions of Terms. When a CE needs to define such terms as aggravation, precipitation or acceleration, he or she should do so in a letter to the physician along with the questions to be answered.

g. Discussion of Legal Issues. These should be discussed in a memorandum to the file.

h. Appeals and Administrative Actions. Histories of appeals, remands, and administrative actions of the OWCP, such as requests for investigations, do not help to resolve medical issues and may actually prejudice the outcome of a claim. An exception can be made in situations where a brief explanation would be useful in a long running case to note that the case has undergone multiple appeals or where ECAB has instructed that a new SOAF must be prepared.

8. Modification of SOAFs.

a. Modification of a SOAF is required whenever the previous SOAF ceases to accurately represent all current facts of a case record. It is important to note that modifying a prior SOAF is distinct from correcting an inaccurate SOAF. Updating factual or medical information would be a modification of a SOAF.

Correcting gross inaccuracies in a prior SOAF that may lead to a reduction of benefits, such as rescission of either a previously accepted condition or of an accepted case in its entirety, requires due process (notice and an opportunity to respond) and a formal decision with appeal rights [see FECA PM 2-0804.17(k)].

Whenever the CE determines that a request to a physician is necessary to obtain a reasoned medical opinion on issues of causal relationship, such as the nature, extent and degree of a work-related condition, the CE will undertake a formal review of the case record. This review will be conducted in order to determine whether factual or medical changes have occurred since issuance of the previous SOAF. A physician's opinion would only be considered valid and be assigned the weight of medical evidence if that opinion was based upon an accurate factual and medical history. The CE, therefore, should consider amending a previous SOAF whenever further medical opinion is being sought.

b. There are certain instances when a CE must undertake modification of a SOAF. All modifications made to a SOAF must be supported by the evidence of record. Reasons for modifying a SOAF include, but are not limited to:

(1) A change in the work-related medical condition, where the evidence of record supports the acceptance of additional medical conditions.

(2) Rescission of a previously accepted medical condition when due process was given and a formal denial was issued.

(3) New information that reflects other changes in the claimant's life, such as a change in work duties or hours of work, or the claimant returns to any type of employment not previously noted in the SOAF.

(4) Receipt of an Investigative Memorandum which yields relevant findings not already known, such as a claimant regularly engaging in strenuous physical activity such as soccer games or operating a construction business.

c. Responsibility for modifying a SOAF rests solely with the CE. Neither the claimant nor the employing agency has an unqualified right under the Federal Employees' Compensation Act, its implementing regulations or procedures to approve or amend the SOAF. See *Leopold J. Gunston*, 15 ECAB 83, 86 (1963). (A SOAF is not a counterpart of a "stipulation of facts" between adversary parties in court procedure. In determining the facts in a claim for compensation, OWCP is acting in its adjudicatory function)

Should an employing agency or claimant object to the content of a SOAF, they may submit additional evidence for the CE to review, but a CE is not required to modify a SOAF based upon an agency's or claimant's request.

Accordingly, while the CE may seek input or comment on a SOAF, the CE shall not obtain the approval of an outside party to the case in creating or modifying a SOAF. The CE alone is responsible for reviewing the case record for relevant changes in factual or medical evidence which warrant modification of the previous SOAF prior to obtaining additional medical opinion.

A claimant's disagreement with the SOAF is not a valid reason for refusing to attend an OWCP-directed medical examination. See, V.H., Docket No. 07-1200 (issued September 10, 2008), in which the appellant objected to the statement of accepted facts because it was over two years old. ECAB held that this was not a valid excuse to refuse to attend an impartial medical examination. If any adverse action were to arise from such an examination, the claimant may raise his or her objections during the appeals process.

d. If a SOAF should have been modified prior to requesting additional medical opinion but was either not modified or modified improperly and the SOAF contained a substantial error, the CE should amend the SOAF and request clarification from the physician who provided a report based on the inaccurate SOAF. The CE must specifically ask the physician for a reasoned medical opinion as to whether the modified SOAF affects the doctor's conclusions. Failure to return to the physician for clarification in this circumstance would diminish the probative value of that physician's opinion.

ECAB has ruled on the importance of ensuring that a SOAF accurately portrays the factual and medical aspects of the claim, remanding cases where the SOAFs were not current or accurate. In the case of Gwendolyn Merriweather, 50 ECAB 411 (Docket No. 97-2137, issued June 3, 1999), ECAB found that the referee examiner was not entitled to special weight because the doctor's opinion was not based upon a proper factual background. ECAB noted that OWCP made no findings as to whether the claimant had sustained a work-related aggravation of a preexisting condition and found that the SOAF was unclear. See also Liliana M. Martinez, 42 ECAB 517 (Docket No. 90-1944, issued March 20, 1991). ECAB found that the deficient factual background left the referee physician without a proper factual basis on which to form a medical opinion and ruled that this deficiency rendered that medical opinion of diminished probative value.

Exhibit 1 - TI Sample

STATEMENT OF ACCEPTED FACTS
IN THE CASE OF JAMES JONES
FILE NUMBER: xxxxxxxxx

James Jones, date of birth 03/22/1975, is employed as a maintenance worker with the Department of Veterans Affairs. On April 14, 2009, he sustained an injury when a desk he was

moving slid off a fork lift and slammed into his left knee, pinning his knee between the desk and a wall. He received initial medical attention at the Northwestern Medical Center on April 14, 2009.

The conditions of a left knee contusion and left knee sprain are accepted as causally related to the April 14, 2009 employment injury.

A left knee arthroscopy was performed on September 10, 2009. Mr. Jones has not returned to work to date.

The duties of a maintenance worker require walking and standing for up to six hours per day; intermittent squatting, bending and kneeling for up to two hours per day; pushing/pulling up to one hour per day; climbing stairs ½ hour per day; and occasional lifting up to 50 lbs.

Prior medical history: Claimant suffered a torn left knee medial meniscus as a result of a soccer injury at age 16.

CE Name

Title

Date

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Exhibit 2 - Basic OD Sample

STATEMENT OF ACCEPTED FACTS
IN THE CASE OF JANE DOE
FILE NUMBER: xxxxxxxxx

Jane Doe, date of birth 04/06/1965, is employed by the US Department of the Treasury, Internal Revenue Service, as a Data Transcriber.

A Data Transcriber performs repetitive keyboard related tasks with an average keystroke of 7,500 to 8,500 per hour. In early May of 2008, Ms. Doe increased her keystrokes to 10,150 per hour and in so doing developed cramping in both hands and wrists. She subsequently developed numbness involving the 4th and 5th fingers of the right hand.

Ms. Doe stopped work on 05/18/08 and received initial medical attention on this date at the Memorial Hospital emergency room. She returned to modified work on 05/19/08 performing keyboarding on a reduced 4 hour per day schedule. Effective 05/25/08, Ms. Doe came under the care of her family practitioner. She stopped work completely on 06/10/08.

The claim has been accepted for right ulnar nerve entrapment and left lateral epicondylitis as work-related.

On 06/27/2008, Ms. Doe underwent a right elbow ulnar nerve decompression and right elbow medial epicondylectomy, which were both accepted as work-related. She remains out of work following her surgery.

CE Name

Title

Date

Exhibit 3 - Sample HL

STATEMENT OF ACCEPTED FACTS
IN THE CASE OF JOHN JAMES
FILE NUMBER: xxxxxxxxx

Mr. James, date of birth 11/22/1954, was employed by the Department of the Army from July of 1985 until his retirement on June 1, 2009. His pre-employment physical on August 1, 1985 reported that he had normal hearing. During this timeframe, Mr. James held the following jobs; his occupational noise exposure for each position is summarized below:

September 7, 2003 to June 1, 2009 Mobile Equipment Repairer/Inspector

As a Mobile Equipment Repairer/Inspector, Mr. James was exposed to noise emanating from air tools, trucks and combat vehicles for approximately 2 hours per day. The dBA levels in the auto maintenance shop where he worked ranged from 84-104 dBA, with an average reading of 88 dBA. Mr. James wore ear muffs while working in the shop.

June 9, 1986 to September 6, 2003 Heavy Mobile Equipment Mechanic

As a Heavy Mobile Equipment Mechanic, Mr. James was exposed to noise emanating from air tools, trucks and combat vehicles for approximately 8-9 hours per day. Decibel levels to which he was exposed ranged from 85 to 91.1 dBA. He wore ear plugs during this period.

October 27, 1985 to June 8, 1986 Warehouse Worker

As a warehouse worker, Mr. James was exposed to noise emanating from air tools and trucks for approximately 4-5 hours per day. He wore ear plugs while working in this capacity.

Non-Federal Employment History:

April 1983 to July 1985 Mechanic, Welder

Mr. James worked in the private sector in various capacities as both a mechanic and a welder. He was exposed to noise emanating from air tools, construction, and car and truck engines for approximately 4 to 12 hours per day. Ear plugs were used during this period for protection.

Hobbies:

Mr. James is an avid hunter and has been since the early 1970's. He began wearing earplugs for hearing protection in 1979. He is also a motorcyclist.

CE Name

Title

Date

Exhibit 4 – Emotional Stress

STATEMENT OF ACCEPTED FACTS
IN THE CASE OF MARY SMITH
FILE NUMBER: xxxxxxxxxx

Ms. Smith, date of birth 11/27/1972, is employed by the US Postal Service as a PTF (part-time flexible) Letter Carrier in Anytown, USA; she has worked as a PTF Letter Carrier since June of 2000. On 08/30/09, she filed a notice of occupational disease due to emotional stress. She initially sought treatment from _____, M.D. and has since transferred her care to _____, PhD. She stopped work on 08/30/09 and remains out of work.

Federal workers' compensation law does not apply to each and every illness that is somehow related to employment. Therefore, we have to differentiate between employment events that are considered to be related to the employee's duties; those that are somehow related to the employment, but are not directly related to his/her duties; and allegations that have not been established. This Statement of Accepted Facts outlines these three categories.

I. Accepted Event(s) That Are Factors of Employment:

1. On May 9, 2009, Ms. Smith was told by a supervisor to throw bulk mail for a male co-worker because he was lagging behind. The co-worker told Ms. Smith she was throwing the mail too fast and needed to slow down. She continued to work at a fast pace and the co-worker got angry and began to throw the newspapers and magazines at her legs.
2. Several letter carriers were out from June 1, 2009 to August 20, 2009. This increased her daily workload, requiring that she work 50 -60 hours per week.
3. On August 21, 2009, a co-worker yelled and swore at Ms. Smith, accusing her of making all the other carriers look bad by sorting her mail in advance of everyone else. This same co-worker warned Ms. Smith to watch her back, adding "I know where you live."

II. Accepted Event(s) That Are Not Factors of Employment:

1. On August 25, 2009, Ms. Smith was assigned to a different post office. This re-assignment added an additional hour to her commute and created conflicts with child care arrangements.

2. Ms. Smith was dissatisfied with her new delivery route and considered it less desirable than her previous route.

III. Incident Alleged Which the Office Finds Did Not Occur:

Ms. Smith alleged she was physically assaulted by her supervisor in a December 3, 2008 meeting where two other witnesses attending the meeting said that the supervisor did not touch Ms. Smith.

CE Name

Title

Date

Chapter 2-0810, Developing and Evaluating Medical Evidence

1. Purpose and Scope. This chapter discusses the Claims Examiner's (CE's) function in evaluating medical evidence and authorizing treatment. FECA PM Part 3, Medical, also contains useful chapters relating to medical issues and should be consulted.

2. Introduction. The CE is responsible for obtaining the appropriate type of medical evidence, evaluating it, and weighing it to resolve inconsistencies and conflicts in medical opinions. This chapter defines and discusses the terms and procedures involved in the weighing process and provides examples of common situations in accepted disability cases where medical development is needed and guidelines for determining the weight of medical evidence.

3. Important Principles in Reviewing Medical Evidence.

a. Once the OWCP accepts a claim, it has the burden of justifying termination or modification of compensation. After the OWCP has determined that a claimant has disability causally related to his or her employment, the OWCP may not terminate compensation without establishing that the disability has ceased or is no longer related to the employment. [Kathryn E. DeMarsh, 56 ECAB 677 (2005); Robert R. Henderson, 30 ECAB 549 (1979)]

b. Resolving the issue of whether disability has lessened or ceased, or is no longer causally related to the employment, rests primarily within the realm of the medical expert. [Eloise L. Berry, 25 ECAB 61 (1973)] This is why development and weighing of medical evidence are both so important in accepted disability cases. A thorough understanding of how to weigh medical

evidence will assist the CE in determining when and how further medical development should be undertaken and in assigning weight to the medical evidence received.

c. When evaluating medical evidence to substantiate causal relationship, both during the adjudication process and then later during medical management, the following concepts should be considered.

(1) Aggravation occurs if a pre existing condition is worsened, either temporarily or permanently, by an injury arising in the course of employment.

(2) Temporary aggravation involves a limited period of medical treatment and/or disability, after which the employee returns to his/her previous physical status.

(3) Permanent aggravation occurs when a condition will persist indefinitely due to the effects of the employment related injury, or when a condition is materially worsened such that it will not revert to its previous level of severity. In order to establish that permanent aggravation has occurred in a physical disability case, there should be objective evidence of a physiological change in the claimant's pre-existing condition.

(4) Acceleration occurs when an employment-related injury or illness hastens the development of an underlying condition and the ordinary course of the disease does not account for the speed with which a condition develops.

(5) Precipitation means that a latent condition, which would not have become manifest but for the employment, occurs. Similar to a temporary aggravation, any ensuing episode of the disease would be considered work-related only if medical evidence supported such a continued relationship.

4. Sources of Medical Evidence. This paragraph describes some of the usual sources of medical evidence likely to be found in a case file.

a. While this list is not exhaustive, most medical evidence will fall into one of the following categories.

Attending Physician (AP). The claimant's AP is the primary source of medical evidence in most cases. That physician usually sees the claimant soon after the injury or the onset of symptoms. He or she may also be familiar with the claimant's medical history and therefore may know of any pre-existing condition which may be responsible for the symptoms, or which may have been aggravated by the incident or employment factor claimed.

District Medical Advisor (DMA). The DMA furnishes opinions, guidance and advice based upon review of the case file and familiarity with FECA requirements.

Second Opinion Specialist. At the request of the OWCP, a second opinion physician provides examination, indicated diagnostic testing, and rationalized medical opinion when a detailed, comprehensive report and opinion is needed from a specialist in the appropriate field.

Referee Specialist. Where the medical reports from the claimant and the medical reports from the OWCP-designated physician(s) are of equal but opposing value, 5 U.S.C. 8123(a) of the Act, as interpreted by the ECAB, requires an examination by a third physician who is termed a referee or impartial specialist. The referee or impartial specialist examines the claimant, arranges diagnostic tests, and furnishes rationalized medical opinion to resolve a conflict or disagreement between a claimant's physician and a physician designated by the OWCP (the DMA or a second opinion specialist) where the weight of medical evidence is equally balanced.

Clinical Psychologist. A clinical psychologist is considered a physician under section 8101(2) of the Act within the scope of his or her practice as defined by state law. The following criteria must be met: the individual is licensed or certified as a psychologist at the independent practice level of psychology by the state in which he or she practices; either possesses a doctoral degree in psychology from an educational institution accredited by an organization recognized by the Council on Post-Secondary Accreditation or is listed in a national register of health service providers in psychology which the Secretary of the Department of Labor deems appropriate; and possesses two years of supervised experience in health service, at least one year of which is post degree. See PM 3-100.

Chiropractor. Under section 8101(2) of the FECA, chiropractors are recognized as physicians only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.

Hospital or Emergency Facility. Hospital in-patient reports, such as the admission history and physician examination, the doctors' progress notes and the discharge summary, along with emergency and out-patient reports, are frequently valuable in documenting the time of injury and associated factual circumstances bearing on work-relatedness (from the date and time of admission and the history recorded), the nature and extent of injury, and the duration of disability anticipated.

Diagnostic Test Results. These include reports of x-rays, computerized axial tomography (CAT), magnetic resonance imaging (MRI), electrocardiograms (ECG or EKG), electroencephalograms (EEG), electromyograms (EMG), audiograms, treadmill stress tests, cardiac catheterization, intravenous pyelograms, and similar techniques of visualizing or recording physiological conditions.

Therapy Reports. While not useful for making adjudicatory or medical determinations in a case, therapy reports from physical and occupational therapy are useful for documenting treatment for a work related condition. See Jennifer L. Sharp, 48 ECAB 209 (1996) (physical therapists are not physicians as defined under the FECA; their reports, therefore, do not constitute competent medical evidence to support a claim).

Nurse Practitioner or Physician's Assistant. Treatment by an advanced practice nurse or a physician's assistant is payable as a medical expense under 5 U.S.C. 8103 of the Act. However, a report from an advanced practice nurse or a physician's assistant is not competent medical evidence to support a diagnosis, disability or need for additional medical treatment unless the report is co-signed by a physician.

Fitness for Duty Examinations Directed by the Employing Agency. A report from such a physician should receive due consideration; however, since the agency directed the examination, reliance upon the findings for case action must be tempered. If the findings or conclusions differ materially from those of the AP, the CE may consider further development, but the reports cannot be used as the basis for a formal reduction or termination of benefits. Also, under FECA procedures, such a report may not be used to create a conflict in medical evidence that requires resolution under 5 U.S.C. 8123(a).

b. Occasionally, other documentation is submitted to support a medical condition or causal relationship in a case, but it not considered to have any evidentiary value.

Internet articles, medical texts and excerpts from publications. These are of no value in establishing the necessary causal relationship between a claimed condition and employment factors because such materials are of general application and are not determinative of whether the specifically claimed condition is related to the particular employment factors alleged by the employee. See Dominic E. Coppo, 44 ECAB 484 (1993).

Findings of other agencies (such as the Social Security Administration or the Department of Veterans' Affairs). The ECAB has held that findings of other government agencies are not dispositive with regard to questions of disability arising under the FECA. See Dona M. Mahurin, 54 ECAB 309 (2003) and Daniel Deparini, 44 ECAB 657 (1993).

Evaluations from Social Workers. Social workers are not considered to be physicians under the Act. See Debbie J. Hobbs, 43 ECAB 135 (1991) and Jacqueline M. Johnson, Docket No. 98-2450 (issued March 9, 2000).

5. Content of a Medical Report. A medical report should ordinarily contain:

a. History. A medical opinion is only as good as the "frame of reference" on which it is based. It should be based on an adequate factual and medical background. In other words, the record should show whether the history obtained by the physician is substantially in accord with the facts of the accident or accepted employment conditions. For example, if the physician provides a history of sharp pain upon twisting the right knee when stepping from a curb and diagnoses a torn medial meniscus resulting from the twisting event, the medical opinion expressed is of diminished value if the facts surrounding the claim do not involve a twisting component but rather the sudden onset of pain while walking on even ground. Or, if a physician simply refers to the claimant having sustained an injury at work without identifying the cause or mechanism of injury, the physician's opinion relating a condition to an injury at work lacks probative value as there is no indication that the physician is basing the opinion on an accurate history.

However, sound judgment must be applied. For instance, if Form CA-1 shows concurrence of the employer with a report of an ankle injury due to falling off a ladder, and this history is repeated in the emergency room report of treatment soon after the time of injury, there is no need to question a subsequent report which fails to record the specific history.

b. Findings. The scope of findings needed in a case will vary based on the type of medical problem and the complexity of the case. Only minimal findings need to be reported for a traumatic amputation of a finger, but the physician should be required to set forth a detailed account of the findings where the nature of injury, causal relationship to employment, or extent of disability is not so apparent.

The three general classes of findings are:

- (1) Physical findings, which are noted by the physician's visual inspection, palpation and manipulation of the body. They include readings of temperature, pulse, respiration, blood pressure, range of motion, etc.
- (2) Laboratory findings such as blood tests, urine and tissue samples, etc.
- (3) Reports of a diagnostic procedure, such as an x-rays, MRI, EMG, etc.

Tests requiring cooperation by the patient, such as visual, hearing and pulmonary function tests, may be accompanied by a comment from the person administering the test regarding the extent of the patient's cooperation and the validity of the results. If a tester indicates that the patient exhibits poor effort or did not cooperate with testing in conjunction with a medical examination, a concerted lack of cooperation may be considered obstruction of a medical examination under 5 U.S.C. 8123(d). See paragraph 13 in this chapter.

To be acceptable as medical evidence, a laboratory test or diagnostic procedure should be performed by, or under the supervision of, a person licensed to perform it in the state or local jurisdiction where it was done. Reports of such tests and procedures should contain the patient's name, date of the test, the objective data obtained, and the name of the person responsible for performance of the test or procedure.

Where appropriate, reports should include the physician's interpretation of laboratory tests and diagnostic procedures. Tests for which such interpretation is necessary include, but are not limited to, x-rays, EKGs, EEGs, EMGs, MRIs, CAT scans, cardiac and pulmonary stress tests, pulmonary function tests, biopsy or surgical specimen pathology reports, ultrasound, visual field, echo cardiograms and intravenous pyelograms.

c. Medical Opinion with Rationale.

(1) Not all medical opinions require detailed rationale. In a simple traumatic injury such as slip or fall which is reported to and seen by the physician promptly, there is no need to obtain a "rationalized" explanation of causal relationship.

(2) When causal relationship is not obvious or when there may have been an intervening non-occupational cause, it is essential that the physician give his or her medical reasons for relating the condition to the history obtained. A rationalized opinion is also necessary, and should be requested, when disability appears to last beyond the time frame anticipated for an injury of the type accepted.

(3) A medical opinion couched in such terms as "might be," "could be," or "may be" does not have as much probative value as an opinion stated unequivocally or with reasonable medical certainty.

6. Weighing Medical Evidence. Weighing is the process of evaluating medical opinions to determine which has more probative value. When medical evidence is present from more than one source, as in most cases, this process consists of determining the relative value, or merit, of each medical opinion.

a. When evaluating the merit of a medical report, the ECAB has repeatedly stressed the importance of certain criteria. Based on these criteria, the CE should ask the following questions with regard to each report when weighing medical evidence:

(1) Is the opinion based on a complete, accurate, and consistent history covering both the medical and factual aspects of the case?

A medical opinion that takes into account the claimant's medical history, the relevant family medical history, non-work factors that could have led to the injury or disease, and a complete and consistent history of the incident or exposure or work factors alleged to be the cause of the injury or illness carries more weight than an opinion that has omissions, errors or inconsistencies in any of these areas.

For example, a physician may indicate that a torn cartilage is due to a work-related fall, in a situation where 10 days earlier the employee had developed knee pain after playing basketball off the job. In this situation, the physician's opinion relating the cartilage tear to the work injury, even with a medical explanation, will not have weight if the physician failed to note and discuss the pertinent history and the recent basketball incident.

An incomplete or inaccurate history reduces the probative value of a medical opinion. The lack of any history in a report also usually diminishes the value of the report. See Donney T. Drennon-Gala, 56 ECAB 469 (2005) (The ECAB held that the Board-certified psychiatrist's opinion was of diminished probative value as the report provided no history of any specific employment factors). When two physicians give reasoned but differing opinions concerning causal relationship and one physician's opinion is based on an inaccurate or incomplete factual or medical background, the opinion based on an accurate factual or medical history typically has more probative value. See Floyd Stilley, Docket No. 02-2016 (issued February 19, 2003) (The claimant's attending physician based his opinion on an inaccurate history, while the Office referral physician based his opinion on a thorough review of the factual and medical evidence of record, an accurate history of injury, and the results of objective testing. The ECAB held the weight of the medical opinion rested with the Office referral physician).

(2) Is the opinion well-reasoned and well-rationalized?

A rationalized opinion is of greater probative value than an opinion which is not rationalized. The physician should generally explain the basis for the opinion. This is of particular importance where the question involves a difficult medical problem, or where there is conflicting opinion. A

medical opinion consisting solely of a conclusive statement regarding disability, without supporting rationale, is of little probative value.

The terms "reasoned" or "rationalized" mean that the statements of the physician are supported by a medical explanation. In some situations, no explanation is required. For example, when an injury is incurred during the performance of duty, the claimant obtains prompt medical care, and the mechanism of injury is clearly sufficient to cause the claimed condition (e.g., a cervical sprain from a rear-end motor vehicle collision), a simple affirmative answer by the physician on the issue of causal relationship may suffice.

In most cases, however, medical rationale will be required. An occupational disease case or a traumatic injury case with pre-existing or subsequent injury to the same part of the body will require, in addition to the physician's affirmative opinion, an explanation of the causes of the condition claimed and a discussion of these factors in relation to the claimant's condition. This explanation and discussion are what constitute medical "reasoning" or "rationale." Sufficient objective data (findings on examination, test results, etc.) should be present so that a reviewer can determine on what specific evidence the medical conclusions were based.

A well-reasoned medical opinion should also be consistent with the findings upon examination. Findings may be noted during physical examination, laboratory testing, and diagnostic procedures. Sufficient objective data (findings on examination, test results) should be included in the report to support the medical conclusions. For example, a physician might state that a claimant has a back sprain causally related to a work injury that occurred ten years ago, without citing physical findings to support this conclusion. The physician explains that the claimant's injury is causally related to the past injury because prior to the incident the claimant had no complaints of back pain, whereas since the injury the claimant has continued to complain of back pain. An explanation such as this, not supported by physical findings, will not constitute a well-rationalized medical opinion.

A well-reasoned medical report sometimes contains citations from medical reference sources and other information to support the opinion.

(3) Does the physician have the expertise and credentials to provide medical opinion in this case?

The ECAB has held that a physician's qualifications may have a bearing on the probative value of his or her opinion. The opinions of physicians who have training and experience in a specialized medical field have greater probative value concerning medical questions pertaining to that field than the opinions of other physicians. See Lee R. Newberry, 34 ECAB 1294, 1299 (1983). Thus, the opinion of a specialist in the appropriate field of medicine often will carry more weight than the opinion of a non-specialist or a specialist in an unrelated field.

Various medical specialty boards exist, including the American Osteopathic Association (see PM 3-0500-7). Each Board conducts a certification program in an effort to ensure quality of medical services by adherence to standards of medical training and practice in the specialty. Although any licensed physician may limit his or her practice to a certain specialty, a Board-certified specialist has met the minimum standards of training and competency in the field as set by the

Board. Some medical boards also award certifications in subspecialties. For instance, a physician certified by the American Board of Internal Medicine may also be certified in a subspecialty such as cardiology. Board certification should not, however, be confused with Board eligibility, which means that a physician has completed the educational requirements for taking certification examinations but confers no special status.

The opinion of a Board-certified specialist in the appropriate field will usually carry more weight than that of a specialist who is not Board-certified or who is certified in an unrelated field. The opinion of a Board-certified specialist of professorial rank in a medical school or teaching hospital, or of a specialist who is an acknowledged expert or author on the specific medical problem, may carry added weight.

(4) Does the physician have enough knowledge about the employee to have arrived at a sound medical opinion?

A comprehensive report is one which reflects that all testing and analysis necessary to support the physician's final conclusions were performed. Generally, greater probative value is given to a medical opinion based on an actual examination. An opinion based on a cursory or incomplete examination will have less value compared to an opinion based on a more complete evaluation. The ECAB has remanded cases where a physician has indicated that further testing or evaluation is necessary to resolve an issue and the OWCP has not arranged for the required testing or evaluation. See Glenn P. Buckmann, Docket no. 96-356 (issued December 5, 1997).

Other things being equal, the probative value of an opinion increases when the physician reports specific detailed findings, based on a full and careful physical examination, x-ray studies, and appropriate laboratory and clinical tests. Opinions not supported by medical findings, or otherwise indicative of cursory examinations, carry little weight compared to opinions based on detailed examinations and findings. Furthermore, the opinions and conclusions reached by the physician should be consistent with the examination and test results.

In cases where the medical issue is the current extent of disability, the well-reasoned opinion of a well-qualified specialist who examined the claimant only once can weigh as heavily as, or even heavier than, that of a non-specialist who has seen the claimant regularly over time. If the specialist was provided with the appropriate medical records contained in the case as well as the Statement of Accepted Facts (SOAF), he or she will have a sufficient history to render a well-reasoned opinion regarding the extent of disability following his or her examination of the claimant.

(5) Is the medical opinion speculative or equivocal?

Medical opinions which are speculative or equivocal in character have little probative value. Opinions which can be characterized as equivocal, speculative or conjectural are those which contain language which is unclear or vague. Terms such as "could," "may," or "might be" indicate that the report is equivocal, speculative or conjectural and has less probative value compared to a positively expressed medical opinion.

The terms "probably" and "most likely" are less speculative and should be viewed in the context of the rest of the medical report and the factual evidence, since sometimes this could mean that the physician is expressing an opinion based on reasonable medical certainty, as opposed to absolute certainty. If the physician's meaning is in question, he or she should be asked to explain the basis for any doubt and to state with reasonable certainty whether or not the disability is related to employment.

b. After these criteria have been considered, the CE must determine to his or her satisfaction the merit of each opinion. The value of the evidence cannot be established by making a "checklist" or counting the "pros" and "cons" for each criterion. No individual factor standing alone necessarily determines the weight of medical evidence. Medical evidence is weighed on a case by case basis considering the specific evidence needed to resolve the medical issues in that particular case.

c. An example of weighing, in which two reports are submitted and both reports are from Board-certified orthopedists. Both physicians provided well-rationalized reports based on an accurate medical and factual background; however, they offer differing opinions regarding the extent of the claimant's disability. Although both physicians examined the claimant, one physician performed current diagnostic testing and referred the claimant for a functional capacity evaluation. Therefore, this physician was able to provide his opinion based upon the most current test results and findings. Based on the overall comparison of the reports, they may be equal in many aspects but the weight can be afforded to the physician who provided his reasoned opinion based upon the most current test results pertinent to the issue under review.

d. Weighing Medical Evidence in Formal Decisions. Section 8124 of the FECA provides that a finding of fact shall be made in determining an award for or against payment of compensation. Decisions that are based on medical evidence should contain an analysis of the relative merits of the pertinent medical evidence of record as it relates to the issue for determination in the decision. Weighing is a part of this process if conflicting reports are on file. This means that the CE should not only state that a particular piece of medical evidence constitutes the weight of that evidence, but also give the reasons for assigning that weight. For example:

(1) In a case where continuing benefits are denied on the basis of a report from a second opinion specialist, the CE may note that the second opinion specialist was Board-certified in the appropriate field of medicine, performed a full and complete evaluation, reviewed a current SOAF, and provided a rationalized medical opinion. The CE would contrast the second opinion report with the report of an AP, finding that the AP's supportive opinion on continuing disability was of diminished probative value compared to that of the second opinion physician, since the AP was not a specialist and did not provide detailed reasoning in support of his or her opinion. A CE should use discretion when finding that the weight of medical opinion rests with the second opinion examiner over the AP.

(2) In a case where a referee (impartial) medical evaluation was sought to resolve a true conflict in medical opinion, the explanation should identify the physicians whose reports are in conflict and the issue of disagreement, and may include reference to the provisions of 5 U.S.C. 8123(a) pursuant to which the referral to the impartial specialist was made. The CE may then make the

finding that because the opinion was thorough, unequivocal, rationalized and prepared by an appropriate Board-certified specialist, it should be afforded special weight. See James P. Roberts 31 ECAB 1010 (1980); R.C., 58 ECAB 238 (2006).

7. Requesting Information from the Attending Physician (AP). In all cases of serious injury or disease requiring hospital treatment or prolonged care, the CE should request detailed narrative reports from the AP at periodic intervals. The AP "will be asked to describe continuing medical treatment for the condition accepted by the OWCP, a prognosis, a description of work limitations, if any, and the physician's opinion as to the continuing causal relationship between the employee's condition and factors of his or her Federal employment." 20 CFR §10.332

a. The AP will be a primary source of contact for medical updates. At regular intervals, the AP should provide medical updates addressing the claimant's current condition and medical status, continuing causal relationship of the condition to employment, treatment plans, projected healing times, and work restrictions. Non-receipt of regular updates should usually prompt development for such information from the CE.

b. A request for medical information from the AP may be the most efficient and expeditious means to obtain a medical status update and address any unresolved medical issues. The CE must ensure, however, that the AP's reply is well-reasoned and responsive to the questions asked. The quality of AP reports will vary greatly. Sometimes reports are lacking in detail because the physician is unaware of the type of information required to meet OWCP standards in a given case. If reports from the AP lack needed details and opinion, or if the subjective complaints and time loss from work appear inconsistent with the objective findings and the claimant's diagnosis, the CE can write back to the physician, clearly state what is needed, and request a supplemental report. Development for a schedule award may also prompt an inquiry to the AP regarding the extent of permanent impairment and date of maximum medical improvement.

A copy of the CE's request to the physician should be sent to the claimant for informational purposes.

c. If a Field Nurse (FN) is involved in the case, the CE may confer with the nurse regarding specific questions to be asked, and may also ask the nurse to contact the AP to obtain the necessary information.

d. The lack of a well-reasoned or fully responsive reply may suggest that a referral to a DMA for clarification or a second opinion examination is warranted.

e. The time allowed for the AP's reply should be carefully monitored. If the reply is not received within the specified time frame (usually 30-45 days), or if the reply is equivocal, the CE should consider a second opinion.

8. Reviews by a District Medical Advisor (DMA).

a. The DMA's primary medical functions are evaluating medical evidence and interpreting physician reports. The CE seeks evaluation from the DMA in order to proceed with developing and weighing the medical evidence. The CE seeks interpretation from the DMA only where the medical evidence is complete and sufficient prior to such review. In either case, the comments or opinions of the DMA should be explained or rationalized.

b. The DMA's performance of these functions does not lessen the CE's responsibility in case management. The CE must always maintain responsibility for the case and should not consult the DMA to adjudicate claims or determine benefit entitlement, as these are primary functions of the CE.

c. The DMA has no authority to decide the facts in a case, as this is a function of the CE. However, the DMA may state whether an accepted incident was competent to produce the injury claimed. The DMA should be presented with the correct factual framework for the medical opinion requested. A SOAF is often the best avenue for conveying this information. Where the DMA finds that a determination pertinent to the medical opinion has been omitted, he or she should inform the CE of the additional factual information needed to place the case in posture for a rationalized medical opinion.

When referring a case to the DMA, the CE should submit medical questions which are case and issue specific.

d. The CE must utilize the DMA in the following circumstances:

(1) The CE is adjudicating a schedule award claim and requires a calculation of the percentage of impairment in order to establish the schedule award.

(2) The AP has requested authorization to perform a significant elective surgery (e.g., organ transplant, spinal surgery, joint replacement, chordotomy, rhizotomy, amputation, etc.). The CE may also refer the case to a second opinion specialist to determine whether the requested surgery should be approved. See Paragraph 10.

e. The CE may utilize the DMA in the medical management of a case in the following circumstances:

(1) The CE is uncertain about the accuracy of the AP's medical opinion, diagnosis of injury, or medical rationale. The CE may request the opinion of the DMA to determine whether the DMA agrees with the AP's opinion or deems it questionable.

(2) The AP certifies continuing disability without objective medical findings or sufficient rationale, and the CE believes that the physician's opinion may be unreasonable.

(3) The AP does not provide the CE an estimate of how long disability will continue. The CE may ask the DMA about the probable duration of disability in order to determine the next appropriate case management action.

(4) If the CE needs advice on unfamiliar or technical medical issues, the CE may ask the DMA to clarify those issues. For example, the CE may ask the DMA to discuss whether the tests performed by the physician are appropriate and whether the test results support the physician's opinion.

It must be noted that the DMA should be used only when the CE truly needs medical guidance to interpret the reports in file or to clarify a medical issue. If the CE can determine on his or her own that a discrepancy exists between the reported disability status and the physical findings, or between the nature of injury and the degree/duration of reported disability, other CE action may be appropriate (e.g., writing to the AP, arranging for a second opinion evaluation, etc.).

f. The ECAB has affirmed that a DMA may create a conflict in medical opinion necessitating a referee medical evaluation under the provisions of 5 U.S.C. 8123(a). See Harold Travis, 30 ECAB 1071 (1979). However, the CE should exercise discretion when concluding that the DMA opinion creates a conflict in medical opinion with the AP.

In order for the value of the referee opinion to be enhanced and based on an actual conflict in medical opinion, the referee should receive a DMA report containing a well-reasoned opinion of equal weight to the AP opinion that actually creates a conflict in medical opinion. For example, when asked whether work-related disability continues, the DMA's unexplained response "no" is not sufficient to create a conflict in medical opinion. In order for the DMA's opinion to be of equal weight with the treating physician's opinion and create an actual conflict, the DMA's opinion should be rationalized and based on a complete and accurate factual and medical history.

g. While the DMA may create a conflict in medical opinion, the DMA may not resolve it. Furthermore, the DMA's reasoned medical opinion will not usually constitute the weight of the medical evidence in an accepted disability case, even if the DMA is a Board-certified specialist in the appropriate field of medicine and the AP is not a specialist and offers no rationale, because the DMA has not examined the claimant and the AP has a critical function in determining extent and duration of injury-related disability.

h. The DMA may provide an opinion which is not strong enough to constitute a conflict with the opinion of the treating physician but which is nevertheless of sufficient value to warrant additional action. For instance, where an AP states that a claimant is still disabled from a work-related back strain six months post-injury, the DMA may state that a two-month recovery period should have been sufficient. In this instance, referral for a second opinion examination would be appropriate.

i. In a claim for a schedule award, if the medical evidence of record indicates maximum medical improvement has been reached and describes the permanent partial impairment of the affected member in accordance with the current edition of the AMA Guides to the Evaluation of Permanent Impairment, the case should be referred to the DMA for review.

The DMA should review the report to verify correct application of the AMA Guides and confirm the percentage of permanent impairment and the date maximum improvement was reached. The DMA should specify his or her reasons for assigning a certain percentage of loss of use to the measurements or factors provided. If the medical evidence does not contain the required elements for a schedule award impairment calculation, the CE should request such information from the AP prior to a DMA review. If the AP does not submit the requested information, the CE should obtain the evidence through a second opinion evaluation prior to a DMA review.

j. The DMA's opinion may constitute the weight of medical opinion in schedule award cases. If an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this 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.

As long as the DMA explains his or her opinion, shows values and computation of impairment based on the AMA Guides, and considers each of the reported findings of impairment, his or her opinion may constitute the weight. The CE must ensure, however, that the DMA properly considers all reported findings, gives rationale, and uses the AMA Guides correctly in computing the percentage. The DMA should also explain any difference between his or her findings and the findings of the AP report upon which the DMA is basing his or her opinion. This is necessary to determine whether weight can be assigned to the DMA or whether a conflict of medical opinion exists.

If the AP misapplied the AMA Guides, no conflict would exist because the AP report would have diminished probative value and the DMA's opinion would constitute the weight of medical opinion. However, if the DMA and the AP disagreed on, for instance, the level of impairment in a sliding scale, this could constitute a conflict of medical opinion.

k. If a case has been referred for a referee evaluation to resolve the issue of permanent impairment, it is appropriate for the DMA to review the calculations to ensure the referee physician appropriately used the AMA Guides. However, the ECAB has held that while an Office medical advisor may review the opinion of a referee specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility. The DMA cannot resolve a conflict in medical opinion. If necessary, clarification to the referee examiner may be needed. See Richard R. Lemay, 56 ECAB 341 (2005).

Also, where a referee examination is arranged to resolve a conflict created between a claimant's physician and an Office DMA with respect to a schedule award issue, the same DMA should not review the referee's report for proper application of the AMA Guides.

9. Second Opinion Examinations.

a. The decision to refer a case for a second opinion examination rests with the CE, though such an exam may be recommended by a FN or DMA, or requested by the employing agency. A fitness for duty examination directed by the employing agency may not be considered a second

opinion examination; however, if the findings or conclusions of such an exam differ materially from those of the AP, the CE may consider a second opinion referral.

A second opinion specialist should be selected who is administratively qualified, as discussed in FECA PM 3-0500. Second opinion examinations are generally conducted by a physician selected by a medical referral group that has contracted with the OWCP to provide second opinion medical referrals. The methods for selecting second opinion physicians are more flexible, since a strict rotation of physicians is not required for this type of examination.

The second opinion specialist should be provided with:

- (1) A statement of accepted facts (SOAF);
- (2) A list of pertinent questions or issues to be addressed;
- (3) Copies of medical records from the case file based on the age of the case and/or the nature of the referral as follows:
 - (a) For unadjudicated case referrals and all referrals for medical management, disability management or surgery:
 - (i) All operative reports regardless of age;
 - (ii) All diagnostic tests regardless of age;
 - (iii) All medical records from any qualified physician as defined in 5 U.S.C. 8101(2) authored within three years of the date of the second opinion referral.
 - (b) For schedule award referrals:
 - (i) All operative reports regardless of age;
 - (ii) All diagnostic tests regardless of age;
 - (iii) All medical records from any qualified physician as defined in 5 U.S.C. 8101(2) that address permanent partial impairment and maximum medical improvement; and
 - (iv) The most current comprehensive medical narrative report from a qualified physician as defined in 5 U.S.C. 8101(2).

If the CE determines in the exercise of his or her judgment that the unique circumstances of a case file require deviation from these requirements in order to assist the physician in rendering a rationalized medical opinion based on an adequate medical background, the CE should document such circumstances and the specific deviations/changes in a Memorandum to the File to be made part of the case record. An example of a situation where inclusion of additional medicals might be appropriate would be in a complex catastrophic case with numerous accepted conditions.

(4) If a medical report has been excluded from the case record, it should be omitted from the medical evidence sent to the second opinion specialist. See PM 2-0810.12.

b. The CE should refer a claim to a second opinion specialist in the following circumstances:

(1) The CE has gathered all the medical information and evidence from the AP and does not have enough evidence about a diagnosis or an adequately reasoned opinion about causal relationship to accept the case, but does have sufficient evidence to suggest that the claimant might be entitled to benefits.

(2) The AP's examinations and reports in occupational disease cases do not provide the specific evidence that the OWCP requires for adjudication. The primary examples include hearing loss and asbestosis claims requiring examination in compliance with the specifications outlined in FECA PM 3-0600, or an emotional injury case where a compensable factor of employment is identified.

(3) Temporary total disability (TTD) has gone on longer than usual in a case, and the AP is not an appropriate specialist or has not satisfactorily explained the reason for the continued disability or why the disability is causally related to the original work injury.

(4) The CE has reason to believe that a claimant is no longer disabled due to the accepted work injury, or no longer has objective residuals of the accepted injury, but the AP maintains that the claimant has residuals or disability from the work injury and does not submit sufficient medical rationale to support that opinion.

(5) The AP cannot or will not send an acceptable permanent impairment evaluation based on the AMA Guides. If the AP has submitted an examination report which outlines medical findings and calculates a percentage of impairment based on the appropriate version of the AMA Guides, the CE should submit the AP's report to the DMA for the schedule award calculation and forego referring the claimant to a second opinion specialist for the same purpose.

(6) Following a consult or referral with the DMA, the DMA indicates that the file does not contain sufficient medical evidence to make a decision on the medical issue or provide a rating of impairment. In such cases, the DMA may recommend referring the case to a second opinion specialist.

c. The second opinion examination should constitute a complete evaluation of the claimant. The specialist should be asked to submit a report which includes a history of injury, a description of objective findings found on examination, the claimant's subjective complaints, and the results of diagnostic tests. Depending on the circumstances of the case, the specialist may also be asked to provide identification of any underlying or pre-existing condition(s); a diagnosis; a prognosis; the recommended course of treatment to be followed; any medically warranted restrictions or limitations (using Form OWCP-5); discussion of whether the work restrictions are due to work-related or non-industrial condition(s); a clinical estimate of the date of partial and/or full recovery; and/or a rationalized opinion on whether the claimant has objective residuals and/or

disability from the work-related condition. Any other specific issues raised by the CE should also be addressed.

d. If the case has not yet been accepted and causal relationship is at issue, the specialist should be asked for an opinion with medical rationale which confirms or negates a causal relationship between any condition found and the accepted incident or accepted factors of employment. The specialist should be instructed to use the SOAF as the factual background for the accepted employment incident or factors.

e. In cases involving a pre-existing or underlying condition, the specialist should be asked to provide a rationalized opinion as to whether the pre-existing or underlying condition was aggravated by the employment incident or factors and, if so, whether the aggravation was temporary or permanent. If temporary, the specialist should also state when the aggravation ceased or can be expected to cease. Depending on the case, acceleration or precipitation may also be at issue. See paragraph 3 in this chapter for an explanation of these terms.

f. The information described above should give the CE a clear picture of the nature and extent of the claimant's disability and its relationship to the accepted condition(s). It should also allow the CE to determine the next logical intervention in the case.

g. If a surveillance video of a claimant has been submitted by the employing agency (EA) or an investigative agency, and the CE has determined that this evidence should be incorporated as part of the case record and is germane to issues being addressed by the second opinion specialist, the CE should direct the specialist to review the video evidence and reference it in his or her report. Should the video evidence be submitted directly to the specialist prior to CE review, the CE should request a copy of the video from the EA; if the EA does not provide the video to the OWCP, the CE should direct the specialist to disregard the video evidence.

Once a surveillance video is provided to the OWCP with a request that it be used in the management of the case, it becomes part of the official case record and a copy will be released to the claimant, if he or she requests it, just like any other portion of the case record. The ECAB held in J.M., 58 ECAB 478 (2007), that the OWCP has the responsibility to make the claimant aware that it is providing surveillance video evidence to a medical expert. If the claimant requests a copy of the surveillance video, one should be made available, and the claimant given a reasonable opportunity to offer any comment or explanation regarding the accuracy of the recording.

h. The CE should not generally refer second opinion examination reports to the DMA for review unless the DMA is calculating a schedule award and requires the report to determine the impairment rating. A second opinion report may also be referred to the DMA by the CE if guidance is needed with regard to a specific medical issue.

i. The findings or opinions of a second opinion physician may differ from those of the claimant's AP. If of equal weight, the differing opinions would constitute a conflict requiring referral to a referee physician. This is a time-consuming process, however, which is not always necessary.

Often a decision can be reached by weighing the medical evidence of record without referral to a referee specialist.

While every case must be reviewed individually, the following are examples of situations in which differences of opinion may be resolved without a referee examination:

(1) The AP (a general practitioner) and the second opinion physician (a Board-certified specialist in the appropriate specialty) differ with respect to an issue such as diagnosis or causal relationship. With all other factors in their medical reports being equal, the opinion of the physician who has training, knowledge, and Board-certification in a specialized medical field related to the claimant's specific injury would usually have greater probative value concerning medical questions pertaining to that field than the opinions of other physicians. In determining the weight of medical opinion, the CE should ensure that all factors in both medical reports are in fact equal prior to assigning the weight to a physician based on medical specialization alone.

(2) The opinions of the AP and the second opinion physician, both Board-certified specialists, differ on an issue such as causal relationship or the nature and extent of work limitations. However, the opinion of one physician is speculative, equivocal, and/or not rationalized, while the opinion of the other physician is supported by objective findings and is fully rationalized. Medical conclusions unsupported by rationale are of diminished probative value.

j. If the second opinion specialist submits an opinion which is equivocal, lacks rationale, or fails to address the specified medical issues, the CE should seek clarification or further rationale from that physician. When the OWCP undertakes to develop the evidence by referring the case to an Office-selected physician, it has an obligation to seek clarification from its physician upon receiving a report that did not adequately address the issues that the OWCP sought to develop. As such, the CE should seek clarification from the referral physician and request a supplemental report to clarify specifically-noted discrepancies or inadequacies in the initial second opinion report.

Only if the second opinion physician does not respond, or does not provide a sufficient response after being asked, should the CE request scheduling with another physician.

10. Obtaining Second Opinions for Surgery. In some instances, the CE may find it necessary to obtain a second opinion prior to authorizing surgery.

a. Emergency surgery may be defined as any procedure which needs to be performed promptly after the onset of a condition or injury in order to preserve life or function of an organ or body part. For emergency surgery, no prior authorization by the Office is required.

b. Elective (or non-emergency) surgery may be defined as any procedure which is necessary for the adequate or normal function of an organ or body part, but which does not need to be performed promptly after the onset of the condition in order to achieve its purpose. Prior authorization is required for all elective surgery.

When requesting authorization, the following minimum documentation should be submitted: the name of the surgical procedure; diagnosis of the specific condition(s) which will be treated by the surgery; and the reason surgery is needed for the work-related condition. Any ambiguity or omission in a request for surgery should be resolved by the CE, usually via a written request unless the omission is a simple matter than can be clarified via telephone. If the CE does contact the physician by telephone, a summary of the conversation should be captured on a CA-110 and placed into the case file.

c. When authorization is requested for certain types of elective surgery, the CE must obtain an opinion from the DMA or a second opinion specialist concerning the need for the procedure. The elective surgical procedures involved are: spinal surgery, joint replacements, organ transplants, destructive procedures (e.g., chordotomy, rhizotomy, or amputation of a body part) and experimental surgical procedures.

d. In cases involving spinal surgery, the CE should obtain the minimum documentation described in paragraph 10(b) above and send the case file to the DMA. The DMA will evaluate the request for surgery on the basis of the written record and should provide a rationalized opinion concerning the need for the surgical procedure.

(1) The following guidelines should be used during this evaluation:

(a) The surgical procedure must be related to the claimant's accepted work-related condition.

(b) The history, physical examination, and/or results of pertinent diagnostic tests should support a specific diagnosis.

(c) The medical reports must adequately describe the clinical history and severity of the condition, the results of the physical examination of the claimant, and the results of pertinent diagnostic tests. The presence or absence of complications should also be described.

(d) As appropriate, an adequate trial of conservative treatment should have been attempted prior to the decision to perform surgery.

(e) The diagnosed condition should warrant surgical intervention according to current medical concepts, and the proposed surgical procedure is within the realm of accepted medical practice.

(2) If the DMA agrees that surgery is warranted, it can be authorized.

(3) If the DMA's opinion is equivocal or negative, or if it indicates the need for clinical data not present in the file, the CE may choose to prepare the file for a second opinion examination. The CE may alternatively choose to ask the AP to submit a report which includes the required clinical data so that the DMA may formulate an opinion on the medical necessity for surgery. Upon receipt of the AP's report, the CE should resubmit the case record to the DMA for comment.

(4) If a second opinion examination is arranged, the usual procedures for notifying the claimant of the second opinion examination should be followed. The Office may also provide the claimant

and the AP with a copy of the DMA's opinion which prompted the need for the second opinion examination.

The second opinion physician should provide a report which contains a clinical history, results of a physical examination, results of any diagnostic tests performed, and a reasoned opinion regarding the appropriateness of the proposed surgery and its relationship to the accepted work condition. The physician should use the SOAF provided by the CE as the framework for his or her responses.

(5) If the second opinion physician agrees that surgery is warranted, it can be authorized.

(6) If the second opinion physician does not concur that surgery is warranted, and the CE finds that the opinions of the second opinion specialist and AP are of equal weight after carefully weighing the medical evidence, the case should be referred to a referee medical specialist to resolve the conflict of medical opinion with respect to the surgery request.

If however, the CE finds that the second opinion physician's report holds the weight of medical evidence and supports that surgery is not warranted, the CE should issue a formal decision denying authorization for the surgery, explaining the basis for denial and providing a copy of the specialist's report. The CE should use prudence in assigning the weight of medical opinion to the second opinion specialist in this circumstance.

(7) Even if payment for surgery is denied, compensation for disability resulting from the surgery is payable in cases where the claimant was disabled for work (due to the work injury) prior to the surgery. Such payment may be made regardless of any indications that the period of disability would have been shorter without surgery. In addition, continuing medical care after discharge from the hospital should be authorized just as it would have been if surgery had not been at issue.

e. In cases involving organ transplants or destructive procedures, the CE should obtain the minimum documentation described in paragraph 10(b) above and send the case file to the DMA. The DMA will evaluate the request for surgery on the basis of the written record and should provide a rationalized opinion concerning the need for the surgical procedure. In many instances, though, the Office will ultimately need to arrange for a second opinion examination to evaluate the request for surgery.

The same sequence of events outlined for spinal surgery applies for these surgical procedures as well. In some instances, though, evaluation of the case record alone may be preferable, and this is acceptable.

f. Where the claimant fails to request prior authorization for surgery, the CE should instruct the claimant to submit the minimum documentation (described in paragraph 10(b) above) from the AP, as well as a copy of the operative report. The CE should then refer the case for an evaluation of the written record by the DMA. Should the DMA conclude that surgery was unnecessary, a referee examination of the case record only will be arranged. A second opinion examination should not be requested under these circumstances, since a physical evaluation after the surgery was performed would have limited value.

Based on the results of this evaluation, the cost of surgery will be reimbursed or a formal decision will be issued denying payment for the surgery. Any such decision should address only the surgical bills, including hospitalization expenses, anesthesiologist's fees, etc. In cases where the claimant was disabled for work prior to the surgery, payment of compensation for disability will not be affected by the decision to deny payment for surgery, and continuing medical care after discharge from the hospital should be authorized just as it would have been if surgery had not been at issue.

g. If the claim has not been adjudicated when authorization for surgery is requested, the CE should advise the claimant and the AP that the OWCP cannot consider a request for surgery before the case is adjudicated; however, the request will be evaluated if the case is accepted. The procedure described in the preceding paragraph will be applied in making such determinations.

h. Where the claimant requests exemption from the requirement that he or she undergo a second opinion examination because of severe pain or inability to travel great distances, the CE should request a report from the AP which substantiates why the claimant's medical condition precludes the claimant from traveling to or attending the second opinion examination. If the physician's rationale is deemed reasonable, the CE may permit the claimant to forego the second opinion examination. If the AP's opinion is unclear or unsubstantiated, the CE may send the report to the DMA and ask for an opinion on the reasonableness of the exemption request. If an exemption is granted, the CE will so advise the claimant and AP in writing.

If the exemption request is denied, the CE shall inform the claimant and AP in writing. The CE will also instruct the claimant to attend the scheduled medical appointment and advise the claimant that benefits may be suspended for failure to attend the examination. If the claimant does not report for the scheduled appointment, the claimant's entitlement to benefits may be suspended under 5 U.S.C. 8123(d). See paragraph 13 of this chapter.

11. Referee Specialist Examinations.

a. The authority for referee medical examinations is found at 5 U.S.C. 8123(a), which states in pertinent part, "if there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination." Because this method of resolving conflicts is provided in the FECA, the probative value of the referee specialist's report is great and will normally constitute the weight of the medical evidence of record. In Albert J. Scione, 36 ECAB 717 (1985), the ECAB held that a conflict in medical opinion under 5 U.S.C. 8123(a) cannot occur between two attending physicians, nor can a conflict of medical opinion occur between two DMA's or two second opinion specialists.

b. Prior to referring the case for a referee examination, a conflict of medical opinion must actually exist as determined by weighing the medical evidence. The CE must decide the relative value of opposing opinions in the medical record, giving consideration to all factors of physician specialty and qualifications, completeness and comprehensiveness of evaluations, and rationale and consistency of opinions.

It may be, as in the case of Jordan M. Carter, 32 ECAB 856 (1981), that no conflict in medical opinion truly exists and, if so, merely declaring a conflict and referring the claimant and the case record out for a supposed impartial examination will not afford that physician's opinion any special weight. However, if a significantly greater weight cannot be assigned by the CE to one opinion, then it is proper to determine that a conflict in medical opinion exists and that a referee medical examination is appropriate.

An agency sponsored fitness for duty examination cannot be considered a second opinion for purposes of creating a conflict in medical evidence.

c. Once a decision has been made to refer a case for a referee examination, a physician should be selected as discussed in FECA PM 3-0500. The referee physician should be provided with a SOAF and a list of pertinent questions or issues to be addressed, which should include a statement outlining the conflict(s) for resolution in the case. The referee physician should also receive a copy of the entire case record.

Surveillance video evidence may also be sent to a referee physician. In such cases, the Office should notify the claimant that it is doing so. See J.M., 58 ECAB 478 (2007). If the claimant requests a copy of the surveillance video, one should be made available, and the claimant given a reasonable opportunity to offer any comment or explanation regarding the accuracy of the recording.

d. Upon review of the referee physician's report, the CE should consider the following:

(1) A conflict of medical opinion relates to an issue and not to a case. A case is referred to a referee based on a conflict of opinion regarding certain issue(s). While the referee's report may constitute weight on the specified issue(s) based on the authority in 5 U.S.C. 8123(a), opinions expressed with regard to other issues do not necessarily hold weight by mere virtue of the physician being designated as a referee. A CE may still make a finding that the referee holds weight on other issues, beyond the conflict, but that finding may not be made based on the designation as a referee.

(2) The referee specialist's report must actually fulfill the purpose for which it was intended; it must resolve the conflict in medical opinion. The ECAB has stated, "an impartial specialist's report is entitled to greater weight than other evidence of record as long as his conclusion is not vague, speculative or equivocal and is supported by substantial medical reasoning." See James P. Roberts, 31 ECAB 1010 (1980).

Therefore, the CE should ensure that the referee specialist's report is comprehensive, clear and definite, and that it is based on current information and supported by substantial medical reasoning, as well as a review of the case file. See Billie M. Gentry, 38 ECAB 498 (1987). If the report is vague, speculative, incomplete or not rationalized, it is the responsibility of the CE to secure a supplemental report from the referee specialist to correct the defect.

e. If the referee specialist submits an opinion which is equivocal, lacks rationale, or fails to address the specified medical issues or conflict, the CE should seek clarification or further

rationale from that physician. When the OWCP undertakes to develop the evidence by referring the case to an Office-selected physician, it has an obligation to seek clarification from that physician upon receiving a report that did not adequately address the issues that the Office sought to develop. As such, the CE should seek clarification from the referee physician and request a supplemental report to clarify specifically noted discrepancies or inadequacies in the initial report.

Only if the referee physician does not respond, or does not provide a sufficient response after being asked, should the CE request a new referee examination.

f. Cases returned from a referee medical examiner should not routinely be sent to the DMA for review unless a schedule award is at issue. Where a referee examination was arranged to resolve a conflict created by a DMA with respect to a schedule award issue, that same DMA should not review the referee specialist's report. Instead, another DMA or office medical consultant should review the file. See John W. Slonaker, 35 ECAB 997 (1984).

12. Exclusion of Medical Evidence. In the cases of Carlton L. Owens, 36 ECAB 608 (1985); Aubrey Belnavis, 37 ECAB 206 (1985); and George W. Coast, 36 ECAB 600 (1985), the ECAB established criteria for excluding improperly obtained medical reports from the case record. The purpose of this paragraph is to describe these criteria and the actions which should be taken with respect to reports which must be excluded from the case record.

a. Improper Contact. The Board has required exclusion of medical reports if:

(1) The physician selected for referee examination is regularly involved in performing fitness for duty examinations for the claimant's employing agency. While such physicians may not be used as medical referees, they may be used as second opinion specialists.

(2) A second referee specialist's report is requested before the OWCP has attempted to clarify the original referee specialist's report. Only if the selected physician fails to provide an adequate and clear response after a specific request for clarification may the OWCP seek a second referee specialist's opinion.

(3) A referee medical report is obtained through telephone contact with the physician or submitted as a result of such contact. The CE must refrain from verbal contact to discuss any substantive issue in the case with a physician who has been engaged to provide a referee opinion. All such communication should be in writing.

(4) A medical report is obtained as a result of "leading questions" to the physician in a referee context.

(5) If a surveillance video is provided by the EA directly to a medical specialist acting in the capacity of a referee physician, the CE should advise the EA that the physician's opinion has been tainted and will be excluded from consideration in the Office's decision. If there is convincing evidence that the surveillance video is vital to the case and should be used, the CE

should direct the EA to provide the OWCP with a copy of the surveillance video to be used in conjunction with a referral to a new referee specialist.

b. Annotating the File. A CE who identifies medical evidence which was obtained improperly should annotate the file so that the referee examination and all accompanying medical reports from the case record are excluded from consideration.

A memorandum for the file must be prepared explaining why the report is excluded from consideration. The referee report, and any clarification reports, should then be deleted and combined with this exclusion memorandum. The exclusion memorandum should be the first page of the combined document. The date of the memorandum will serve as both the author date and received date of this combined document, and it should be indexed in the imaged file as MISC/Memo to File rather than Medical evidence. (Prior to the advent of imaging case documents, the pages of an excluded medical report were stapled together, with the word "Excluded" and the date written across the front of the report.)

It is not necessary or desirable to remove an excluded report from the case record, nor is it necessary to expunge all mention of an excluded report from factual summaries, formal decisions, and other documents contained in the file. Letters to any physician who is sent the entire case record should instruct the physician to disregard the excluded report, and such reports should be omitted from copies of medical evidence sent to second opinion specialists.

13. Suspension of Benefits. This paragraph describes the circumstances under which benefits may be suspended for obstruction of or failure to undergo a medical examination as directed by the OWCP.

a. Legal Provisions. Section 5 U.S.C. 8123(d) states, "if an employee refuses to submit to or obstructs an examination, his right to compensation under this subchapter is suspended until the refusal or obstruction stops. Compensation is not payable while a refusal or obstruction continues, and the period of refusal or obstruction is deducted from the period for which compensation is paid."

In accordance with 20 C.F.R. §10.323, the actions of an employee's representative will be considered the actions of the employee for the purpose of determining whether a claimant refused to submit to, or in any way obstructed, an examination required by the OWCP.

b. To invoke this provision of the law, the CE must ensure that the claimant has been properly notified of his or her responsibilities with respect to the medical examination scheduled.

Once a medical appointment has been scheduled, the claimant and representative, if any, must be notified in writing of the name and address of the physician to whom he or she is being referred, as well as the date and time of the appointment. The notification of the appointment must contain a warning that benefits may be suspended under 5 U.S.C. 8123(d) for failure to report for examination. The claimant must have an opportunity to present any objections to the Office's choice of physician, or for failure to appear for the examination, before the CE acts to suspend compensation.

c. Follow-up Action. If no medical report is received within 30 days of the date of the appointment arranged by the Office, the OWCP should follow up to determine the status of the report. The CE may follow up sooner than 30 days to determine whether the claimant attended the appointment as scheduled. No discussion of the case should take place at the time of this inquiry.

If the claimant reported for examination, the OWCP should inquire when the report may be expected.

d. Failure to Appear and Obstruction. If the claimant does not report for a scheduled appointment or obstructs an examination, he or she should be asked in writing to provide an explanation within 14 days.

The Board has held that the OWCP has properly suspended entitlement to compensation in accordance with 5 U.S.C. § 8123(d) for failing to appear for the scheduled appointment.

The OWCP properly notified the appellant that he was scheduled for a second opinion examination. The appellant was appropriately informed of his obligations to attend and cooperate with the examination. The notice clearly explained that the appellant's compensation benefits would be suspended for failure to report to, or for obstruction of, the examination. The appellant was also provided the date, time, and location of the appointment. The appellant did not appear for the appointment, nor did he attempt to reschedule the appointment prior to the designated time. The OWCP provided the appellant 14 days to submit a valid reason for his failure to attend the scheduled medical appointment, but no response was received. As a result, the Board found that the appellant had not established good cause for failing to appear for the scheduled examination. The OWCP properly determined that the appellant failed to attend a scheduled medical examination without good cause and suspended his wage-loss compensation and medical benefits. *G.R.*, Docket No. 20-0915 (issued January 29, 2021).

The Board has also held that the OWCP did not properly suspend compensation in accordance with 5 U.S.C. § 8123(d) because it did not follow established procedure (such as not providing the required 14-day notice following a missed appointment, suspending compensation before the expiration of the 14-day period, or suspending compensation prior to allowing the claimant to attend a rescheduled second opinion examination). *See L.C.*, Docket No. 11-1344 (issued Dec. 16, 2011).

If the claimant does appear for the appointment, but obstructs the examination, a sanction may also be appropriate. Some examples of obstructing an examination include (1) engaging in hostile or threatening behavior before, during, or after an examination; (2) refusing to complete, or fraudulently completing, any necessary paperwork required by the examining physician; and (3) refusing to cooperate with the examining physician who is attempting to complete a clinical history and/or physician examination. These are just examples, and any behavior that obstructs the ability of the physician to conduct the examination can result in the suspension of compensation.

(1) Engaging in Hostile or Threatening Behavior. Engaging in hostile or threatening behavior before, during, or after a scheduled medical examination is considered obstruction of the examination. The behavior can be in person, verbal, or in writing.

The Board has held that the OWCP has properly suspended entitlement to compensation in accordance with 5 U.S.C. § 8123(d) for threatening behavior.

The appellant appeared late at the IME's office and was in a very agitated state. He notified the office staff that he was carrying a handgun. The record contains statements that the appellant was "verbally angry and loud" in the lobby, and continued in the same frame of mind when he met with the physician who noted that he had concerns for his own safety and that of his staff. As a result, he did not feel it was safe to proceed with the examination. The Board found that from the time that he appeared for his scheduled appointment, the appellant was uncooperative and threatening in his demeanor with the physician and his staff. It was not reasonable to expect the physician to proceed with the examination of the appellant due to his agitated and threatening state, and his argument regarding his right to carry a handgun into a medical examination. In these circumstances, the OWCP properly suspended appellant's compensation under 5 U.S.C. § 8123(d) for his obstruction of the examination. *J.J.*, Docket No. 11-693 (issued November 1, 2011).

(2) Refusing to Complete, or Fraudulently Completing, Necessary Paperwork. As part of a scheduled medical examination, the claimant must complete any necessary paperwork, including intake documentation, completely and truthfully.

The Board has held that the OWCP has properly suspended entitlement to compensation in accordance with 5 U.S.C. § 8123(d) for not cooperating with the examination by not properly completing paperwork.

The appellant appeared for the scheduled examination, but refused to sign the intake documentation. As a result, the examination was not conducted. The Board found that the appellant's refusal to follow standard intake procedures constituted obstruction of an OWCP-directed medical examination. The appellant's disagreement with the physician's routine business practices, and her feeling that other procedures should have been followed, do not constitute good cause for her failure to cooperate. *K.H.*, Docket No. 14-1611 (issued January 7, 2015).

(3) Refusing to Cooperate with the Examining Physician while Attempting to Complete a Clinical History and/or Physical Examination. The claimant must provide full cooperation with all elements of the scheduled medical examination. This includes providing a truthful and complete medical history, participating in any testing and evaluations, and the claimant must put forth full effort in all aspects of the examination.

The Board has held that the OWCP has properly suspended entitlement to compensation in accordance with 5 U.S.C. § 8123(d) for not cooperating with all aspects of the examination.

In *P.B.*, the ECAB noted that the use of the § 8123(d) penalty provision was proper when the appellant refused to fully participate with physical testing and refused to answer questions. Docket 17-1426 (issued June 19, 2018).

In *M.T.*, the ECAB held that while the appellant attended the medical examination, her failure to schedule and appear for follow-up diagnostic tests necessary for the physician to make a final determination constituted obstruction. Docket 18-1675 (issued March 8, 2019).

However, prior to sanctioning the claimant for failing to cooperate with the physician while obtaining a clinical history and/or performing a physical examination or requested evaluations, the CE should seek clarification from a district medical advisor (DMA) to review the totality of the medical documentation and provide a rationalized explanation as to whether the noncooperation was sufficiently detrimental to the outcome of the examination to reasonably be considered obstruction.

However, in determining whether an individual was being obstructive in cases affected by the above circumstances or similar, a CE shall not be bound to accept the conclusion of obstruction where there is sufficient evidence that the claimant's failure to demonstrate full effort is the result of "exceptional circumstances." Exceptional circumstances may exist where there is other evidence of an impairment or of objective pain limitation that might justify a failure to exhibit full effort. For example in *M.A.*, the ECAB determined the OWCP's finding that appellant obstructed the medical examination was unreasonable due to the exceptional circumstances. No. 20-0317 (issued October 9, 2020). Specifically, it noted that the appellant's caregiver had to assist the physician to lift her out of a wheelchair and onto the examination table, she could barely maneuver or function, and suffered cognitive issues. *Id.*

e. If good cause is not established, entitlement to compensation should be suspended in accordance with 5 U.S.C. 8123(d). Benefits should be suspended as of the date of the decision until the date on which claimant agrees to attend the examination. Such agreement to attend the evaluation may be expressed in writing or by telephone (documented on Form CA-110). When the claimant actually reports for examination, payment retroactive to the date on which the claimant agreed to attend the examination may be made.

The claimant's statement that he or she will not appear for an examination is not sufficient to invoke the penalty (Leanna Garlington, 37 ECAB 849 (1986)). Refusal to schedule an examination at the direction of the office is also insufficient to invoke section 8123(d) of the FECA (Herbert L. Dazey, 41 ECAB 271 (1989)).

14. Authorizing Medical Treatment and Care. Section 8103 of the FECA states, "The United States shall furnish to an employee who is injured while in the performance of duty, the services, appliances, and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of the monthly compensation." The ECAB has recognized the OWCP's broad discretion in approving services provided under section 8103, with the only limitation on the OWCP's authority being that of reasonableness. See D.K., 59

ECAB ____ (Docket No. 07-1441, issued October 22, 2007); Lecil E. Stevens, 49 ECAB 673, 675 (1998).

Authorization is requested for a wide variety of medical treatment and equipment; where the need for a particular treatment or type of equipment is well established, expedited approval may be granted.

When needed, though, the CE should develop and evaluate the information from the claimant, AP, service or equipment provider, and (if applicable) the FN or RC assigned to the case. This section describes general authorization procedures. More specific information pertaining to the authorization of diagnostic testing, functional capacity evaluations, special equipment and furniture, health facility memberships, physical therapy, and chiropractic treatment can be found later in this chapter. Part 3 of the PM also discusses medical treatment in detail.

Vehicle and housing modifications are addressed in PM Chapter 2-1800. Transfer or termination of authorization for medical care is discussed in PM Chapter 3-0300.

a. When a request for authorization is received, the CE should review the case for the following information:

- (1) A description of the specific test, equipment, service, treatment, and/or facilities needed to address effects of the work-related injury or condition.
- (2) Identification of the supplier or provider. The supplier's or provider's contact information is needed. The location of a facility or provider and its proximity to the claimant's home or work may be an important factor.
- (3) The anticipated timing, frequency and/or duration for which authorization is requested should be specified.
- (4) A statement of medical necessity from the treating physician is needed. The physician's opinion on necessity is to be supported by rationale. The physician's rationale is to include an explanation as to how authorization is expected to be effective in treating the accepted condition. The diagnosis for which the authorization is requested must be identified (if not obvious). The type of request will dictate how much rationale is needed. For instance a request for an MRI for an accepted herniated disc requires little rationale, while a request for health club facility membership for a rotator cuff injury would require a more detailed explanation.

b. Development of a request for authorization. Upon receipt, the CE should evaluate the information from the physician, claimant, service/equipment provider, and (if appropriate) FN or RC. If the information received is incomplete or if doubt exists as to the appropriateness or need for the authorization requested, the CE may:

- (1) Request clarification from the AP.
- (2) Request an opinion on necessity from the DMA.

(3) Obtain a second opinion medical examination.

(4) Obtain a referee physician's opinion to resolve any conflict over necessity.

If a second opinion or referee examination is required to establish the need for any authorization, the CE should refer the claimant to a specialist conversant with the issue for determination.

c. If, after any necessary development, the weight of medical evidence does not support authorization for the request, the claimant should be sent written notification and advised of the reasons why authorization is not being given along with any alternatives which can be considered. If requested, the CE should provide a formal decision with appeal rights. Copies of a non-authorization letter by the CE or a formal decision should also be sent to the employing agency and to the AP, as necessary.

A pre-termination notice is not required if the claimant was notified of a specific period of authorization and any specified period of extension. In this circumstance, the OWCP has not led the claimant to expect that the benefit/payment will continue beyond the authorized period. A notice is needed, followed by a formal denial (as appropriate and as described in PM Chapter 2-1400), if an indefinite authorization was provided.

d. If the information received adequately supports the request, it can be authorized.

15. Diagnostic Testing. Diagnostic procedures are used to determine the exact nature and extent of the claimant's condition. Such assessments often clarify medical status and may save the claimant additional pain and time loss from work.

a. Development. If a diagnostic procedure such as an MRI, CAT scan, or arthroscopy pertains to the accepted condition, the request should not routinely be developed. Even in the case of arthroscopy, the diagnostic nature of the test should take priority over its surgical nature when authorization is at issue, and the procedure should usually be authorized and paid for without further investigation in a case involving injury to the knee.

b. Sequence of Tests. For many conditions, a standard sequence for such tests exists. For example, an initial x-ray may be followed by a CAT scan or MRI if needed. If the CE is unaware of the usual sequence for a particular condition, or if the nature of the test is unfamiliar, consultation with the FN or DMA may be in order. But unless a specific reason exists to obtain further information, the test should usually be authorized.

16. Functional Capacity Evaluations (FCEs). These evaluations may be classified in two types according to their purpose, duration and content: a general-purpose FCE and an FCE for placement into an Occupational Rehabilitation Program (ORP) for work-hardening or work-conditioning.

a. A general-purpose FCE may be authorized by the CE in cases where management of disability calls for clarification of job tolerances, work restrictions, etc., and the AP, second opinion

specialist, or referee examiner recommends or requires this service. A request should be submitted for consideration from the requesting physician or facility. Once the request is approved, an authorization letter will be sent to the requestor. If a FN is assigned to the case, the FN should also be notified of the approval.

b. Only a Rehabilitation Specialist can authorize an FCE in connection with an ORP being performed as part of the vocational rehabilitation process (see PM 2-0813).

17. Durable Medical Equipment. The OWCP authorizes durable medical equipment (DME) to aid in the relief and healing for an accepted work-related condition under 20 C.F.R. § 10.310(c).

When evaluating requests, consideration should be given to whether rental or purchase is most cost effective, and whether the cost is commensurate with the basic (unadorned) item required for treatment. The OWCP will not approve elaborate or specialized equipment where a more basic alternative is suitable.

a. The OWCP will consider approval of DME when the following criteria are met:

(1) The equipment provides therapeutic benefit to the claimant;

(2) The DME is prescribed by a physician; and

(3) The DME is likely to cure, give relief, reduce the degree of disability, or aid in lessening the amount of the monthly compensation (U.S. Code § 8103).

b. The OWCP identifies DME items in 2 categories: Personal Appliances (Devices), and Non-personal Appliances (Equipment).

(1) Personal Appliances (Devices) are items that cannot be reused, as they are primarily fitted or adjusted for a specific individual. Devices which are specifically fitted to and worn by the claimant, such as back braces, eyeglasses, cervical collars, wrist, hand and elbow splints, as well as and knee and ankle braces, are considered personal items rather than government property. Upon the recommendation of the attending physician, such appliances may be repaired or replaced without advance approval when the estimated cost is less than \$500.

(2) Non-personal Appliances (Equipment) are items that can be rented, or purchased. If the non-personal DME item was a used item at the time of the initial request for rental or purchase, the CE would not be aware that the item is used due to the use of modifier "RR" and "NU". Therefore, if modifier "UE" is submitted on the authorization request, purchase price is required. The service will be processed as a purchased item. DOL will not pay for a long term rental, but will pay the cost of maintenance of the equipment, if the equipment is used. Examples of non-personal DME items are; Pacemaker monitor digital device, Implantable pump replacement, Nebulizers, and Oxygen Equipment, etc. Prior to authorizing any item of a non-personal nature, the cost of purchase should be compared to the cost of renting, taking into consideration the

prognosis and the estimated duration of need. Generally, the less expensive method will be used. If the cost of the equipment purchase is less than \$250, no comparison is required.

c. Miscellaneous DME. Authorizations for DME requested under code E1399 constitute "miscellaneous" DME.

The CE should consult with the DOT (coder) concerning these requests (or any other request billed as miscellaneous), as they are not subject to OWCP's maximum allowable amount (MAA). The CE should request that the provider identify and submit a procedure code from the AMA booklets that describe the equipment and identify the appropriate code and should deny the E1399 request or any unlisted procedure code. Only if the provider cannot identify a procedure code that better describes the procedure, the CE should request from the provider justification for using the 1399, and then apply the cost analysis (rental versus purchase) process as referenced in paragraph 17f.

d. Evidence Required. The level of medical evidence required depends on the type and cost of the DME. Upon receipt of a request for authorization for DME, the CE should review the file to ensure it contains the evidence outlined below. If evidence is not present in the file, it should be requested by letter to the attending physician, with a copy to the claimant.

(1) A description of the basic equipment or furnishing required to treat effects of the job-related condition.

(2) An explanation of how the item will address the effects of the work-related condition and the anticipated improvement. This type of rationale, however, is not needed for routine DME requests for items such as braces, crutches, etc. where there is an obvious need post-injury or post-surgery.

(3) The anticipated duration of the need for the item, to assist in determining whether the item is to be rented or purchased.

(4) If the information received is incomplete or doubt exists about the appropriateness or need for the equipment, the CE should undertake development, such as requesting clarification from the AP, consulting the DMA or obtaining a second opinion examination.

e. Purchase of DME. As noted above, OWCP will authorize purchase of DME where the evidence demonstrates that the claimant has a medical need for the DME. Where the DME purchase price, is greater than \$2500, the CE should obtain the following additional evidence from the claimant; the CE may utilize the services of a field nurse to assist with obtaining the following additional evidence:

(1) The full name of at least two authorized providers, along with complete contact information for each.

(2) From each potential provider, a signed statement describing in detail the basic, unadorned item meeting the physician's specifications, and a breakdown of all costs, including delivery, set-up, etc.

(3) The basic, unadorned DME with the lowest cost that meets the physician's specifications should be authorized. A higher priced item should not be substituted absent a memorandum in the case file explaining why the lower priced alternative was not suitable.

(4) If the circumstances surrounding the authorization request and the case file establish that performing the above analysis is not appropriate or would result in an undue hardship to the claimant (such as the urgent need for DME immediately following major surgery), the request may be authorized as long as the medical evidence required in paragraph 17d above is present. However, a memorandum should be placed in the case file explaining why further cost analysis was not appropriate.

(5) Note that additional procedures apply for hearing aid authorization requests. See paragraph (i) below.

f. Rental versus purchase. DME rental versus purchase coverage is based on the item prescribed, the patient's prognosis, the time frame required for use, and the total cost (rental vs. purchase) of the equipment. FECA regulations permit use of refurbished equipment where appropriate. See 20 C.F.R. 10.310(c).

(1) The CE should document the file with the rental versus purchase analysis.

(2) If the required information is not in the case file, the CE may obtain the information via a telephone call and document the information. If unable to do so, the CE should request it from the attending physician and/or DME provider and send a copy of the letter to the claimant. It may be beneficial to request this information following the initial rental authorization, or close to the expiration of the initial rental period, to avoid a lapse in DME authorization following the allowable 90 day rental period. If a Field Nurse (FN) is assigned to the case, the CE can ask for his/her assistance in obtaining this information.

(3) If the necessary information cannot be obtained quickly at the 90 day timeframe, and the claimant is in definite need of the continued DME, the CE may authorize an additional 30 day rental, providing that the additional rental does not exceed the purchase price, while developing the issue and determining whether continued rental versus purchase is appropriate.

(4) Continued rental should not be authorized past 90 days without a cost analysis as described in this paragraph.

(5) Periodically, a medical provider or claimant will request authorization for rental of used DME equipment. As previously noted, FECA regulations permit use of refurbished equipment where appropriate. See 20 C.F.R. 10.310(c). The contractors system will process the request for "RR" (Rental), the request for "NU" (Purchase), or "UE" (Used Equipment) as follows:

(a) Rental "RR" of DME may be authorized for up to 90 days if supported by the medical evidence as addressed in paragraph 17d above.

(b) Rental "RR" of DME beyond 90 days requires the CE to make a determination as to whether further rental or purchase is most cost effective. The CE should review the anticipated duration of the need for the DME, the monthly rental price, and the purchase price to make this determination.

(c) Submitted Prior Authorizations for the Rental/Purchase of DME using modifier "UE" (Used) equipment will be treated as a purchase of the item. DOL will not pay for a long term rental, but will pay the cost for maintenance of the equipment, if the equipment is used.

Example-1, if the rental price of the DME is \$500 per month, and the purchase price of the DME is \$2500, and the attending physician anticipates that the claimant will need the DME for 90 days the purchase price (\$2,500) will automatically be applied to the claimants authorization file specifically in the "authorized amount field". In this example, since the purchase of the DME is NOT more cost effective, further rental should not be authorized. This analysis is BASED ON the cost of renting the DME for THREE months equals \$1500 (\$500 x 3) and the purchase price is only \$2500. The CE will authorize only the purchase of the DME, and the authorization will be entered into the system for the DME as a purchased item to be paid at \$2,500.

Example-2, if the rental price of the DME is \$500 per month, and the purchase on the DME is \$4,000, and the attending physician anticipates that the claimant will need the DME for 90 days, the purchase price (\$4,000) will automatically be applied to the claimants authorization file specifically in the "authorized amount field". The rental amount will be credited against purchase in the event the equipment is needed for a time period beyond eight months.

Example-3, if the authorization request is submitted from the provider with modifier "UE" used equipment, the cost analysis will be applied.

g. Maintenance, Repairs, and Replacement of Rental DME. Maintenance, repair, or replacement and supplies are eligible for separate reimbursement, providing that the DME supplier is properly enrolled with CBP.

(1) If the expense for repairs exceeds the estimated expense of renting or purchasing another item of equipment for the remaining period of medical need, no payment can be made for amount in excess.

(2) The repair charge may include the use of "loaner" equipment when necessary.

(3) When equipment is rented, coverage for a maintenance or service agreement may be authorized.

(4) Replacement of a rental item may occur when the item is irreparably damaged, or if replacement is required during repair and/or maintenance of a specific item. The cost will be negotiated under the DOL rental versus purchase policy.

(5) Replacement or repair of an item that has been misused or abused by the claimant or claimant's family or caregiver will be the responsibility of the claimant.

h. Special Equipment and Furniture. The procedures outlined above, pertaining to purchase price and rental versus purchase considerations pertain to the usual DME and medical supplies found in medical supply facilities. If the CE receives a request for equipment or furnishings not commonly obtained from medical supply sources or prescribed for treatment (e.g., whirlpools, special beds or mattress sets, lift chairs, exercise equipment, motorized scooters, etc.), a detailed analysis is required.

(1) A rationalized medical opinion is needed regarding the need for such equipment. Upon receipt of the physician's report pertaining to the issue, the CE should seek the opinion of the District Medical Advisor (DMA) prior to authorization. A second opinion may also be necessary.

(2) For any purchase of this type, the information outlined in paragraph 17e should be requested and reviewed.

(3) If rental is requested, the CE should not authorize even an initial 90 day period without obtaining the necessary medical evidence. This is unlike routine DME where a 90 day initial rental period may be approved.

i. Hearing Aids and Supplies. Hearing aids may be authorized when hearing loss has resulted from an accepted injury or disease if the attending physician so recommends. Audiologists and other hearing aid technicians do not qualify to make such a recommendation.

(1) Evidence Required. Upon receipt of a request for authorization for hearing aids or supplies, the CE should review the file to ensure it contains the following evidence.

(a) The hearing aid is being supplied by a hearing aid dispenser based on a prescription of an otolaryngologist or the claimant's attending or primary care physician.

(b) An audiological evaluation including a hearing aid evaluation was performed by or under the supervision of the above physician.

(2) Hearing Aid Trial Period Request. The OWCP may authorize a 30 day trial period during which time the claimant can determine if the hearing aid provides satisfactory benefit. If the claimant finds that the hearing aid does not provide benefit, the claimant should be encouraged to return the item, knowing that there may be a small non-refundable portion for the services/supplies used during the 30 day trial period.

(a) The OWCP reserves the right to authorize a 30 day trial period for hearing aids prior to purchase, when medically appropriate.

(b) Prior authorization is required for the 30 day trial period of the actual hearing aids device, hearing aid repairs or other supplies, which exceeds a cost of \$250.00 per item (an item is defined as all related components of a given device).

(3) Initial Hearing Aid Purchase Request. When a request for authorization for an initial purchase of hearing aids is received, the CE should follow the procedures outlined for other DME, as described paragraphs 17d and 17e above, except that a request for price quotes from multiple suppliers need not be made. The CE should still ensure that the hearing aids requested represent the basic, unadorned aids that meet the prescribing physician's specifications. The CE should not approve hearing aids costing in excess of \$5,000 (monaural) or \$10,000 (binaural) if well-rationalized medical evidence is absent in the case file.

(4) Repair and Maintenance. Hearing aid repairs may be authorized as needed. Requests for repairs should be accompanied by documentation indicating the reason for repairs and types of repairs being made prior to approval. Hearing aids are generally limited to a repair of only 5 episodes per year, and the repair cost should not exceed \$1,000.00 per year.

(5) Replacement. Hearing aids typically last three to five years. Upon receipt of a request for authorization for replacement hearing aids, the CE should first determine the length of time since the last hearing aids were authorized. Hearing aid replacement may be authorized only if:

(a) The prior hearing aid has been lost, stolen, or irreparably damaged due to circumstances beyond the claimant's control, or;

(b) The hearing impairment of the claimant requires amplification or correction not within the capabilities of the claimant's present hearing aid, or;

(c) Five years or longer have elapsed and the file is documented with the ongoing need for hearing aids, or;

(d) Less than five years has elapsed and the file is documented with the following: (1) a detailed statement indicating why replacement is reasonably necessary, and (2) an indication that repair is either impossible or less cost-effective than the purchase of replacement hearing aids.

(6) Hearing Aid Supplies Limitations. Requests for hearing aid batteries need not be accompanied by supporting medical documentation. Hearing aid batteries, after the initial purchase of batteries for the hearing device, are limited to 200 per year.

j. Authorization. If a request for DME can be authorized, the claimant should be advised in writing of the approval. This approval is typically issued via the Central Bill Payment Unit.

k. Denial of Approval. If the evidence does not support the rental or purchase of the requested item, the CE should advise the claimant in writing, explaining the reason(s) and listing the alternatives which may be considered, if any. A formal decision with appeal rights should be issued if requested by the claimant. See PM 2-1400 for more information on formal denials.

18. Health Club/Spa Membership. Such memberships may be authorized if rationalized medical evidence establishes they would be therapeutic to treat the effects of an injury. In all cases where such memberships are at issue, the CE must determine that the membership is likely to be effective and cost efficient, given that exercises performed at such

facilities are generally done without supervision, the membership term may be incompatible with or extend beyond the duration of the prescribed program, and membership dues often include charges for services not related to the treatment regimen. The OWCP will not approve an elaborate facility or service where a more basic one is suitable.

a. Development with the physician. The CE should obtain the following evidence from the physician:

- (1) A description of the specific therapy and exercise routine needed to address effects of the work-related injury, including a description of the specific equipment or facilities needed to safely perform the prescribed regimen.
- (2) The frequency with which exercises should be performed and the anticipated duration of the recommended regimen.
- (3) The nature and extent of supervision, if any, that the physician feels is required for safety while the claimant is performing the exercises.
- (4) The physician's opinion of the anticipated or actual effects of the regimen, the treatment goals sought or attained, and the frequency of the AP's examinations to determine the effectiveness or ongoing need for the program.
- (5) A statement directly addressing whether the exercise routine can be performed at home, and the viability of a public facility, such as a community recreation center or pool, in accomplishing the treatment goals.

b. Development with the claimant. The CE should also obtain the following evidence from the claimant:

- (1) The full name and address, and distance from the claimant's home or work, of suitable public facilities.
- (2) The full name and address, and distance from the claimant's home or work, of suitable commercial facilities.
- (3) If applicable, the claimant's specific reason(s) for requesting approval of a commercial facility if a suitable public facility is available or the AP has indicated the regimen can be performed at home.
- (4) A signed statement from the health club or spa manager verifying that the facility is fully suitable for the exercise routine prescribed by the physician. The manager should also provide detailed fees and charges for various membership options and terms (e.g., short-term vs. lifetime membership). The statement should describe all facilities, services, and special charges not included in the membership fee.

The CA-6043 letter can be used for this development of these issues.

c. Review and Authorization. If the information received is incomplete or doubt exists about the suitability, appropriateness, or need for the membership, the CE should undertake suitable development, such as requesting clarification from the AP, consulting with the DMA or obtaining a second opinion examination.

If the information received adequately supports the request, the CE may approve membership, provided the cost does not exceed \$750. Requests for higher amounts should be referred to the Quality Assurance and Mentoring Examiner or Supervisory CE with a written recommendation explaining the basis for approval.

Only individual (not family or group) health club memberships may be approved, and usually only for period of six months at a time. The claimant should be advised of the period of approval. The claimant should also be advised that if a further period of approval is requested, a request with a medical report explaining the gains achieved to date and supporting an extension for a specified period, should be submitted approximately 45 days prior to the expiration of the current membership term for consideration.

d. Denial of Approval. If the evidence does not support paying for a membership, the CE should advise the claimant in writing, explaining the reason(s) and listing the alternatives which can be considered. A formal decision with appeal rights should be issued, if requested.

19. Physical Therapy. For most orthopedic injuries, physical therapy (PT) services within the first 120 days after a traumatic injury are allowed without any prior authorization required. It is also customary to automatically authorize PT post operatively for orthopedic surgeries, usually for a period of 60 days post surgery. If a request for therapy beyond these time frames is received, the CE needs to review the file to determine whether further services should be authorized.

a. PT requests must include the following: specific CPT-4 codes, number of units, frequency and duration of treatment. This request must also be accompanied by a prescription and treatment plan from the attending physician.

b. Evaluating PT requests. To evaluate the need for therapy beyond the initial period of authorization, the CE is to review the case for the following medical evidence:

(1) An established need for PT directed to the accepted condition or to an accepted complication of the claimant's injury or condition, including surgery.

(2) The specific modalities being prescribed, which should include some form of active PT.

(3) The existence of a functional deficit where the additional therapy is expected to produce some functional improvement. Pain alone does not constitute a functional deficit. To authorize additional physical therapy for pain or to maintain function, the CE should ensure that the pain is associated with measurable objective findings such as muscle spasm, atrophy and/or radiologic changes in joints, muscles or bones, or that pain has placed measurable limitations upon the claimant's physical activities.

c. Prior to authorizing additional PT, medical development may be needed if the file does not substantiate the need for ongoing therapy. The CE may need to request further information from the physician, such as the following:

- (1) Specific modalities, procedures and/or tests and measures to be administered.
- (2) Specific functional deficits which are to be treated, including a description of how these deficits affect the claimant's physical activities.
- (3) Specific functional goals of the additional therapy.
- (4) Appropriateness of a patient-directed home exercise program as an alternative to supervised physical therapy, especially in light of the efficacy of past supervised therapy and the magnitude of any expected functional improvement.

d. Additional PT may be approved if the need has been established as outlined above.

e. Denial of Approval. If there is insufficient evidence, after development, no further physical therapy should be authorized. If the claimant inquires, the CE should explain the reason(s) in writing. A formal decision with appeal rights should be issued, if requested.

f. Extended PT may be approved for severe brain or spinal cord injuries, extensive second or third degree burns, or other severe injuries that have rendered the claimant bed-ridden permanently or for an extended period of time. The CE may authorize physical therapy services for up to one year in these circumstances. However, the accepted condition(s) must support this exception.

20. Authorizations for Chiropractic and Osteopathic Treatment. If a spinal subluxation has been accepted, manual manipulation of the spine by a chiropractor is payable. However, other physical therapy services, even if performed by a chiropractor, are subject to the requirements in the preceding paragraph. When the AP prescribes manipulative treatment by a chiropractor or an osteopathic physician, this therapy is subject to the above procedures. Physical therapy services provided by a chiropractor or osteopath must be recommended and directed by the AP.

21. Attendant Allowance. 20 CFR §10.314 allows payment for services of an attendant where it is medically documented that the claimant requires assistance to care for personal needs such as bathing, dressing, eating, etc. Such services are paid as a medical expense directly to the provider of services under 5 U.S.C. 8103.

Prior to the January 1999 revision to the Federal Regulations, an attendant allowance was paid directly to the claimant. Any such allowance approved prior to January 1999 will continue to be paid to the claimant until the need for the attendant ceases. Any new claims for an attendant allowance will be processed under §10.314, consistent with the guidance in this chapter.

a. Development of a new request. Where the evidence strongly suggests that the claimant may require the services of an attendant, or where the claimant inquires about such entitlement, the CE should request further information from both the claimant and the physician.

b. Evaluating the request. When making a determination on the claimant's entitlement to an attendant, the CE is to consider the following factors:

(1) The particular kinds of activities for which assistance is needed. The assistance must be for personal needs such as bathing or dressing, not for such tasks as cooking or housekeeping.

(2) The need for daily assistance in these activities.

(3) The nature of the disability.

c. Authorization. When the services of an attendant are approved, the CE should prepare a memorandum for the file outlining the reasons for approving the attendant allowance, and stating the period for which it is approved. A CE may approve the services of an attendant for up to one year if the medical evidence supports a long-term need.

If the services of an attendant are required beyond that period, the CE should prepare a memorandum to the Supervisory Claims Examiner (SCE) making recommendations and requesting approval for a longer period. If the SCE concurs with a longer authorization period, or that an attendant will be needed indefinitely, the SCE may approve a longer period. This decision should be documented in the case file.

d. The provider should submit an itemized bill for services directly to the OWCP as directed in 20 CFR §10.801.

e. Continued entitlement to the attendant allowance should be verified by the CE annually during the periodic entitlement review process. General procedures for determining continued entitlement are contained in FECA PM 2-0812.

22. Claimants in Prison. Incarcerated persons do not lose entitlement to medical treatment for work-related injuries simply because they are imprisoned.

Medical treatment and examinations should be arranged through prison officials. It may be sufficient to obtain routine medical services from the prison physician. If needed, and with the cooperation of prison authorities, the claimant may be taken to a specialist's office or arrangements may be made for the specialist to visit the prison to see the claimant. Such arrangements may be made not only for treatment and periodic examinations, but also to obtain physical work limitations for use in determining the claimant's wage-earning capacity. Copies of correspondence with prison officials regarding medical examination and treatment should be sent to the claimant (and his or her representative).

Chapter 2-0811, Nurse Case Management

1. Purpose and Scope. This chapter discusses the early intervention phase of disability management claims. The focus is primarily on the necessity and appropriateness of nursing intervention and techniques for the management of disability claims at the earliest possible point to facilitate return to work. It outlines the different roles and types of nurses, provides guidance to the Claims Examiner (CE) regarding how and when nursing intervention should be undertaken, and discusses the necessary components of successful claims management during this phase.

See FECA Procedure Manual (PM) chapter 2-0600 for a complete overview of the Disability Management process.

See also FECA 3-0201 and 3-0202 for more detailed information on the management of contract nurses.

2. Introduction. The Office of Workers' Compensation Programs (OWCP) is committed to seeing that benefits for compensation and medical services are appropriate and provided timely. OWCP is also committed to assisting injured workers in returning to work as soon as possible in order to minimize the period of disability. Benefits should not continue after the effects of the work-related condition have ceased.

Management of disability claims begins as soon as a new claim is received indicating that the claimant has lost time from work as a result of the injury or is disabled from his or her date of injury position. The CE assists the claimant in returning to work as soon as possible; however, the return-to-work effort consists of more than just CE intervention. The best outcomes stem from an active team approach where OWCP, the employing agency (EA), the claimant, and the medical providers use all available tools to facilitate medical recovery and a sustainable return to work.

Nurse intervention is an integral part of the overall disability management of a claim, with a registered nurse providing liaison services to assist in medical and claims management with a return-to-work focus. However, even when a nurse has been assigned to a case, the CE remains responsible for the management and overall direction of the case.

The CE uses the Disability Management (DM) Tracking system in iFECS to record actions taken during disability management, including those taken with regard to the assigned nurse. Additionally, the interaction between the DM Tracking system and the Nurse/Rehabilitation Tracking System (NRTS) provides the ability to effectively track and manage a disability claim from assignment to closure. PM Chapter 2-0601 discusses the DM Tracking system in detail.

3. Types of Nurses. The OWCP has contracted with registered nurses who have case management experience to provide intervention at the earliest stages of disability management. A Staff Nurse is responsible for oversight of the contracted nurses.

a. Staff Nurse. As part of the oversight process, the Staff Nurse (SN) should see there is a sufficient number contract nurses to service the district office's needs. The SN assigns contact nurses to specific cases; monitors contract nurses' performance in correlation to both the contract specifications and the quality of services provided; reviews nurse reports for completeness and timeliness prior to authorizing payment of bills; and communicates with the CE as needed with regard to issues that arise during the nurse intervention phase.

b. Continuation of Pay (COP) Nurses. COP Nurses (CN) are registered nurses assigned in traumatic injury cases where the injured worker has immediate time loss and has not returned to work within seven (7) days following the date of work stoppage. The CN is strictly a triage nurse and all work is performed telephonically. The CN contacts the employee, the EA and the treating physician. Within seven (7) days of the case assignment, the CN initiates contact with all three to obtain the necessary information and then closes the case. The CN closure report should contain the return-to-work status and provide a recommendation regarding early intervention and assignment to a field nurse.

c. Field Nurses. The Field Nurse (FN) is a registered nurse who assists in the management of disability claims in a number of ways. The FN assists in coordinating medical care during the recovery period and helps to facilitate a safe and timely return to work. The FN also acts as liaison between the CE, claimant, EA, and medical providers. The FN's contact is generally in person; however, in some instances the activity may be only telephonic in nature.

4. The COP Nurse (CN). Although nurse intervention is not extensive during the COP period, the medical knowledge and experience of a CN enables the CE to identify cases that require more extensive intervention due to the severity of the injury, contemplated surgical intervention, or lost time from work.

a. CN Assignment. Based on the data entered when a traumatic injury case is created (specifically, the date work was stopped), a case becomes automatically eligible for a CN assignment if the claimant does not return to work within 7 days of the date the claimant stopped work. This assignment occurs even if the case has not yet been formally accepted. If the EA reports a return to work prior to CN assignment, a CN should not be assigned. CN assignments are done electronically through iFECS, and necessary information is accessed by the CN via remote access to iFECS.

Note - As COP is not payable in occupational disease cases, CN assignments are not made in those cases.

b. CN Actions. Upon receipt of the assignment, the CN should make a three-point contact in order to effectively triage the case, and then report these findings via a COP Nurse Report to the SN and CE.

- (1) Claimant - The CN should make initial contact with the claimant and obtain details concerning the injury. The CN should also determine whether the claimant has a treating physician, and, if so, contact information should be obtained.
- (2) Employing Agency (EA) - The CN should contact the EA to confirm the claimant's work status and determine whether appropriate work accommodations are going to be available during recovery. The CN can also discuss with the EA the possibility of a future FN assignment in a particular case.
- (3) Attending Physician - The CN should contact the physician's office to obtain information concerning treatment and the date of the claimant's next appointment. The CN can also advise whether work accommodations can be made at the agency, if known, and provide general information about the FECA program.

Once information has been obtained from the claimant, EA and attending physician, the CN provides that information, via a written report, to the SN and CE. Any other relevant information pertaining to possible issues for a foreseeable recovery or return-to-work barriers should also be included. The CN should also make a specific recommendation pertaining to whether a FN assignment would be beneficial.

c. CN Timeframes. The CN should obtain the necessary information, as outlined above, and submit a closure report within 7 days of assignment. There is a limited amount of flexibility with this 7-day timeframe. If the CN has determined that the claimant will be returning to work within the following week, and the specific contact information supporting a definitive return-to-work date has been obtained, the CN case can be held open beyond the 7-day window to verify and report the return to work. CN closure, even with this kind of limited extension, should occur no later than 14 days after assignment.

d. Once the CN Closure Report is received, the SN reviews it and submits the bill for payment. At that point, the COP Nurse Report will be viewable by the CE, who can use the information provided to determine the next appropriate step for the case. The closure type and date will also be visible to the EA in the Agency Query System (AQS) at that time.

If the CN closes the case and the claimant has not returned to work in a full-time capacity, the CE should review the case for adjudication. The CE can also use the information obtained by the CN to expedite adjudication or guide the next intervention action. The CE should also review the case for appropriateness of assignment to an FN, as a case may be assigned to an FN even if the COP period has not yet expired. A FN may also be assigned if the claimant has returned to work full time, but in only a limited duty capacity.

5. The Field Nurse (FN). A FN is assigned when work-related disability has been identified. Unlike CN assignments, the CE must initiate a referral to a FN. A FN's contact is generally in person; however, in some instances the activity may be only telephonic in nature (e.g. in an instance where there is no contract nurse in the vicinity of the claimant's locale). Whether the nurse's contacts during these kinds of assignments are in the field or only telephonic

in nature, they are all called FNs. The FN's responsibilities include, but are not limited to, the following:

- a. Developing a rapport with the claimant and answering questions about what to expect from OWCP, while at the same time clearly establishing the return-to-work goal for the claimant from the outset.
- b. Making determinations about the initial extent of the injury, treatment necessary for recovery, and return-to-work expectations (using the CN's report, if available, as part of this process).
- c. Attending the claimant's medical appointments to facilitate communication about return to work and ease any authorization difficulties the claimant may be encountering.
- d. Obtaining functional capacities, restrictions and limitations from the physician as early as possible, and then providing these to the EA and exploring job modification options.
- e. Identifying possible barriers to the claimant's return to work and then developing a plan of action with the CE to resolve the identified barriers.
- f. Continual evaluation of the likelihood of return to work with the EA and physician, with the goal of following the plan through to successful full duty return to work and closure.
- g. Communicating regularly with the medical providers, claimant, EA, SN and CE to keep all parties informed of the status of the case to facilitate a timely, sustainable return to work.
- h. Making recommendations for vocational rehabilitation when necessary.

6. When a Field Nurse is Needed. The need for a FN can occur in many different situations. Some of the most common situations in which referral for FN services is needed are: coordinating medical care, obtaining work limitations, assisting the CE in resolving medical issues, visiting the work site and ensuring that duties of the position do not exceed the medical limitations as represented by the weight of medical evidence established by OWCP, and addressing any problems the employee may have in adjusting to the work setting.

- a. Nurse services are a valuable tool for assisting claimants in returning to work and assisting CEs in moving a case towards resolution. Early referral for nurse intervention services is critical to successful disability management.
- b. Nurse intervention should begin as soon as possible after the injury occurs in accepted cases if the claimant has not returned to work, even if the Continuation of Pay (COP) period has not yet expired. The referral for FN services may also be made if the claimant has returned to work but is disabled from performing his or her date of injury position.
- c. The need for a nurse referral, in general, can be established with any situation where the claimant is not working his/her full regular duty. The following is a breakdown of some

scenarios that illustrate when a case may be considered for referral for nurse intervention services:

- (1) The claimant is temporarily totally disabled (TTD);
- (2) The claimant is working full time but with restrictions, and a return to less restrictive work, a full-duty release, or establishing permanent restrictions is being pursued;
- (3) The claimant is working less than full time with or without restrictions, and an increase in work hours, a return to less restrictive work, a full-duty release, or establishing permanent restrictions is being pursued;
- (4) Work tolerance limitations have been obtained, but outstanding medical issues hinder or preclude a return to work. The FN can assist with the outstanding medical issue (e.g. pain management, medication, treatment plan, specialist consultations, etc.);
- (5) Surgery is authorized and monitoring medical recovery and coordinating post operative care is needed;
- (6) The return to work date stated does not coincide with the severity of the original injury;
- (7) The return to work date is extended without clear and valid medical reasons;
- (8) The claimant is partially disabled but the file contains no description of work limitations;
- (9) The claimant has sustained a catastrophic injury and coordination of medical care is needed; or
- (10) The claimant stops work (sustains a recurrence) after an initial return to work effort.

d. Referral for nurse intervention services can also be taken for specific task-related actions later in the life of a case, even after a prior nurse closure has occurred. These are generally shorter assignments based on a specific task. Some examples of these instances are:

- (1) The claimant's work tolerance limitations are in question, and the CE determines that with the assistance of a FN, clarification of the claimant's work capabilities can be obtained;
- (2) When questions arise regarding the claimant's current medical status, the FN can meet with the attending physician to obtain a medical opinion on a pending medical issue, assist with obtaining medical records, etc.; or
- (3) A FN would be beneficial to assist the CE and/or claimant with the coordination of medical care due to the severity or complexity of the claimant's medical condition.

7. Field Nurse Referral. Once a CE has decided to refer a case for nurse intervention, the CE should complete a nurse referral.

- a. The nurse referral should provide specific information for the SN to utilize in making the referral to the FN, such as: the claimant's name, address, phone number; the EA name, address, contact person, if known (most likely the EA Injury Compensation Specialist), and phone number; whether there is an attorney or representative authorized in the case; the accepted conditions and ICD codes; the claimant's date of injury and date of birth; the claimant's current work status; the responsible CE's name; and the recognized attending physician's contact information, including name and phone number.
- b. The completed nurse referral should also note the goals of the intervention and the issues which the FN should address with the physician (e.g., obtaining a description of work limitations or treatment plan) and any pending adjudicatory actions (e.g., an imminent second opinion referral). The referral should be specific to the circumstances of the case.
- c. Along with the referral, the FN should be provided a copy of the pertinent medical records from the file, which may also include a copy of a current Statement of Accepted Facts (SOAF), if available.

8. Field Nurse Assignment. If the claimant has not returned to regular full duty and the case has been accepted, a FN can be assigned.

- a. FN assignments should usually be made with the expectation of in-person contact by the FN, since the FN may more easily assess the claimant's environment and job situation in a personal visit. An assignment may be limited to telephonic intervention, though, in uncomplicated cases, or in instances where there is no contract nurse available in the claimant's locale. If the assignment is to be only telephonic in nature, the SN should clearly indicate this in the referral documentation, but there are no differences with regard to the timeframes.
- b. Within one week of receipt of the file the FN should:
 - (1) Contact the injured worker for initial assessment;
 - (2) Contact the attending physician for a treatment plan, projected return-to-work date, and completion of an OWCP-5 (or equivalent). In addition, the attending physician should be notified that light duty may be available when the injured worker is able to return to some form of work;
 - (3) Contact the EA regarding availability of light duty and return-to-work options; and
 - (4) Contact the CE and provide a synopsis of medical issues, current work status, and estimated dates for return-to-work at light or regular duty.

If the FN is unable to meet this one-week timeframe (e.g. the treating physician cannot be available for 2 weeks), notification should be made to the SN and CE.

c. After the initial status report from the FN, if necessary, the CE should direct the FN with regard to what course of action to pursue. This type of direction should continue throughout nurse intervention depending on the information provided by the FN.

d. Within one month of assignment, the FN should obtain a position description for the date of injury (DOI) job, which includes the actual physical requirements. If the claimant has been working a light duty job since the injury occurred, the FN should also obtain this documentation for the light duty job. The FN should also have a face-to-face meeting and job-site walk through (when possible) with the EA to assess potential job modification possibilities.

e. The FN should submit medical evidence as soon as it is received and contact the CE to report the following:

(1) Changes in the claimant's medical condition (e.g., newly diagnosed conditions whether work-related or not, requests for surgery, etc.).

(2) Claim expansion (e.g. the attending physician may request an expansion of the work-related conditions in the case to include a diagnosis that better matches the claimant's work-related condition).

(3) If the EA states it will not make light duty work available, or if the EA withdraws light duty work.

(4) Report of a new injury, whether sustained at work or not.

(5) Return-to-work status or changes in work status (e.g. full-time to part-time or change in hours worked). This requires immediate notification.

(6) Release to return to work (with follow-up verification of actual the return-to-work date).

(7) Any event that significantly impacts a claimant's ability to return to work or seek treatment (e.g. the death of a family member, personnel issues, etc.).

(8) The need for a second opinion examination.

(9) Claimant's willingness or unwillingness to cooperate with the treatment recommendations of his/her physician and the return-to-work effort.

f. The FN should submit a monthly written progress report that includes:

(1) Current Work Status. This includes the number of hours (if working), the effective return-to-work date, and type of work, with EA confirmation; or the projected return-to-work date (if not working).

(2) Claimant Contact. This includes a synopsis of the information obtained and an assessment of the home environment and family structure, as well as the date/type of the contacts. Information

pertaining to the home environment will usually only be documented in the initial assessment report and need only be referenced in subsequent reports if the FN determines that such issues present an ongoing barrier to rehab/recovery. Also, depending on the nature of the case, assessment of the home environment may not be necessary.

(3) Physician Contact. This includes the date of medical visits; physician requests (surgical approval, physical therapy, etc.), and detailed requests made by the FN to the physician based on the treatment plan.

(4) EA Contact. This includes the job site evaluation performed and date, as well as the name of contact person with whom job accommodations were discussed.

(5) Planned Actions and Comments. This includes specific actions the FN plans to take during the next reporting period, e.g. the next physician appointment, possible increase in work hours, job site walk through, etc.

(6) Barriers or Issues. This includes any barriers to medical recovery or the return-to-work effort. This may also include issues that the FN requires CE direction on before moving forward. While these issues should be communicated prior to the monthly report if significant, the CE should always review this section of the report carefully to determine whether intervention is needed.

g. The FN should submit a closure report when directed by the CE or SN to close the case. When a case is scheduled for closure of nursing services, the FN should inform the injured worker, physician, and EA of the closure.

h. Non-cooperation. Sometimes a claimant may not wish to cooperate with the nurse intervention program. If this occurs, the CE should obtain specific details regarding the situation. While OWCP cannot issue any type of sanction specifically for non-cooperation with the FN, the CE should take appropriate follow-up action to address the situation if it is hindering recovery and return-to-work. Several options are available, but each case must be assessed individually.

(1) If work tolerance limitations are already on file, the CE can refer the case for vocational rehabilitation services.

(2) The CE may wish to hold a conference with the claimant and FN to explain the purpose of the nurse intervention program and the advantages for the claimant.

(3) If the FN can still be productive without direct contact with the claimant, the FN may remain assigned to the case and complete further tasks as directed by the CE.

(4) In other instances, it may be best to close the case for nurse intervention while the CE medically manages the case and possibly refers the case for vocational rehabilitation services at a later date.

9. Communication. Returning injured employees to work and minimizing the effects of a work injury are goals that require regular and timely communication between the CE, SN, and

FN. Effective, well directed, and organized disability management can be achieved with this team approach.

a. Communication between the CE and the SN.

(1) The SN is a valuable resource for the CE. The CE may ask the SN for advice where the claimant has sustained a catastrophic injury or has undergone surgery. Likewise, a brief consultation with the SN may be in order to assess whether a particular treatment is appropriate, to help the claimant explore treatment centers, or to understand the purpose of a particular diagnostic test.

(2) The SN should communicate with the CE on cases assigned to FNs regarding important or time sensitive information so that action can be taken by the CE, if necessary.

b. Communication between the CE and the FN. During the period of FN intervention, the CE and the FN will confer, either by telephone or written communication, to determine the next action. Timely response to FN inquiries is crucial to successful case management. The CE determines the best approach to achieve progress in the case and directs the FN in obtaining necessary information or completing specific tasks needed to achieve those goals.

The FN will report to OWCP, either by telephone, in writing, or both. Written reports are usually required every 30 days, but effective disability management hinges on more frequent communication in most cases. More immediate communication can be accomplished via the phone or email.

Note - Email may be used by the CE or SN to direct the activities of the FN during the nurse intervention period. If email is used, all protocols to safeguard Personally Identifiable Information (PII) must be followed (e.g. no identifying information in the subject line, and no reference to the claimant's complete SSN, name, or other protected PII in any part of the email message). Case specific communication concerning significant case actions should be placed in the case file.

(1) When the CE refers a case for nurse intervention, the CE should communicate via the nurse referral: the goals of the intervention, any issues that the FN should address with the physician, and any pending adjudicatory actions.

(2) The FN will report to the CE by telephone, in writing, or both. The FN may note such information as the attending physician's opinion concerning length of disability, work limitations, etc. The CE may use this information as the basis for questions to the physician but should not base adjudicatory actions on it, as a FN report is not medical evidence. However, if the FN arranges for submission of a medical report from the physician, the physician's report may be used for adjudicatory purposes.

(3) Periodically during the FN intervention period, the FN and the CE will discuss the specific circumstances of the case and confer to determine the next course of action in order to minimize disability and the effects of the work injury.

(4) The CE should regularly assess the claimant's medical condition and return-to-work status and decide what type of intervention is appropriate. For instance, the FN may recommend a second opinion examination, or recommend medical or vocational rehabilitation services, or other kinds of evaluation. The CE should promptly respond and take whatever claims intervention is needed.

(5) The FN should confirm the closure date with the CE prior to closing the case. When directed to close the case, the FN should contact the claimant, physician and the EA to advise them of the closure and refer them to the CE if they have any concerns. The FN should also notify the SN and then submit a closure report.

10. Length of Field Nurse Assignment. The length of FN assignment will depend on the circumstances of the case. Factors such as the type of injury, the medical conditions involved, and the availability of light or modified duty may play a role.

a. Initial Assignment. A FN will generally be assigned to a case for 120 days initially, regardless of whether the claimant has returned to work already or not; however, a shorter assignment may be considered. The CE should consult with the SN for additional guidance if needed.

Note - This assignment is made based on a unique period of disability. For instance, if a FN is assigned and the claimant returns to work during that assignment but then sustains a recurrence for a period of work-related disability, a FN can be reassigned and the initial assignment period (and the remainder of the protocol outlined in this section) begins again in a new DM Tracking record. See FECA PM 2-0601 for more information on creating DM tracking records.

b. Return-to-work monitoring. The full 120 days may not be needed when the claimant is already working at the time of FN assignment.

(1) Light Duty monitoring. If the FN obtains medical evidence indicating no full duty release, the claimant has permanent/stable work restrictions and has been working a job within the work tolerance limitations for 60 days while the FN has been assigned, the FN assignment may end. The FN should generally provide light duty follow up and oversight for a period of 60 days after the claimant has returned to work in a light duty position, unless the rationale for a longer period of monitoring is provided.

(2) Full Duty monitoring. If the claimant returns to work full duty, the FN should follow the case for 30 days (not 60), unless there is a specific reason for the longer 60-day monitoring period.

(3) Automatic extensions. An extension is not needed if the return to work occurs early enough in the 120-day period such that the 60 day monitoring will be completed prior to the 120 days. If the full 120 days has not been used, though, and the 60-day monitoring period is complete, the remaining days can be used if needed without further documentation (e.g. if the FN may be able to obtain a full duty release).

An extension to complete the return-to-work monitoring described in this paragraph is considered to be automatic, even if it takes the assignment period past the 120-day initial

assignment period. As long as the return-to-work date (and type) is clearly identified in the file, the monitoring (and any necessary extension) is automatic.

c. At the end of 120 days, the CE must evaluate the case and determine whether further FN services are necessary. For optimal case management results, collaboration between the CE and SN should occur when extensions are to be granted, or if there is any question regarding the appropriateness of FN closure.

(1) If the claimant has not returned to work, and there is no clear indication that FN services would be useful for a specific purpose, the FN should be closed. This closure should be documented in the file, and the CE should take another appropriate disability management intervention action promptly thereafter in an effort to move the case towards a resolution.

(2) If the claimant has not returned to work, and there is something specific the FN could do within the next 30 to 60 days to further the return-to-work efforts, the CE can extend the FN for 30 or 60 days at his or her discretion, 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.

For instance, if on day 105 the attending physician advises that after 3 more weeks of physical therapy, he will be able to provide work tolerance limitations, an extension could be authorized. Another example would be a case where the physician provided work restrictions towards the end of the 120-day period and the FN indicated that she was working with the EA on the formulation of a job offer, an extension could be granted to facilitate formalizing any such offer of employment.

If the CE authorizes a 30-day extension initially and later decides that an additional 30 days is needed, the same kind of rationale (purposeful decision making), direction, and file documentation is needed.

(3) If the claimant had an initial return to work during the first 120 days, and the 60 day monitoring of that return to work takes the FN past 120 days, the extension to follow up past the 120 days is automatic through the completion of that 60-day period. No extra file documentation is needed through day 60 of the light duty return to work (or day 30 for full duty).

(4) If the claimant had been working at the time of the initial assignment and has not been released to full duty and the work status has not changed, the FN should be closed. An extension may be granted if one of the following is expected (as evidenced in the file) within the next 30-60 days: a) full duty release, b) permanent or less restrictive work tolerance limitations, or 3) permanent job offer. Once this particular goal is accomplished, the FN should be closed. In these situations, where the claimant was already working at the time of the nurse assignment, the assignment period should not usually exceed 180 days.

d. At the end of 180 days, supervisory approval of any further extension is needed, with one exception.

(1) The 180-day automatic exception - If the claimant had an initial return to work during an extension period (between day 120 and day 180), and the monitoring of that return to work takes the FN past 180 days, the extension to follow for the 30 or 60 days is automatic through the completion of that 30 or 60-day period. No extra file documentation is needed through day 60 of the light duty return to work (or day 30 for full duty), but the FN assignment should be closed at the end of that monitoring period.

(2) Other than the automatic extension noted above, any assignment past 180 days needs an explanation in the file regarding why the extension is needed and what is expected during the next period. There should be 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 after the 180-day mark should usually be granted in 30 or 60-day increments (except for catastrophic cases). If an initial extension (after 180 days) is authorized, then another such extension is authorized, the same kind of rationale (purposeful decision making), direction, and file documentation is needed.

A typical scenario may occur when surgery is performed during the initial 120-day period, and if, despite a delayed recovery, the treating physician presents a clear prospect of a return to work release at the end of the 180-day assignment period, the extension of services could be given so that the FN can provide the EA with those restrictions and work with the EA on an appropriate job offer.

(3) If the claimant has an initial return to work during an extension period (after 180 days), the extension to follow is automatic through the completion of the 30/60 (full duty/light duty) period. No extra file documentation is needed for the return to work extension.

e. After 10 months of FN intervention, regardless of prior extensions, nurse intervention services should cease unless the case is within its first 30/60 day return-to-work monitoring period or is a true catastrophic case requiring ongoing intervention.

If the Supervisor (based on a recommendation from the CE and SN) believes that ongoing FN services would be useful (beyond 10 months) due to the unique circumstances of a given case (e.g. a case where major surgery was significantly delayed, and then the claimant encountered significant obstacles during medical recovery which took longer than expected to resolve), the Supervisor may authorize an additional extension as long as the file is documented appropriately as outlined above.

f. The assignment period for task-based assignments is significantly shorter. These assignments occur later in the life of a case, usually after early nurse intervention services have expired, and the goal is very task oriented. When assigned, the FN should be notified of the specific task and the time period allotted for completion of the task. Once that specific task has been accomplished, FN services should be closed. Usually these assignments should last no longer than 30-60 days.

11. Dual Tracking. The CE has the option to take a dual track intervention approach on certain cases. Dual tracking is when both a FN and rehabilitation counselor (RC) are assigned to a case at the same time. The CE should also refer to FECA PM Chapter 2-0600-8, 2-0600-9 and 2-0813-5. Accepted cases with active FN involvement may be assigned to a RC in order to facilitate an earlier return to employment. The FN may recommend such an approach to the CE, or the CE can determine the benefit and direct such action independently.

There are certain instances when this dual intervention is appropriate and there are specific and distinct goals for both the FN and RC.

a. Criteria for Dual Track Intervention. The dual track approach is warranted in two basic circumstances:

(1) Placement Previous Employer. If the EA is trying to accommodate the claimant's work restrictions, but is having difficulty formulating a position, the FN or CE can recommend the services of an OWCP RC. For instance, if vocational testing, an ergonomic evaluation, or assistive technology would enable the EA to offer a job to the claimant or explore job opportunities for placement in another departmental position, dual assignment of an RC in conjunction with the FN may be appropriate and useful.

(2) Placement New Employer. 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, the claimant may benefit from a dual approach where the FN continues to assist with medical recovery while the RC begins early vocational assessment and planning.

b. Purpose and Scope of Dual Tracking. The purpose of the dual track approach is to obtain medical recovery as soon as possible while at the same time achieving an early return to work. This may be with either the EA or a different employer.

(1) The FN primarily works with the treating physician to obtain as early a recovery as possible and maximum work tolerance limitations.

(2) The RC can provide rehabilitation services to the claimant and the EA that will allow the EA to formulate a suitable job offer, e.g. vocational testing, a transferable skills analysis, an ergonomic evaluation, etc. Or the RC can work with the claimant to determine his/her skill level and the potential labor market for medically suitable employment if the EA is unable to accommodate the claimant.

(3) If the EA cannot accommodate the claimant's work restrictions, once the FN has obtained stable, well-defined work tolerance limitations, nurse intervention will end and the vocational rehabilitation program will continue.

(4) The FN and RC should communicate with one another during this process. Also, the FN will work with the SN, and the RC will work with the rehabilitation specialist (RS), but the CE will lead the process.

c. CE Responsibilities. The CE is responsible for recognizing this dual track potential and for making the VR referral during the nurse intervention phase. It is recommended that the CE discuss this potential with both the SN and the RS before making such a referral. Ultimately, it is the CE's responsibility, in coordination with the SN and RS, for keeping both the FN and the RC within their roles and achieving the best outcome.

Once a case has been accepted for both types of intervention, the CE should send out a letter to the claimant and EA about this dual track approach, explaining the roles of both the FN and the RC as well as the claimant's own responsibilities in cooperating with this approach.

12. Medical Management. A variety of medical issues arise while a case is in nurse intervention. It is the CE's responsibility to be aware of these issues and to take prompt action on those requiring further clarification and CE response. 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. It is important, therefore, for the CE to utilize the services of the FN in a constructive way, keeping in mind that the ultimate goal of nurse intervention is to minimize the length and extent of disability whenever possible.

a. Initial Actions. The CE has two primary medical intervention options during Nurse Intervention. One is a letter to the claimant's treating physician, and the other is a second opinion referral. Also, the CE may consult with the District Medical Advisor (DMA) or SN regarding diagnosis, length of disability, proposed treatment plan, or any medically-related issue for the purpose of gaining a better understanding of the nature of injury and to help formulate the next appropriate intervention. Any or all of these types of medical interventions may be taken simultaneously while a FN is working on a case.

The timing of these actions is important. First, the CE must recognize that there is a need for such an intervention, and then the CE must determine the best type of intervention. For example, if a treating physician notes a change in diagnosis or extends disability without rationale, the CE should recognize these as obstacles or barriers and take prompt action to determine whether that change in diagnosis is medically supported, whether it is related to the accepted mechanism of injury, and then obtain information on the probable outcome. Other red flags requiring CE medical intervention action are continued extensions for physical therapy without clear goals or direction, as well as multiple, concurrent medical conditions which may further complicate a successful return to work.

The type of intervention depends upon the CE's determination of the quickest resolution to these obstacles, knowledge of the claimant's EA's ability to reemploy injured workers in various capacities, as well as awareness of claimant motivation. The FN may also make recommendations.

(1) Treating Physician. The claimant's treating physician generally has the most knowledge about the claimant's work-related medical condition, as well as any non-work related medical issues, and the attending physician is the one who is recommending specific treatment options for the claimant. When any concerns or issues are identified by the CE or raised by the FN, the CE has two options during the nurse intervention period.

(a) The CE can issue a targeted letter to the claimant's treating physician specifically requesting rationalized medical information in order to clarify any medical issues. Any letter should be tailored to fit the specifics of the case, identifying the specific medical issues or concerns and seeking clear responses in order to obtain the best results.

(b) The CE can direct the FN to obtain the specific information from the physician. Since the FN should have a working relationship with the claimant's physician, in many instances he or she can obtain the clarifying or necessary information in a more expedient manner.

(2) Second Opinion Referral. The CE may opt to obtain a second opinion examination during Nurse Intervention. When possible, it is recommended to make this referral while the FN is still assigned to the case so that upon receipt of the report the FN can assist with the medical information obtained. For example, if the second opinion physician recommended surgery or a different treatment modality, the FN can be instrumental in coordinating pre- and post-operative care for the claimant.

(3) DMA Referrals. The DMA can be a valuable resource for the CE to help better understand a claimant's medical condition, treatment proposed, and potential outcomes with respect to whether a claimant may be able to return to some form of gainful employment. The DMA can provide an opinion with regard to the appropriateness of certain types of surgical requests and, if necessary, advise whether further information is required, or whether a second opinion might be necessary.

(4) Consultations with the SN. The SN is uniquely qualified to assist CEs with medical issues that arise during the nurse intervention process. The SN may help CEs gain a better understanding of the FN reports and recommendations offered, and then to direct FNs to obtain clarifying information. The SN may also help the CEs formulate appropriate questions to the attending or second opinion physicians.

SNs are able to assist the CEs in understanding the particular treatment being recommended or undertaken by a claimant. The SN may also assist with determining whether a functional capacity evaluation (FCE), a consultation with a specialist, or a home health aide would be necessary, or whether more information is required. Together with the CE, the SN can help to explore the medical intervention options in order to maximize early recovery and return to work.

b. Secondary Actions. After a response has been received from the attending physician or a second opinion report has been received, the CE is responsible for reviewing the report and formulating the next course of action. The CE should send a copy of the report to the FN, if he or she does not already have it, and discuss the next course of action. The SN may also be involved if necessary. In problematic cases it may be advisable to conduct a conference call with the FN. Such a call may also include the SN, claimant, and/or EA to discuss the evaluation results and potential for return to employment.

It is essential that the CE take prompt follow-up action on these medical interventions, since the FN has a limited assignment period on the case. It may be necessary to extend the FN's time on the case, but that can best be determined if the CE reviews the medical evidence promptly and

discusses the findings with the FN and/or SN. The sooner the next course of action is determined, the greater the likelihood that the claimant obtains the necessary treatment and achieves a faster recovery so that he/she may return to work. If a claimant returns to work while the FN is still assigned to the case, the FN may assist the claimant with certain post-employment services, which generally help the claimant remain at work.

13. Best Practices. The CE and FN work together as a team to assist the claimant in the earliest and best recovery possible, as well as a successful return to work. The goal is for the claimant to return to full-duty work within one year from the date of injury (during the period of retention rights set forth in 5 U.S.C. 8151). Timely and appropriate disability management, good CE judgment, and directed action make the likelihood of achieving this goal more realistic. Adjudication of a claim at the first opportunity, prompt payment of compensation to a claimant who is disabled, and early nurse referrals greatly assist in this endeavor.

Once a FN has been assigned to an accepted case, there are some practices that a CE should utilize in order to obtain the targeted outcome. Some of these best practices are identified below, but each case is unique and every intervention action should be crafted to the specific circumstances of that particular case. All of these practices involve consistent and timely communication between the FN and the CE, timely CE response to FN recommendations, and identification of medical obstacles as well as prompt intervention with a non-cooperative claimant.

a. Conference Calls. During the nurse intervention phase, CEs will find that conference calls with all parties are most useful. These multi-party calls can involve the SN, the claimant, the EA and the FN. Depending upon the stage of recovery, the CE may initiate a conference call with all of these parties at the same time. When a job offer is found unsuitable, a conference call with the EA, the claimant and FN often effectively defines the deficiency and the result is a suitable offer. If a claimant has been out of work for a longer period of time, a conference call can help get the worker involved again with the EA and can be helpful in addressing fears about returning to work. The CE may ask the FN to coordinate the scheduling of the conference with all parties, which will enable the CE leading the conference to focus on the direction and goals. See PM 2-0600-12 for more information on conferences during Disability Management.

b. Surgery. If a surgery has been authorized, the FN may assist in both the pre- and post-operative management of the medical care for the claimant. The FN may attend the pre-operative appointment, assist the medical providers with billing, and help the claimant with recovery coordination and support. The CE can rely on the FN to coordinate securing any prescribed durable medical equipment and home health aides, if necessary. Results are best attained when the CE is available to the FN, who may have authorization and compensation questions. After surgery and sufficient recovery, the CE should direct the FN to obtain work restrictions and to make contact with the EA for a job offer. A pre-surgery conference call with the claimant and the FN is a good tool, as it provides useful information to the claimant, allows the CE to better identify intervention points based on anticipated stages of recovery, and often facilitates an earlier return to work because it sets the stage for what the claimant may expect from OWCP post-surgery.

c. Extensions. A FN should be aware of the time frames within which he or she is working and, if an extension is necessary, the FN should request such in advance. The CE should be aware of what the FN has been accomplishing and the current status, so that when an extension is requested, the CE will know whether it should be authorized. Extensions are most useful when a return to work is imminent or there are work restrictions in file and the EA is willing and able to accommodate work limitations. The CE should be reasonably assured that a return to work will occur and should be clear about the reasons for, and the goals of, the extension. If it is not for an imminent return to work, then an extension should only be authorized to finalize some work restrictions or to obtain some other clearly defined goal.

d. Recurrences. To be most effective, a FN referral should be made when a recurrence of disability is accepted. Such a referral should be treated similar to an initial referral for FN services. There should be a targeted goal outlined by the CE to the FN, and the CE should work closely with the FN to attain these goals: recovery and an early return to work. The CE may want to discuss the selection of the FN assigned with the SN prior to referral, since the reassignment of the same FN that had been assigned prior to the recurrence may be appropriate based on that FN's background on the case and rapport previously established.

e. Partial Disability. The CE may make a FN referral when a claimant has already returned to work in a light-duty capacity. In order for nurse intervention to be successful, the CE should identify the referral goal as maintaining the claimant at work or attempting to increase the claimant's work tolerances. The FN may arrange for an FCE and for the treating physician the opportunity to review the results of the FCE. The FN can also help to coordinate a treatment plan which greatly encourages an increase in work tolerance limitations. The EA should be willing to accommodate any changes in work restrictions and be generally supportive of the FN or RC in facilitating an ergonomic assessment, if needed, and the purchase of ergonomic equipment. The CE, however, should be actively involved in this activity and work closely with the FN on the goal of increasing work hours and activities.

f. Catastrophic Cases. Due to the complexity and long-term nature of catastrophic cases, CEs should make a FN referral as soon as the case is accepted. The SN, CE and FN (and RC if assigned) should work together closely for the best results. Often the claimant and family members are involved in such cases. There are often multiple medical or nursing facilities, physicians, therapists, attendants and durable medical equipment providers involved in the care of the claimant, all of which require billing and authorization actions in addition to the coordinated care of the claimant. CEs should work closely with the SN, who is instrumental in directing the FN as to what our program provides in these situations.

Close communication and collaboration is the key to working through the multiple phases of a catastrophic claim. Hospital team conferences may be useful, and the CE and FN should participate. It is often a good idea for the SN to also participate in these conferences in order to provide appropriate guidance about FECA coverage and the benefits available. Often, alternative living facilities or intensive home health care is needed after the initial acute phase of care. CEs should rely on the expertise of the FN and SN to assist in locating the best and most cost-effective provider available to the claimant. Whenever possible, the CE should be cognizant of

the possibility that even a severely injured claimant may be able to perform work activities, and then to consider a vocational rehabilitation referral when indicated.

Chapter 2-0812, Periodic Review of Disability Cases

1. Purpose and Scope. This chapter discusses procedures for monitoring disability claims paid on the periodic roll and for developing evidence to determine continuing entitlement to compensation, as well as the nature of that entitlement. Monitoring of death claims is addressed in FECA PM 2-0700. Forfeiture is discussed in FECA PM 2-1402.

Payment on the periodic roll is an efficient method of ensuring regular payment of compensation to those with long-term compensable disabilities. In all periodic roll cases, it remains the responsibility of the Claims Examiner (CE) to ensure that evidence remains current in the case, that all necessary medical care is provided, and that appropriate use is made of nursing and rehabilitation services. Quality case management, with active monitoring of the progress of the case, should be utilized to obtain the best possible outcome and a return to employment where at all feasible.

This chapter discusses review of the medical evidence, as well as the key factual elements to review in conjunction with the annual Form CA-1032.

2. Statutory Provisions. When a case has been accepted, the claimant is entitled to compensation benefits for disability and medical treatment for the medical condition(s) found to be related to the employment.

a. Sections 5 U.S.C. 8105 (total disability) and §8106 (partial disability) provide that compensation is payable for wage loss caused by a medical condition found to be related to the employment.

b. Section 5 U.S.C. 8107 (schedule award) provides that compensation is payable for the permanent loss or loss of use of certain anatomical members, functions, or organs of the body. Except for disfigurement, a schedule award is payable consecutively, but not concurrently, with an award for wage loss due to the same injury.

c. Section 5 U.S.C. 8111 provides for additional compensation for the service of an attendant where required; after January 4, 1999, this is paid as a medical expense pursuant to 5 U.S.C. 8103.

3. Burden of Proof for Terminating Benefits. Having accepted a claim and initiated payments, OWCP may not terminate periodic compensation without a positive demonstration by the weight of evidence that entitlement to benefits has ceased. Generally, this means that a claimant's failure to reply to a request for a medical report is insufficient grounds to terminate benefits.

Failure to report for or cooperate with an OWCP-directed medical examination constitutes grounds for suspension of benefits under section 8123 of the FECA (see FECA PM 2-0810-13). When a claimant is receiving benefits on the periodic roll, benefits may not be terminated or reduced without giving the claimant prior notice and an opportunity to provide evidence of continuing entitlement except in a limited set of circumstances (see FECA PM 2-1400).

4. Placement on the Periodic Roll. When the medical evidence indicates that disability is expected to continue for more than 60-90 days, compensation should usually be paid on the periodic roll. When periodic roll payments are initiated, the CE should advise the claimant by Form CA-1049 or equivalent narrative letter. The letter should notify the claimant of the conditions for termination of benefits without prior notice and the requirement that employment be reported. A copy of the notice should be sent to the employing agency regardless of the ☐ claimant's current employment status. [Back to Chapter 2-0812 Table of Contents](#)

5. Monitoring Claims on the Periodic Roll. After payment has begun, the CE is responsible for obtaining medical and non-medical evidence to determine continued entitlement. The CE is responsible for annual review of cases on the periodic roll to ensure that payments are correct and that continuing entitlement is substantiated in the file.

All cases on the periodic roll require completion of Form EN-1032 on a yearly basis. Form CA-1032 is the cover letter for the EN-1032. The office generates and mails Form CA-1032 (with EN-1032 attachment) to claimants. The CE should then review each case after 30 days has elapsed and complete the Periodic Entitlement Review (PER) in the Integrated Federal Employees' Compensation System (IFECS). Within 180 days of the PER create date, the CE should either close the PER, or, if a follow up action is needed, the CE should take the necessary action and take subsequent actions at least every 120 days thereafter until resolved. The PER is discussed in further detail in paragraph 15 of this chapter.

a. Elements of the Review. The CE will document the PER annually, and all cases on the periodic roll will be monitored closely to:

- (1) Determine whether the accepted work-related condition is still active or has resolved.
- (2) Verify continuing entitlement to compensation and the appropriate level of payments.
- (3) Reduce or terminate compensation payments when a claimant recovers from the employment-related condition or returns to work.
- (4) Initiate vocational rehabilitation and reemployment action as soon as it appears that permanent impairment may result or a change of job duties may be required due to the work-related injury.

The factual and medical elements of the review are outlined in detail in the following paragraphs.

b. Timeframes for Medical Evidence. The medical evidence is reviewed annually, and the file should contain a physician's rationalized opinion with regard to whether continued disability is causally related to the employee's accepted injury or illness. However, depending on the nature of the condition, such medical evidence may not be required on an annual basis. 20 C.F.R. §10.501(a)(2) provides that, "For those employees with more serious conditions not likely to improve and for employees over the age of 65, OWCP may require less frequent documentation, but ordinarily not less than once every three years." Therefore, the following guidelines should be used when determining the adequacy of medical evidence in the file:

- (1) PR. Cases in which temporary total disability payments are being paid require medical evidence as described in this chapter once a year.
- (2) PW. Cases in which payments are being made for a loss of wage-earning capacity require medical evidence as described in this chapter every two years.
- (3) PN. Cases in which the CE has determined, and the Supervisory Claims Examiner has verified, that no wage-earning capacity exists require medical evidence as described in this chapter every three years.
- (4) PS. No medical reports need to be requested in a case where a schedule award is being paid. These cases require annual release of Form CA-1032 where payment extends beyond one year to determine the status of dependents for which augmented compensation is being paid. If the dependent's status is at issue, the case may be reviewed more frequently. Note, however, that failure to submit the CA-1032 in PS cases should not result in termination of the payment of schedule award benefits. Instead, entitlement to the augmented compensation rate should be suspended and payments should be reduced to the 2/3 compensation rate pending further development and/or receipt of the completed CA-1032 supporting the augmented compensation rate. No action regarding the schedule award benefits is necessary if compensation is being paid at the 2/3 rate.

Claims examiners should ensure that medical evidence is dated within 1 year of the PER create date in PR cases, 2 years of the PER create date PW cases, or 3 years of PER create date in PN cases.

6. Medical Elements of Review. Medical evidence should be obtained in accordance with the case status, as noted in paragraph 5 above, in order to determine the progress of the employment-related condition and the extent of impairment resulting from this condition.

General procedures for obtaining medical evidence are contained in FECA PM 2-0810. Where adequate medical reports are not received at intervals reasonable to the particular case, it is the CE's responsibility to obtain them or to make an appropriate referral for a second opinion medical examination using the authority provided in 5 U.S.C. 8123.

The CE may contact the claimant's attending physician directly, with a copy to the claimant, to obtain medical evidence containing the information shown below. Alternatively, the CE may write directly to the claimant and advise that current medical evidence must be submitted to

support continuing payment of benefits. The claimant need not be examined if the physician can provide the requested information from his or her records and an examination has occurred within the timeframes described in paragraph 5 above.

If appropriate, specific questions should be addressed to the physician regarding whether a temporary aggravation has resolved or whether the aggravation has caused a material change in the pre-existing/underlying condition; whether the claimant's physical condition permits a return to the job held at the time of injury or to a more restrictive position; or whether the claimant would be a candidate for vocational rehabilitation. A copy of a current and accurate Statement of Accepted Facts (SOAF) should be enclosed if it would assist the physician with providing a response. SOAFs are discussed in FECA PM 2-0809.

a. Content of Medical Reports. Regardless of whether the CE contacts the physician or the claimant, the medical report should include:

- (1) The date of the most recent examination.
- (2) Results of recent objective testing.
- (3) Physical examination findings.
- (4) The diagnosis of any conditions present.
- (5) A well-reasoned medical opinion supported by the physical findings and objective testing as to whether the current condition(s) is related to the employment.
- (6) The claimant's work restrictions, including a completed Form OWCP-5, if applicable.
- (7) The type and frequency of medical treatment being provided or recommended.
- (8) Prognosis for continued recovery.

Note: At the discretion of the CE when determining the adequacy of medical evidence in the file, for those employees with more serious conditions not likely to improve and for employees over the age of 65, where the overall evidence of file supports the existence of an employment-related condition and disability and where there is no indication of recovery from the employment-related disability, some of the above elements need not be included in the medical report.

b. Follow-Up Actions.

(1) If sufficient medical evidence is in file, the CE should review the reports to determine whether disability is related to the employment injury; whether disability for the job held at the time of injury continues; whether appropriate medical treatment is being given; and whether the case should be expanded to include consequential conditions. If partial disability is indicated, the CE should determine whether the claimant's work limitations permit any employment. If so, the CE should refer the case for vocational rehabilitation services (see FECA PM 2-0813).

(2) If a medical report is not received within the specified time (30-60 days should be considered reasonable) or is not responsive to the questions asked, the CE may write to the physician for more information.

The CE may also direct the claimant to undergo an examination by a second opinion specialist. If the CE determines that a conflict of opinion exists between the claimant's attending physician and the second opinion specialist, the conflict must be resolved by a referee specialist. The OWCP should make an appointment for the examination. The notification to the claimant should include the warning that under 5 U.S.C. 8123(d) benefits may be suspended for failure to report for examination. Note that the sanctions outlined in Section 8123(d) may be invoked only in connection with a specific appointment (see FECA PM 2-0810).

c. Changes in Medical Status. The CE should take action based on the weight of the medical evidence as follows:

(1) Where injury-related disability has ceased, notify the claimant of proposed termination of benefits (see FECA PM 2-1400). The OWCP has the burden of proof to justify the termination of benefits by positive and specific evidence that injury-related disability has ceased. The inadequacy or absence of a report in support of continuing benefits is not sufficient to support termination.

(2) Where total disability has ceased but permanent residuals of the employment-related injury remain which prevent the employee from performing the regular duties of his or her date of injury position, action should be taken to reemploy the individual through vocational rehabilitation and placement with the previous employer or a new employer. This would be followed by a loss of wage-earning capacity decision, if appropriate.

(3) Where the claimant has no earning capacity and there is no reasonable prognosis for improvement based on the evidence in the file, the CE should prepare a memorandum to file for certification by the Supervisory Claims Examiner to establish placement in PN status. See Exhibit 1.

If the claim has been suspended for failure to complete the CA-1032, the CE can still propose to terminate benefits if the injury-related disability has ceased. However, the case cannot be referred for vocational rehabilitation, or be placed in a PN status, until receipt of the completed CA-1032 and reinstatement of compensation benefits.

d. Attendant Allowance. As part of the medical review of the case, the CE should also determine whether an attendant allowance is being paid and, if so, whether continuation of those payments is appropriate.

20 CFR §10.314 allows payment for services of an attendant where it is medically documented that the claimant requires assistance to care for personal needs such as bathing, dressing, eating, etc. Such services are paid as a medical expense under 5 U.S.C. 8103 and are paid directly to the provider of services. Prior to the January 1999 revision of the Federal Regulations, an attendant

allowance was paid directly to the claimant. Any such allowance approved prior to January 1999 will continue to be paid to the claimant until the need for the attendant ceases.

As part of the attendant allowance review, the CE should consider the following:

(1) Physical Examinations. When the condition requiring the services of an attendant is not permanent, periodic physical examinations must be arranged to determine whether the services of an attendant continue to be necessary. When a claimant is asked to report for examination and is unable to travel alone, transportation and other reasonable and necessary expenses may be paid for the attendant.

(2) Concurrent Receipt of Other Federal Payments. An attendant allowance is payable even though the claimant is receiving salary or sick or annual leave pay. A claimant who has elected benefits under the Civil Service Retirement System (CSRS) or the Federal Employees' Retirement System (FERS) may not receive an attendant allowance except for periods concurrent with payment of a schedule award by OWCP.

(3) Termination of Allowance. Where the evidence of record, including medical opinion evidence from the physician chosen by the claimant to provide treatment, establishes that an attendant allowance should be terminated, the claimant is to be given pre-termination notice and the opportunity to respond.

7. Employment and Earnings. Form EN-1032 serves as a report of earnings which OWCP may require under 5 U.S.C. 8106(b) when a claimant is receiving compensation. Form EN-1032 must be completed at least annually by claimants who are on the periodic roll or on the daily roll for more than one year.

a. Reporting Requirements. On Form EN-1032, claimants are specifically asked to report all employment for which they receive a salary, wages, income, sales commissions, piecework, or payment of any kind. 20 CFR §10.525 states that an employee must report all outside employment, including any concurrent dissimilar employment held at the time of the injury, even if the injury did not result in any lost time in that concurrent position. Claimants are also asked to report any employment held at the time of injury if he/she worked at that employment during any period covered by the form.

In addition to salaried employment, the claimant is required to report self-employment and unremunerated or volunteer employment. 20 CFR §10.526 stipulates that the fact that the claimant did not receive any salary for work is not a basis for failing to report this activity. See P.M., Docket No. 07-2169 (issued March 3, 2009) (ECAB found claimant failed to report volunteer activities where claimant was helping out friends by answering phones, making deliveries, and opening a florist shop); William H. Higgins, 34 ECAB 833 (1983) and Howard M. Sprayberry, 36 ECAB 115 (1984). The fact that business expenses may outweigh income does not excuse the claimant from reporting the earnings. See Gary L. Allen, 47 ECAB 409 (1996) (Although the claimant testified that his lawn mowing business lost money, ECAB affirmed the forfeiture of compensation noting that the CA-1032 form did not instruct the reporting of earnings based on profit or loss, but rather on what it would cost to have someone

else do the same work); William E. Steadman, 38 ECAB 688 (1987). Claimants are also required to report any work or ownership interest in any business enterprise. B.S., Docket 09-76 (issued September 30, 2009) (ECAB found appellant's argument that she was not required to report her assistance with her husband's business as she earned no wages to be without merit).

b. If there is any evidence on Form EN-1032 that the claimant has any type of employment or earnings, further action is warranted. Evidence of employment or earnings may also be found in other documentation in the file, e.g. a medical report, a vocational rehabilitation report, etc. Regardless of the source of the information, the CE is responsible for noting the existence of work activity or earnings and their bearing, if any, on continuing entitlement to compensation. The CE should pursue clarification and obtain further information from the claimant, the Social Security Administration, or the new employer. The CE may also consider referral to the Office of Inspector General if unable to obtain the necessary information.

c. Claimant. If earnings are reported, the CE may seek additional information directly from the claimant. When there is evidence that the claimant owns or is a partner in his or her own business, or is an officer in a corporation, the CE should request additional information from the claimant concerning the specific nature of the business and his/her involvement therein. This request should be made by narrative letter and questions should specifically address the circumstances of the case. The letter should include a reference to the Secretary's authority to require such information and the penalties associated with false reporting (the references contained in Form EN-1032 may be used). The letter should ask the claimant to sign and date his/her response, certifying the accuracy of the information given. Pertinent issues, depending on the nature of the employment, may include:

(1) Sole Proprietorship.

a) The name and address of the business, the owner of the business, and under whose name the business is operated.

b) The manager of the business and whether this person has any relation to the claimant.

c) The exact duties the claimant performed since the business was established, i.e. bookkeeping and accounting; advertising; purchasing merchandise, equipment and supplies; setting prices and hours of operation; sales; and personnel actions such as hiring, firing, rates of pay and promotions.

d) Who is billed by suppliers and who actually pays for the merchandise, with names and addresses of suppliers and clients.

e) Income secured from the business since its establishment and tax returns for all years in which the claimant is entitled to or claiming FECA benefits, and for one year prior.

f) The name of the person(s) who have authority to write checks and draw from the business bank account, as well as the name of the person who paid the business insurance premiums (with a copy of the policy).

g) Copies of any tax permits, business licenses, etc., for the business, along with the employer's identification number (EIN).

h) If the business premises were leased, the name of the person who holds the lease and pays the rent, along with the name and address of the landlord.

(2) Partnership. Many of the same issues noted above for sole proprietorship also apply to partnerships. Some issues specific to partnership include the following:

a) The names and addresses of the partners, with detail regarding which individuals have been held out as active partners, as well as the distributive share of the partnership of each partner and a copy of the partnership agreement.

b) The specific duties of each partner and the hours per week/month spent by each partner on those duties.

(3) Corporate Officers. Many of the same issues noted above for sole proprietorship also apply when the claimant is a corporate officer. Some issues specific to corporations though include the following:

a) The name, address and telephone number of the corporation and the date of incorporation, as well as a list of the major stockholders.

b) The type of business and the business structure prior to incorporation.

c) If previously self-employed (as a sole proprietor), the reason for incorporating, and the gross and net earnings in the year prior to incorporation with IRS Form 1040, Schedule F or C, and Schedule SE for that year.

d) A copy of the Articles of Incorporation, copies of the minutes of the corporate officers, and corporate tax returns for all years in which the business was incorporated and the claimant has been entitled to or is claiming benefits under the FECA, as well as copies of all W-2 forms attached to the claimant's personal tax return.

e) Names, addresses, salaries and personal relationships to the claimant (if any) of all corporate officers.

f) If there is a board of directors, the names, addresses, directors' fees and personal relationship to the claimant (if any) of all board members.

g) The number of people hired to work in the business, along with the names and addresses for some of these individuals.

h) Monies derived from the corporation broken down by amount, date received and type (i.e. monies representing dividends, rents, loan repayments, wages, reimbursement of personal expenses, and use of a company vehicle).

i) An explanation of how corporate profit has been distributed in any year since the date of incorporation, and if it has not been distributed, an explanation regarding why not.

d. Social Security Administration (SSA). When information of any kind is received suggesting possible employment or earnings, the CE should send Form CA-0935, with enclosure Form SSA-581, to the claimant in cases where compensation is being paid on the periodic roll for total disability. Form CA-0935 requests the claimant to sign the Form SSA-581 so that OWCP can obtain wage information from SSA for a specific period. Based on the circumstances in the case, it may also be necessary to send the Form CA-0935 to the claimant in cases where compensation is being paid based on a loss of wage-earning capacity. The CE should write the claimant's case number on the SSA-581 before it is mailed to the claimant.

Form CA-0935 need not be sent to every claimant every year, but should be sent when there is evidence of earnings that requires further development.

(1) If the claimant does not sign and return the Form SSA-581, a second request should usually be made. If Form SSA-581 is not signed and returned after a second request is made (and there is some indication in the file that the claimant may have earnings or work activity), the case may be referred to the Office of Inspector General (OIG) for investigation to determine if the claimant has in fact earned wages for the period under consideration. See FECA PM 2-0402. If so, forfeiture may be appropriate. See FECA PM 2-1402.

Benefits may not be suspended for failure to complete Form SSA-581, however, as authorization to obtain reports from SSA is not a requirement for receipt of compensation.

(2) If the claimant signs the Form SSA-581, the CE should release Form CA-1036 to SSA. Form CA-1036 must be accompanied by the signed release from the claimant on Form SSA-581. The form must include the claimant's full name, social security number, and date of birth in the spaces provided. The period must also be specified clearly with a beginning and end date.

Form SSA-581 is valid for only 60 days from the date signed by the claimant; hence, the CE should check the date the SSA-581 was signed before releasing the CA-1036. If the SSA-581 is older than 60 days, the CE must reissue a CA-0935 with a new SSA-581 to the claimant for completion before sending a CA-1036 to SSA.

The costs to OWCP for supplying the information are related directly to the period of time covered by the request. Therefore, the CE should ensure that the information is truly needed and that the request does not cover a longer period than necessary for the proper handling of the claim. Particular care should be exercised where the request concerns a period in excess of five years. The request should not include any period for which information has previously been requested from SSA.

e. New Employer. When information about a claimant's employment and earnings from a private employer will be helpful in determining the nature and extent of continuing entitlement to compensation, the CE may ask the new employer to respond to Form CA-1027 or an equivalent request. The new employer should be asked to provide the claimant's job title and brief

description of duties performed; the number of hours worked per week; the inclusive dates of employment; the weekly rate of pay, exclusive of overtime, but including the value of any board lodging, or other advantages received in addition to or in lieu of wages; any change in the rate of pay and the approximate date of each change; and, if the claimant is no longer employed, an explanation regarding why.

f. Investigation. Investigation may be considered when evidence concerning the extent of the claimant's disability, earnings or activity is in question and cannot be determined adequately by the evidence of record. See FECA PM 2-0402.

g. If the evidence demonstrates that the claimant worked during a period when compensation was paid, the nature and regularity of the work may be sufficient to demonstrate an earning capacity warranting adjustment of the compensation (even if the work itself did not result in earnings).

If the employee knowingly omits or understates earnings, compensation will be declared forfeit for the period covered by the requested report. Also, forfeiture may be declared for failure to report self-employment if a value could be placed on the work performed in the open labor market, and the evidence establishes that the claimant was aware or reasonably should have been aware of the requirement to report such employment. See FECA PM 2-1402 for a more detailed discussion of the forfeiture provision.

Note: Claimants are required to report and describe volunteer activity even if no remuneration is received, as reporting these activities and employment is material to a determination of continuing disability. Even if there is no immediate change in monetary compensation, OWCP must evaluate this information in the context of further case action. A claimant who is regularly performing his/her second job or engaged in regular volunteer activity may be sent for a second opinion evaluation or evaluated for vocational rehabilitation.

8. Dependents. A claimant's entitlement to augmented compensation is usually determined from information supplied by the claimant on Form EN-1032, although it may come in narrative form.

a. Reporting Requirements. On Form EN-1032, claimants are reminded that payment is made at 66 2/3% of the applicable pay rate if there are no dependents, and at 75% of the applicable pay rate if there are one or more eligible dependents. The EN-1032 asks relevant questions pertaining to a claimant's spouse and children.

The language on Form EN-1032 clearly defines a dependent as: (a) a husband or wife who lives with the claimant; (b) an unmarried child, including an adopted child or stepchild, who lives with the claimant and is under 18 years of age; (c) an unmarried child who is 18 or over, but who cannot support himself or herself because of mental or physical disability; (d) an unmarried child under 23 years of age who is a full-time student and has not completed four years of school beyond the high school level; or (e) a parent who totally depends on the claimant for support.

Further, Form EN-1032 clarifies that augmented compensation may be claimed for a spouse or dependent who does not live with the claimant if a court has ordered the claimant to pay support to that person. The augmented rate would also apply for a spouse, an unmarried child under 18, or an unmarried child between 18 and 23 who is a full-time student, even if that person does not live with the claimant, as long as regular direct payments are made for his/her support.

Lastly, the claimant is reminded that he/she may not receive augmented compensation for an ex-spouse, even if court-ordered alimony is being paid, and that it is the claimant's responsibility to report any changes in dependents as soon as those changes occur.

b. If there is any question pertaining to the status of the claimant's dependents, the CE should request clarification from the claimant. Birth, death and marriage certificates should be requested if necessary. Investigation, as outlined in FECA PM 2-0402, should be considered when evidence concerning the existence of eligible dependents is in question and entitlement cannot be determined adequately by the evidence of record.

c. Students. A letter to verify student dependency should be released to the claimant for completion shortly before a child reaches the age of 18 if augmented compensation is being paid solely on the basis of a dependent whose dependency status rests on the "student" requirement. A request should be released for completion on yearly basis thereafter for the duration of the award, or for the duration of entitlement to augmented compensation on the basis of status as a "student." The claimant is required to report any changes to student status in the interim. The Student Dependency letter can be used for this verification.

d. Dependent Incapable of Self Support. If the claimant has a dependent over the age of 18 due to the fact that the dependent is incapable of self support, the CE must review the case record to determine continued eligibility. The medical evidence in the file pertaining to the dependent should reflect that the dependent is incapable of self-support by reason of a mental or physical disability. A claimant is not entitled to augmented benefits for a child over 18 due to the child's inability to obtain employment due to economic conditions, lack of job skills, etc.

A request should be released on a yearly basis asking the claimant to submit a medical report verifying that the dependent's medical condition persists and that it continues to preclude self-support. Such a request should be sent each year for the duration of entitlement to augmented compensation on the basis of a dependent over the age of 18 being incapable of self-support. The Student Dependency letter can be used for this verification.

As outlined in 20 CFR §10.417(d), if the status of such a dependent is unlikely to change, the claimant may establish the permanency of the condition by submitting a well-rationalized medical report which describes that condition and the ongoing prognosis of that condition. Once the permanency of the condition is established, the CE does not need to seek further information regarding that condition; however, if there is a change in that condition, the claimant is required to immediately report that change to OWCP. If the permanency of such a condition is established, the CE should prepare a memorandum to the file for concurrence by the Supervisory Claims Examiner.

e. Entitlement to augmented compensation may be suspended (i.e., compensation may be reduced from 75% to 66 2/3%) if OWCP does not receive a timely response to a request for information concerning eligible dependents. See 20 CFR §10.536 and paragraph 14 in this chapter.

9. Dual Benefits. Receipt of benefits from other Federal agencies such as the Office of Personnel Management (OPM), Social Security Administration (SSA), or the Department of Veterans' Affairs (VA) may require an election of benefits or an offset. Other benefits such as separation incentives or buyouts may also require an offset of compensation benefits. See FECA PM 2-1000 for a detailed discussion of dual benefits.

a. OPM Retirement Benefits. Form EN-1032 asks the claimant to report any retirement benefits (either disability or regular) received from the OPM, the Foreign Service, or any other Federal disability or retirement system. Claimants are asked to provide their CSA number, if applicable, and specifically note whether any check received is for disability or retirement.

When a claimant or beneficiary is entitled to disability/death benefits under the FECA and annuity benefits from OPM under the Civil Service Retirement System Act (CSRS) or the Federal Employees' Retirement System Act (FERS), the claimant/beneficiary must make an election between OWCP and OPM benefits.

b. VA Benefits. Form EN-1032 asks the claimant to report any increase in VA disability benefits resulting from the accepted work-related injury. The claimant is asked to provide his/her file number, the kind of disability for which the award was made, and whether the percentage of the VA award has increased since the accepted work-related injury for which the individual is receiving benefits under the FECA. If the award did increase, the claimant is asked to provide the date of the increase.

If the claimant is receiving benefits from the VA for the same injury for which FECA benefits are being paid, the CE should send Form CA-1019 or equivalent request to the VA. If the claimant's award from the VA has increased as a result of the injury, the claimant must make an election between FECA benefits and the increased VA benefits.

c. SSA Benefits. Form EN-1032 asks the claimant to report any benefits received from SSA as part of an annuity under FERS. Claimants are instructed that they are not required to report any benefits received from the SSA on account of employment in the private sector.

The CE should review the file carefully if the claimant is 62 years or older and is under the FERS retirement system, since a FERS offset may be required. An offset is not required for CSRS benefits. If the CE cannot determine what retirement system the claimant is under, the CE should send a letter to the claimant and to OPM to request information. The CE should review the case for this possible dual benefit regardless of the claimant's response to the relevant question on the EN-1032.

d. Other Benefits. Form EN-1032 asks the claimant to report any Federal Black Lung benefits or any other benefits paid by the Federal government, not including benefits under the FECA, to include the type and value of any such award.

10. Third Party Settlements. Form EN-1032 asks the claimant to report any settlement or award from a claim or suit against a third party in connection with the injury or illness for which he/she is receiving compensation. The claimant is reminded that this includes any product liability or medical malpractice settlement/award received that relates to treatment for the accepted injury or illness.

The CE should refer any cases in which settlements have been newly made to the Office of the Solicitor.

11. Fraud and Felony Conviction. Form EN-1032 asks the claimant whether he/she has ever been convicted of a fraud-related offense in connection with the application for or receipt of workers' compensation benefits, and whether he/she has been incarcerated for any period during the past 15 months for any felony offense.

If a claimant is convicted of fraud in connection with the application for or receipt of benefits under the FECA, 5 U.S.C. 8148(a) requires termination of all future benefits, including medical benefits. If a claimant is imprisoned based on a felony conviction unrelated to the FECA claim, 5 U.S.C. 8148(b) requires suspension of benefits to the claimant, but allows payment of benefits to eligible dependents during the time that the claimant is imprisoned.

12. Address Changes. If the claimant has provided a different address, the CE should update the case record in the case management system.

13. Actions Based on Form CA-1032 Responses. Information received in response to any of the questions posted on Form EN-1032 may require the CE to adjust or terminate compensation, and possibly initiate overpayment proceedings. Follow-up action in response to an outstanding issue on Form EN-1032 should be taken promptly (until the issue is resolved) in order to avoid or minimize any improper payment.

14. Suspension of Compensation. If a timely report of earnings is not made, the right to compensation for wage loss is suspended until the report is received. See 20 CFR §10.528. Likewise, entitlement to augmented compensation may be suspended (i.e., compensation may be reduced from 75% to 66 2/3%) if OWCP does not receive a timely response to a request for information concerning eligible dependents. See 20 CFR §10.536.

If the claimant fails to return Form EN-1032 within 30 days, the CE should first examine the file to determine whether extenuating circumstances exist (for example, the claimant is hospitalized or has just moved and had no time to notify the office). The CE should also verify whether the form was sent to the correct address.

a. If extenuating circumstances are not present and benefits are being paid for other than a schedule award, the CE should act to suspend compensation entirely, since no report of either earnings or dependents (if any) will have been received.

If extenuating circumstances are not present and a schedule award is being paid, only the entitlement based on dependents will be at issue. The CE need not act to suspend augmented compensation if some recent communication (a letter from the claimant or information from the student's school, for example) appears in the file showing that the claimant has at least one eligible dependent.

b. If extenuating circumstances apply or the form is received but not substantially completed, the CE should advise the claimant of the information which is still required and indicate that, unless a fully completed form is received within 30 days, benefits will be suspended.

c. Before effecting the suspension (whether of all compensation or of augmented compensation), the CE should send a narrative letter to the claimant which explains the basis of the action and notes the regulatory authority for it. The letter should state whether a report of earnings, a report of dependents, or both, are lacking and cite the date of the previous request. The letter should also advise the claimant that benefits will be restored retroactively once the necessary information is received (as long as it supports continuing payment). The decision should include appeal rights.

d. Fiscal Action. Compensation should be suspended as of the date of the final decision. No deductions for Health Benefits (HB) and/or Life Insurance (LI) will be made during the period of suspension.

e. If the requested information concerning earnings and/or dependents is received, the CE should act promptly to restore benefits. Compensation should be reinstated retroactive to the effective date of suspension where the evidence submitted supports the payment of benefits, and should include retroactive deductions for HB and/or LI premiums, as needed.

f. Medical Development. At the time of the suspension, if the medical evidence is not sufficient to support continued entitlement, the CE should proceed with medical development. Medical development should continue until current evidence is received containing the information necessary to evaluate the claimant's benefit level. Medical review of disability claims is discussed in FECA PM 2-0812.6.

15. Periodic Entitlement Review (PER) Codes. Codes used for documenting periodic entitlement review actions are documented by the CE in the Entitlement Review application in Disability Management (DM). PER action codes are noted below.

The PER action codes entered into the Entitlement Review application indicate development undertaken and the result of the entitlement review. Development actions taken as a result of the PER review should also typically be documented in the DM Tracking application in DM, especially if the development is medical in nature. Some final actions taken as a result of the

PER review should also be entered into DM Tracking, such as termination and suspension actions.

a. PER Development Codes are entered in the PER record when further action is required prior to closing the PER. If the CE has to develop the case for any reason, the CE should place the PER record into a development status by selecting an appropriate code as outlined below. In order to use a development code, a case-specific action should be taken corresponding with the date of the code.

NOTE: Even if compensation is being suspended for non-receipt of a completed EN-1032, if the medical evidence is not sufficient to support the previous benefit level (PR/PN/PW), the CE should continue with the necessary medical development and code the PER with the appropriate 1MS or 2MS development code. The PER record for the suspended case should remain open, in a development status, pending the receipt of the supporting medical evidence.

The 3ES code may, however, continue to be used where a suspension is the result of the failure to appear for or obstruction of an OWCP directed medical examination.

1AP	Medical development only, attending physician
1SR	Medical development only, SECOP or Referee
1FO	Factual development only, dependency, SSA/FERS offset, employment information, dual benefits, etc.
1MF	Medical and Factual development
1MS	Medical development after Suspension, to attending physician or SECOP
2SR	SECOP/Referee, or follow up if previously scheduled
2PR	Proposal to terminate/reduce compensation
2FO	Factual only, second request
2MF	Medical and Factual development
2MS	Medical development after Suspension, to SECOP or Referee

b. PER Closure Codes are entered in the PER record when the periodic review is complete. The evidence in the case file should substantiate the code selected as outlined below:

3EA	PER Closed with Payment/Entitlement Adjustment
3ES	PER Closed with Payment Entitlement Suspension/No Medical Entitlement Change
3ET	PER Closed with Payment/Entitlement Termination
3PN	PER Closed with no payment change/PN final memo
3NC	PER Closed with no payment/Entitlement change

16. Disability Management (DM) Status Codes. DM codes are used to document actions taken during disability management, such as sending a letter to a physician or scheduling a second opinion examination. DM codes are also used to document a "resolution" in a PRM case, such as a termination of benefits or a finding that the evidence of file substantiates the current level of entitlement.

DM codes are used to document actions that may coincide with the development undertaken as a result of a PER review or a final PER action. Note, however, that a PER action or closure code will not always coincide with a DM status code. The PER application is distinct from DM Tracking, each serving a unique purpose.

WTL or WTX codes are auto-populated when completing a PER record for any case with a status of PR or PN.

WTL code: If the CE answers "Yes" to the PER question "Valid work restrictions in file for all conditions?" entry of the date of the most recent medical work release outlining the necessary work restrictions in the PER record is required. The WTL code will auto-populate in the DM record. The effective date of the status will auto-populate with the date entered in the PER record (i.e. the date of the most recent medical work release outlining the necessary work restrictions).

WTX code: If the CE answers "No" to the PER question "Valid work restrictions in file for all conditions?" the PER will auto-populate the WTX code in the DM record. The effective date of the status will auto-populate with the date of the PER record closure.

There are DM status codes to reflect reduction of compensation, suspension of compensation, termination of compensation, and no change in entitlement. Not all DM status codes, however, count as a successful PRM resolution. For a complete explanation of DM coding, see FECA PM Chapter 2-0601.

2-0812 Exhibit 1: PN Memo Example

Subject: PN Memorandum to the File
File Number: 123456789
Employee: Claimant Name

Issue: The issue is whether the case should be placed in a "PN" status, since the claimant has no wage-earning capacity or re-employment potential for the indefinite future.

Requirements for Entitlement: In order for the case status to be updated to PN, the medical evidence must demonstrate that the accepted medical condition(s) has reached maximum healing or that no further improvement is anticipated. Additionally, the file must reflect that the claimant has no wage-earning capacity due to the severity of the claimant's medical condition and/or vocational prospects in the claimant's commuting area.

Background: The claimant, born 03/08/1949, was employed as Border Patrol Agent with the U.S. Department of Homeland Security. On 07/25/2002, the claimant was injured when he lifted a tire from the bottom of a stack and then slipped and fell, hitting his head. The claimant was unconscious for 45 minutes and hospitalized for several weeks. The claim was accepted for a herniated disc L4/5 without myelopathy, cervical herniated disc C4/5, and closed head injury. The claimant has not returned to work. He has had two work-related surgeries for his cervical condition and a lumbar fusion.

A request for an updated medical report was sent to the attending physician, Dr. John, on 06/10/2009. No response was received. It was determined that a second opinion evaluation was necessary. The appointment was scheduled for 08/21/2009 with Dr. Henry, a neurologist. Prior to the appointment, the physician was provided with a copy of the medical records on file, a Statement of Accepted Facts, and specific questions to answer. Dr. Henry provided a thorough and well-rationalized report. He opined that the claimant continues to suffer from a herniated disc in the cervical spine and failed back syndrome as a result of the spinal surgeries. Dr. Henry also indicated that the claimant continues to have severe cognitive deficits from the closed head injury. He may not return to work and continues to have severe physical restrictions as indicated on the OWCP-5.

Basis for Determination: Dr. Henry provided a well-rationalized, comprehensive opinion, including objective findings, and his opinion was based on an accurate history of the work injury. He provided a substantial, detailed discussion of his medical opinion. Based on Dr. Henry's report of 08/21/2009, the claimant is totally disabled due to the work injury, and his condition is not expected to improve.

Recommendation: The employee's wage-earning capacity has been considered, including the following factors: nature of injury, degree of impairment, usual employment, age, qualifications for other employment, and availability of suitable employment. The evidence of file establishes that the claimant remains totally disabled for all work, and his condition is not expected to improve. The case, therefore, should be placed in a PN status.

OPTION:

✓ A PCR code in Disability Management Tracking is also recommended, as the claimant continues to be entitled to the current level of benefits.

Chapter 2-0813, Vocational Rehabilitation Services

1. Introduction, Purpose and Scope. The Office of Workers' Compensation Programs (OWCP) emphasizes returning partially disabled workers to suitable employment through vocational rehabilitation efforts.

When it appears that the claimant's work-related injury will prevent a return to the job held on the date of injury (DOI), vocational rehabilitation services may be provided to assist the claimant in returning to the workforce in suitable employment. OWCP will make every reasonable effort to arrange for employment of a partially disabled worker, taking into consideration not only the effects of the work-related condition and any condition(s) pre-existing the injury, but also any medical condition(s) arising after the compensable injury. It is critical to understand that return to work placement efforts with the claimant's previous employer are an essential part of the vocational rehabilitation process and that vocational rehabilitation does not consist only of

testing, training and outside employment. Such rehabilitation efforts will be directed initially to the employing agency (EA), but if reemployment with the agency is not possible, OWCP will help the worker secure employment with a new employer. This may require OWCP to sponsor vocational training, if needed, to furnish the worker with the necessary skills to obtain other employment.

The Federal Employees' Compensation Act (FECA) allows the Office to direct a claimant to undergo vocational rehabilitation and to reduce, prospectively, the claimant's monetary compensation for refusal to do so.

This chapter explains the procedures for referring partially disabled workers for vocational rehabilitation services and describes the services which may be provided.

This chapter also addresses related topics such as restoration rights with the Federal government, medical rehabilitation and the effects of substance abuse, and what actions to take if the claimant elects benefits from the Office of Personnel Management (OPM) during the rehabilitation effort.

Lastly, this chapter explains the procedures for reducing monetary compensation when the worker fails to cooperate with the vocational rehabilitation effort, obtains new employment, or is unable to secure new employment.

Further information about vocational rehabilitation can be found in the OWCP Procedure Manual (PM), Part 3, Rehabilitation.

2. Statutory, Regulatory and Program Requirements.

a. Statutory Requirements.

Section 8104 of the FECA provides that a permanently disabled individual may be directed to undergo vocational rehabilitation. The injured worker shall receive compensation while cooperating and participating in the rehabilitation process.

Section 8111 of the Act allows the Office to pay an individual undergoing vocational rehabilitation additional compensation necessary for maintenance, not to exceed \$200 per month.

Section 8113 of the Act allows the Office to prospectively reduce compensation in accordance with a claimant's wage-earning capacity if he or she refuses, without good cause, to undergo vocational rehabilitation.

Section 8151 of the Act provides restoration rights for injured employees and is administered by the Office of Personnel Management.

b. Regulatory Requirements.

The Code of Federal Regulations discusses the vocational rehabilitation services provided at 20 C.F.R. §10.518. Additionally, the actions taken when the employee refuses to cooperate with

vocational rehabilitation are discussed at 20 C.F.R. §10.519, and the method used for determining compensation after services are provided is discussed in 20 C.F.R. §10.520.

c. Program Requirements.

The Vocational Rehabilitation (VR) Program is comprised of a Rehabilitation Specialist (RS) and the Rehabilitation Counselor (RC), who is a certified counselor and works on a contractual basis. The Claims Examiner (CE), with recommendations from the RS, is responsible for the management and overall direction of the case, even during the rehabilitation period.

A brief outline of the various roles is provided here, but more specific details pertaining to the different stages of vocational rehabilitation are provided throughout this chapter.

(1) The RS's responsibilities include, but are not limited to, the following: ensuring that there is a sufficient number of counselors to service the FECA Program's needs; monitoring the RC's performance in correlation to both the contract specifications and the quality of service provided; assigning RCs to particular cases; reviewing RC reports for completeness and timeliness prior to authorizing payment of bills; communicating with the CEs regarding the cases assigned for VR services; relaying important or time sensitive information to the CEs so that action can be taken if needed; providing guidance to CEs on how to recognize when vocational services are necessary to assist the claimant with returning to work; serving as a vocational resource to the CEs; and providing solutions for return-to-work barriers in cases.

(2) The RC's responsibilities include, but are not limited to, the following: evaluating the claimant's vocational abilities and transferable skills; facilitating employment placement including with the previous employer; arranging for vocational testing and training; overseeing Occupational Rehabilitation Plans; conducting labor market surveys; formulating a vocational re-employment plan; assisting the claimant with job-seeking skills such as resume building and interview techniques; arranging for specialized ergonomic job modification services; and making recommendations to the RS and CE if a particular barrier is hindering the return-to-work effort.

(3) The CE's responsibilities include, but are not limited to, the following: referring appropriate cases for rehabilitation services; evaluating medical determinations in cases; responding to requests from the RS or RC; reviewing rehabilitation plans for medical suitability; issuing warning letters if non-cooperation occurs; and issuing notices of proposed actions and formal decisions pertaining to a claimant's entitlement to compensation.

3. Compensation Entitlement during Vocational Rehabilitation.

a. Compensation for Wage Loss. Section 8104 (b) of the FECA provides that an individual undergoing an OWCP-approved rehabilitation program is entitled to receive compensation at the rate for total disability, less any earnings received from employment which is not undertaken as a specific part of the rehabilitation program.

b. Retirement Benefits. A claimant may not receive vocational rehabilitation services simultaneously with retirement benefits from the Office of Personnel Management (OPM).

However, a claimant may not use the retirement process to avoid the obligation to undergo vocational rehabilitation when directed by OWCP.

c. Schedule Awards. If a claimant requests a schedule award while participating in vocational rehabilitation, development of the award should proceed. Payment of the award, however, should usually be deferred until the completion of rehabilitation, since often a claimant will opt to receive OPM benefits concurrently with a schedule award, and concurrent receipt of OPM and OWCP benefits is prohibited during a period in which vocational rehabilitation services are being provided.

If a claimant is already receiving compensation for a schedule award while in rehabilitation, he or she should continue receiving those benefits unless the claimant is also receiving an annuity from OPM, in which case the claimant should be advised that he or she cannot be provided with vocational rehabilitation services while receiving an OPM annuity. The claimant should be offered an election, and if he or she elects OWCP benefits, the schedule award payments should be converted to payments for temporary total disability until completion of the rehabilitation effort. If the claimant elects OPM benefits, the schedule award benefits should continue and medical and factual development should be undertaken to determine the claimant's Loss of Wage-Earning Capacity (LWEC) at the end of the schedule award, but vocational rehabilitation efforts should be terminated. See paragraph 18 below for further direction when a claimant elects OPM benefits.

4. Restoration Rights with the Federal Government. Section 8151 of the FECA provides civil service retention rights to Federal employees who have recovered either fully or partially from an employment-related injury or illness, and who can perform the duties of the original job or its equivalent. The EA must restore a permanent employee (i.e., one with career or career-conditional status) who recovers within one year after beginning compensation to that position or its equivalent. This provision does not apply to temporary or term employees. 20 C.F.R. §10.505 explains that the employer should make all reasonable efforts to place the employee in his or her former or an equivalent position in accordance with 5 U.S.C. 8151 if the employee has fully recovered after one year. 20 C.F.R. §353.301 provides an overview of restoration rights for fully recovered and partially recovered employees.

OPM has jurisdiction and is responsible for enforcing this section. See *Pedro Beltran*, 44 ECAB 222 (1992) and *Charles J. McCuiston*, 37 ECAB 193 (1985) (claims for job reinstatement are not within OWCP's jurisdiction).

a. OPM's regulations on retention rights are published at 5 C.F.R. §302, 330 and 353. They require agencies to grant leave without pay (LWOP) to disabled workers for at least the first year the injured worker is receiving compensation.

b. An injured worker who has been terminated and who wishes to reclaim his or her job should be advised to contact the EA. If this effort fails, OWCP will contact the EA, citing 5 U.S.C. 8151 as the basis for the worker's attempt to regain employment. In addition, 5 U.S.C. 8151 (b) (2) and its implementing regulations provide for priority placement under certain circumstances. If this

course is also unsuccessful, the injured worker may be advised to exercise his or her appeal rights as provided by OPM.

c. When an injured worker resumes employment with the Federal government, the EA is required to verify that the worker had been receiving compensation during the entire period of absence from work, whether in LWOP status or separated. The agency will ask OWCP to advise whether the worker was receiving compensation and, if so, the period of compensation during which the worker was paid, so that the injured worker may be credited with all rights and benefits based on length of service.

d. Issues pertaining to retention rights should be referred to the EA or OPM, and CEs should not offer claimants advice on these rights. It should also be noted that not all individuals covered by FECA are entitled to restoration rights.

5. Referrals for Vocational Rehabilitation Services. The probability of effective rehabilitation, resulting in the best return-to-work arrangement, is greatly increased when such efforts begin as early as possible in the recovery process. This paragraph addresses the criteria and procedures for referring cases for vocational rehabilitation services.

a. The Claims Examiner (CE) should monitor cases for adequacy of the medical reports in reporting work capacity and ensure that the reports are current. Where a return-to-work date has not been given, but the medical evidence shows that the claimant is not totally disabled and the medical condition has stabilized, the CE, or Field Nurse (FN) if one is assigned to the case, will obtain a completed Form OWCP-5 (or equivalent) to show the work limitations.

If the attending physician cannot furnish work limitations, or if they appear inconsistent with those expected, the CE should initiate a second opinion referral (see FECA PM 2-0810).

If the attending physician has not released the claimant to work, the CE may also seek opinion regarding whether an Occupational Rehabilitation Program (ORP) would be appropriate, as outlined in paragraph 12 of this chapter.

b. The CE should ensure that the file contains the claimant's position description, including a report of the physical requirements, and any special psychological requirements if applicable, for the job held at date of injury. This information may be requested from the EA when the case is accepted, when the first compensation payment is issued to the claimant, or at any other time.

c. Criteria for Referral. If the current medical evidence indicates that the claimant has objective residuals of the work-related condition and has stable, well-defined work limitations which allow him or her to work 8 hours per day, the case should be referred for vocational rehabilitation services. If varying descriptions of work limitations appear in file, it may be necessary to weigh the medical reports and identify the physician's report that represents the weight of medical evidence. (A limited referral may be made for placement services when the claimant can work at least 4 hours per day. See paragraph j(1) below.)

Note - Prior to referral, the CE should review the medical evidence carefully to be sure that the claimant's work related condition is still present and disabling. The work restrictions on file should be reviewed in conjunction with the requirements of the date of injury job to determine if the claimant is capable of performing that position, prior to a referral for vocational rehabilitation. If the claimant's work-related condition has resolved, or he or she is capable of performing the duties of the date of injury position, the case should not be referred for rehabilitation services. Instead, a notice of proposed termination of wage loss and/or medical benefits should be issued. See PM 2-1400.

(1) Work restrictions should be current at the time of the initial referral. The medical evidence can be from the attending physician, second opinion examiner, or referee physician. The evidence should clearly establish that the claimant has stable and well-defined residuals. While the restrictions do not have to be on Form OWCP-5, work limitations from the accepted employment conditions that prevent the claimant from returning to the job held at the time of injury should be set forth in sufficient detail in terms of limitations and capabilities for an assessment of rehabilitation/work readiness to be made.

(2) The claimant should be capable of at least sedentary work, as defined by the Dictionary of Occupational Titles, or OWCP-determined equivalent, (including, pushing, pulling, and lifting at least 10 pounds, one-third of the work day, etc). If placement with the previous employer is not possible, the claimant should be capable of working on a full-time basis. A limited referral for part-time placement with a new employer may be considered in those labor markets with sufficient part-time work in the commuting area. See paragraph j(1) below.

(3) When the referral is made, the CE may advise the claimant by letter what the CE considers the claimant's restrictions and capabilities to be and which physician's opinion represents the weight of medical evidence and why. If work restrictions were provided by a second opinion or referee physician, the CE should identify the weight of the medical evidence by completing a memo to file or addressing it clearly in the letter to the claimant. If the second opinion or referee narrative report and OWCP-5 appear to contradict each other (e.g., the narrative report indicates sedentary work, but the OWCP-5 indicates less than sedentary), the CE should clarify this inconsistency with the physician prior to assigning weight to that particular report and making the referral for vocational rehabilitation services.

(4) There should not be any outstanding medical issues, work-related or non-work-related, precluding participation in the rehabilitation effort. If there are non-work related conditions apparent in the file, any restrictions resulting from those conditions should be clarified prior to referral.

However, if the claimant's only other disabling condition is a non-work condition that post-dates the work injury, you may consider a limited referral for the purposes of establishing a constructed wage-earning capacity (WEC). See paragraph j(3) below.

d. The FN may recommend a vocational rehabilitation referral at the end of nurse services. A referral may also be desirable if the claimant has not collaborated with or fully benefited from nursing services.

e. Active FN cases may also be referred for dual tracking. The referral in these cases will be for Medical Rehabilitation and the period will usually be limited to 3 months for concurrent services. In these cases, the restrictions may not be completely defined. As a result, full plan development cannot begin immediately with these claimants, but, in the interest of expediting the return to work, the RC may assist with work hardening and functional capacity evaluation scheduling and begin the groundwork for the development of a return-to-work plan by obtaining the claimant's work history, performing preliminary labor market surveys, and conducting a transferable skills analysis.

The FN will focus on the medical aspects of the case, and the RC will focus on the vocational aspects of the case. Once the claimant has stable and well-defined restrictions, nurse intervention will cease and the RS will direct the RC to begin actual plan development. Refer to FECA PM 2-0600-8(c) and 2-0600-9(e) for further information on the dual tracking of cases.

f. The FN or CE may also recommend a task based rehabilitation referral in conjunction with FN services. For instance, if vocational testing, an ergonomic evaluation, or assistive technology would enable the employing agency to offer a job to the claimant or explore job opportunities for placement in another departmental position, the FN or CE may recommend a dual assignment for this purpose.

g. To identify cases for early intervention, the Rehabilitation Specialist (RS) may use reports which list unscreened cases on the periodic roll, or cases closed after nurse intervention. The RS will notify the CE of cases which appear appropriate for rehabilitation services, including Occupational Rehabilitation Programs (ORPs). Unless there is a medical reason that the case is not in posture for referral, the CE should refer the case for rehabilitation services.

h. Cases in which rehabilitation services were previously terminated for reasons which are either unclear or no longer pertinent may be referred as long as the claimant is able to work 8 hours.

i. Making the Referral. The CE refers cases for vocational rehabilitation services using Form OWCP-14 (or equivalent). The referral should include:

- (1) The accepted conditions in the case, as well any accepted conditions in other FECA files that are pertinent with regard to medical restrictions. Other significant non-work related conditions should also be noted.
- (2) The name of the attending physician.
- (3) The physician's name and date of medical report which represents the weight of medical evidence.
- (4) The date on which disability (or recurrent disability) began, to identify the one-year time frame for placement with the previous employer.
- (5) Any medical or adjudicatory action which is in process or imminent (e.g., second opinion examination or referral for investigation).

(6) Whether or not the CE authorizes the RS or RC to contact the attending physician directly. The CE may authorize such contact when it will not potentially disturb the weight of medical evidence concerning work limitations. However, the CE should not authorize such contact when work tolerance limitations have been established by a second opinion or referee examination.

(7) The gross amount of compensation the claimant is awarded each week and the pay rate on which this amount is based.

(8) When the case is being referred on a limited basis, the CE should include the nature of the limited referral, the CE's assessment of the situation, and the desired action from the RC. See paragraph j below.

(9) An indication if Field Nurse (FN) services are active and the reasons for continued FN service (e.g., a remaining medical issue is still being resolved).

(10) An indication as to whether or not the agency has specifically indicated that placement services with the previous employer are inappropriate.

Once the referral has been completed and made a part of the case record, the CE should send a Vocational Rehabilitation referral to the RS via iFECS, which will automatically populate the appropriate code in the iFECS Disability Management (DM) record. See PM Chapter 2-601 for more details on DM Coding.

j. Limited Referrals. If the claimant is only able to perform part-time or sub-sedentary work, or could otherwise engage in active vocational rehabilitation services but for a non-employment-related condition which post-dates the injury, a limited referral for vocational rehabilitation services may be appropriate.

(1) For claimants who cannot work 8 hours per day, a referral may be made for placement services with the previous employer. Placement with a new employer may be considered in those labor markets with sufficient part-time work in the commuting area. If later medical evidence demonstrates an improvement in medical status, attempts to establish the claimant's ability to work a full day should be pursued.

(2) An Occupational Rehabilitation Program (ORP) may be appropriate when the specific work limitations are unknown or sub-sedentary but there is an expectation that a short period of medical rehabilitation will result in restrictions which can be used for a return to work. The CE may refer the claimant for an ORP when the physician prescribes a functional capacity evaluation, work hardening, or any other therapy program aimed at exploring work capabilities and documenting work restrictions. See paragraph 12 of this chapter for more information on ORPs.

(3) Where the weight of the medical evidence establishes that the claimant could work in at least a sedentary capacity due to the work injury, but is more severely restricted from work due to a non-employment-related condition which post-dates the injury, the CE should document the file with medical evidence that establishes the claimant's work tolerance limitations based on the

accepted work-related conditions and any pre-existing conditions. Whether a condition is considered a pre-existing condition should be determined by the date of first medical treatment for the non-employment-related condition as documented in the file.

The CE should identify the non-employment-related condition(s) which arose after the work injury and indicate that any resulting restrictions need not be taken into consideration when identifying positions which represent the claimant's wage-earning capacity. A referral will be made solely for the purpose of determining the claimant's capacity to earn wages in the open labor market based on the restrictions attributable to the work injury and any pre-existing medical conditions.

6. Placement with Previous Employer (PPE). Once a case has been opened in vocational rehabilitation for return-to-work efforts, the RC will work with the EA to modify the claimant's DOI job or identify another position within the agency (or department) which the claimant can perform, unless the agency has already indicated that reemployment with the agency is not possible.

a. Roles and responsibilities. In order for placement with the previous employer to be successful, active participation of the claimant, RC, and OWCP staff, as well as the EA, is crucial.

(1) Role of the RS. Within 5 business days of receiving the referral, the RS should take the following actions:

(a) Refer the claimant to an RC to address PPE, ensuring that the RC understands the need to reach a decision concerning employability within one year after wage loss began (or recurred) due to the claimant's retention rights, as described in paragraph 4 of this chapter;

(b) Contact the previous employer to discuss prospects for re-employment, including the use of assistive technology to facilitate work; and

(c) Advise the CE that the case has been opened via Form OWCP-35 or other file documentation.

Once the case has been referred, the RS should advise the CE if the claimant refuses to cooperate with vocational rehabilitation services. The CE will then need to review the case for possible sanctions as described in paragraph 17 of this chapter.

(2) Role of the RC. Working under the guidance of the RS, the RC provides counseling and guidance to the claimant to make sure that he or she understands the process and associated responsibilities. The RC maintains regular contact with the claimant and the previous employer to elicit job offers compatible with the work limitations identified by the CE. The RC may give the employer assistance in preparing a job description and identifying equipment which may be needed in order for the claimant to perform the specific duties of an offered position. As necessary, the RC may also arrange for job site analysis, vocational testing, and/or vocational evaluation to help the previous employer identify placement possibilities.

The RC may be asked to contact the field office after the first visit with the claimant so that all pertinent parties can discuss the rehabilitation effort. The RC may also participate in scheduled conferences.

(3) Role of the CE. The CE responds to any requests for medical documentation and determines suitability of any job offer that is made. If the claimant fails to cooperate or refuses a suitable job offer, the CE promptly issues a warning letter (see paragraph 17 of this chapter) and follows up to ensure compliance or issues a final decision with regard to the job offer.

(4) Role of the claimant. Claimants must be flexible and realistic regarding adjustments needed in the return-to-work effort, such as changes in shifts, salary, new work environment, etc. They are required to cooperate with efforts to find a suitable position with their EA and provide medical documentation when needed.

b. Time Frames. The RS will approve PPE for up to 90 days, with a 30-day extension when necessary, if the previous employer is making active, good-faith efforts to place the claimant.

(1) If the employer has shown no interest by the 30th day of PPE efforts, vocational testing and planning should begin while the RC continues contact with the employer.

(2) If no job offer is developed by the 85th day, or it seems apparent that there is no real interest in formulating a job offer, the RC will make a final contact with the previous employer to assess its interest in extending a job offer. If a job offer is not forthcoming, or there is no interest in developing such an offer, the RC will so notify the RS by telephone.

c. Interruptions. PPE may be interrupted or extended beyond 120 days when surgery, the need for medical treatment, or a change in work limitations warrants. Either the CE or the RS may identify such situations. If the RS advises the CE that a delay or extension of PPE seems appropriate, the CE should promptly notify the RS whether he or she agrees with this assessment. The CE should also notify the RS when PPE efforts should resume.

d. Outcomes.

(1) If the claimant returns to work with the previous employer, the RC will follow the claimant for at least 60 days after placement and submit a final report. The RS will advise the CE by OWCP-3 (or equivalent) of the outcome of PPE effort. The CE should then review the case to determine whether a formal LWEC decision is appropriate, even if the LWEC is 0%. If the job does not reflect the claimant's maximum wage-earning capacity in terms of duties performed and hours worked, the CE should continue to monitor the case.

(2) If the EA provides an offer of suitable employment, but the claimant does not return to work, the CE should review the case for application of sanctions in accordance with 8106(c). See PM 2-814.

(3) If the EA does not provide an offer of suitable employment, the CE and RS will need to take the next appropriate action in the vocational rehabilitation process. In these types of cases, the

RC will usually be asked to develop an alternative plan, based on vocational testing, which may include medical rehabilitation, training, and/or placement services for a new employer.

If the claimant cannot work 8 hours per day, the RS may interrupt services until a full-time schedule is feasible. The CE may also need to obtain additional medical opinion or a recommendation for an occupational rehabilitation plan from the attending physician, or take some other action to increase the claimant's level of readiness to seek work with a new employer. At this stage of the re-employment effort, it is not appropriate to refer the case back to an FN for additional action. The RS and RC should supervise any occupational rehabilitation program or similar effort.

7. Plan Development. If efforts to return the claimant to work with the EA are not successful, then the RC will need to develop a plan for the claimant's return to work with a new employer. During this phase of rehabilitation, the RC will identify jobs that are medically and vocationally suitable and reasonably available in the claimant's commuting area.

In some cases, plan development will be the initial phase of vocational rehabilitation, and in others it will follow services that were aimed at placement with the previous employer. If plan development is the initial phase, then the RC will need to conduct the initial interview. This interview will help the RC establish a rapport with the claimant, allow the RC to provide information about the rehabilitation process, and provide an opportunity for the RC to gather background information from the claimant that is necessary for a reemployment plan, such as employment history and educational background. If services were already provided for placement with the previous employer, the initial interview will already have been conducted.

Regardless of when plan development occurs in the vocational rehabilitation process, the services provided and the method of providing them are the same. The evidence and documentation submitted to support the plan, and the responsibilities of all parties involved, remain constant.

a. Selecting Jobs for the Reemployment Plan. Suitable jobs are identified by the RC while developing the reemployment plan. A number of factors are considered, including medical and vocational suitability and whether the jobs are reasonably available in the claimant's commuting area.

(1) Medically Suitable. All jobs targeted in the reemployment plan have to be medically suitable. The established restrictions are compared to the physical requirements of each position as listed in the Selected Characteristics of Occupations Defined in the Revised Dictionary of Occupational Titles or other guidance such as the FECA Physical Demand and/or Environmental Condition Definitions. See Exhibit 1 (Physical Demand Definitions) and Exhibit 2 (Environmental Conditions Definitions). The job requirements must not exceed the claimant's work abilities. See paragraph 5 of this chapter (Referrals for Vocational Rehabilitation Services) for more details about the medical documentation needed for a reemployment plan.

(2) Vocationally Suitable. The RC's documentation also should support that the targeted positions are vocationally suitable. If job placement will occur immediately after plan approval,

then the claimant must be capable of performing the identified jobs at the time of plan development. Vocational suitability can be established through a transferable skills analysis and vocational testing. If the proposed reemployment plan calls for training, then the evidence should establish that the claimant will have the vocational skills for the targeted jobs following training. In both cases, the claimant's skills and training are compared to the specific vocational preparation requirements as described in the Dictionary of Occupational Titles, or OWCP-determined equivalent.

(3) Reasonable Availability. Reasonable availability needs to be established for each position targeted in the plan. The RC uses professional experience and knowledge of the job market to document that the jobs which are medically and vocationally suitable for the claimant are also available in sufficient numbers to make successful placement reasonable. The RC will conduct a survey of the local labor market and document availability of targeted jobs by citing sources such as the local State employment service, the local Chamber of Commerce, employer contacts, and actual job postings. This research will also be used to establish salary information for the targeted jobs. The concept of "reasonable availability" does not necessarily equate to actual current job openings, which are dependent on the current economic climate. If the position is performed in sufficient numbers within the commuting area, it is considered to be "reasonably available."

b. Elements of a Vocational Reemployment Plan. There are a number of elements that the RC needs to ensure are included when plan approval is requested.

(1) Injured worker factors which affect the plan need to be documented. The claimant's medical status and resulting restrictions should be reviewed in this section. Additionally, any social factors which may affect plan success, such as family support, should be mentioned. Lastly, the results of any vocational testing should be discussed.

(2) Plan goals. At least two different medically and vocationally suitable jobs should be identified. A completed Form OWCP-66 is provided for each position that lists the job description according to the Dictionary of Occupational Titles, or OWCP-determined equivalent, and the physical requirements per the Selected Characteristics or other guidance such as the FECA Physical Demand and/or Environmental Condition Definitions. See Exhibit 1 (Physical Demand Definitions) and Exhibit 2 (Environmental Conditions Definitions). Current starting salary information should also be provided on this form and the source should be documented.

(3) Documentation of job availability in the form of a labor market survey should be included with the plan. In addition to the sources mentioned above, the RC may include additional information such as an industrial survey or a specific number of actual employer contacts.

(4) Plan justification and recommendation. The plan should describe the specific actions which are to be taken by the injured worker, the RC, and other professionals or facilities to reach the stated goals, along with an estimate of the time and the costs required. If training is recommended, the difference between the injured worker's earning capacity with and without training should be discussed.

There should also be a document which establishes that the claimant agrees with the plan as evidenced by his or her signature. This can be accomplished via a document created by the RC (such as an Individual Placement Plan) or via Form OWCP-16 if the plan will require additional funds beyond the amount initially approved by the RS. The plan should list the specific actions to be taken by the claimant and the RC that are necessary to reach the plan goals and provide time frames and estimated costs associated with these goals.

c. Roles and responsibilities. The successful development of a plan for reemployment requires the active participation of the claimant, RC, and OWCP staff.

(1) Role of the RS. The RS actively supervises the development of the plan and ensures the submission of monthly reports, as well as adherence to time frames. The RS issues guidance to the RC if the rehabilitation effort is not proceeding appropriately. Once the plan has been submitted, the RS reviews and approves it or returns it if the identified jobs are not suitable or the plan lacks the necessary documentation. Any extension requests should be reviewed by the RS.

(2) Role of the RC. The RC should be responsive to the RS's guidance, submit a complete and well-supported plan in the time allotted, and refrain from initiating the planned services without the approval of the RS. The RC should immediately report any non-cooperation to OWCP. The RC will maintain regular contact with the claimant, schedule any needed testing, and counsel the claimant. The RC has up to 90 days to submit a vocational rehabilitation plan and should request an extension before this period expires if there are extenuating circumstances.

(3) Role of the CE. The CE responds to any requests for medical documentation. If the claimant fails to cooperate with plan development, the CE promptly issues a warning letter (see paragraph 17 of this chapter) and follows up to ensure compliance or issues a final decision for continued non-cooperation. When the RS approves the plan, the CE has 5 business days to review the plan and make a determination on the medical suitability of all targeted positions. Once the plan has been approved by all parties, the CE should send a plan approval letter to the claimant.

(4) Role of the claimant. The claimant is expected to cooperate with efforts to develop a reemployment plan. This includes responding to phone calls from the RC, appearing for scheduled meetings, providing needed background information, undergoing vocational testing, and being willing to explore new occupations outside of the Federal government. In addition, the claimant cannot refuse to sign a suitable vocational rehabilitation plan without justification. For training plans, it is mandatory that the claimant sign Form OWCP-16 to indicate full understanding and agreement. Failure to sign the form is considered non-cooperation on the claimant's part and may require initiation of sanctions. (Refer to paragraph 17 of this chapter.)

d. Time Frames. The RC has up to 90 days to submit a vocational rehabilitation plan. If there are extenuating circumstances, an extension should be requested before that period expires. After the RS approves the plan, the CE should review the plan and make a determination on the medical suitability of all targeted positions within 5 business days.

e. Once the plan is approved, the CE should send a plan approval letter to the claimant, and the RS will direct the RC to move on to the next phase of vocational rehabilitation. If training was a part of the approved plan, that will be the next phase. Otherwise, the RC and claimant will move directly to job placement.

8. Training. A training program should be considered before placement with a new employer, if there is reason to believe that placement will not be accomplished without training. A training plan may also be considered if the claimant is a good candidate and training will significantly reduce the difference between the current salary of the job held on the date of injury and the salary in new employment with training, as compared to employment following direct placement without training.

After determining the claimant's job skills by completing a transferable skills analysis and vocational testing, the RC will review the claimant's medical restrictions and research the local job market in order to determine the claimant's employment prospects. If placement cannot reasonably be accomplished based on the claimant's current experience and aptitudes, then training may be considered.

Any proposed training program must fit the injured worker's abilities and limitations and must prepare the claimant for jobs that are available in the local labor market. The cost of the proposed training plan should be easily justifiable in view of the resulting increase in the claimant's wage-earning capacity. The claimant's motivation level and likelihood of success in the proposed training should also be considered. The claimant's personal desire to pursue a particular type of training is not the primary factor to consider when assessing training options.

If training is needed, short-term or pre-vocational training that would serve to upgrade basic skills are the preferred options. Long-term training plans should be pursued as a last resort, since returning the claimant to work in the shortest time possible is a primary focus of vocational rehabilitation.

a. Types of training. The type of training provided will depend on the above mentioned factors.

(1) Pre-vocational training is short-term and serves to upgrade basic skills such as literacy, but is not necessarily aimed at a specific occupation. For example, a GED preparation course and test would be considered pre-vocational training; or a several-week course that upgrades basic computer skills needed for many office jobs. Pre-vocational training can either prepare claimants for jobs existing in the labor market or can prepare them for more in-depth training.

(2) Formal training courses, or refresher courses, can be provided through business or trade schools, colleges, apprenticeship programs, tutoring, etc. Formal training can be provided for professional, semi-professional, technical, clerical, agricultural, skilled or semi-skilled occupations.

(a) Short-term training should be considered first because it is likely to be more cost-effective and requires less of a commitment from the claimant. A certification program requiring several months of training is preferable to a multi-year degree program. If the claimant has skills or a

degree in a particular field such as the health field but has not maintained the required certifications or licensure, a refresher course may be considered.

(b) Longer-term training, such as college training, should only be considered if the claimant shows exceptional ability and there is a great probability of employment with minimal or no loss of wage-earning capacity upon completion of the program.

(3) On-the-job training is another option for increasing the employability of the claimant. The program should have a well-defined period and be expected to lead to employment. There should be a written agreement with the employer which identifies the skills that the claimant will gain from this training. Any salary paid to the claimant during this training should also be listed on the agreement.

Assisted Reemployment, as outlined in paragraph 10 of this chapter, should also be considered in conjunction with a training plan.

b. Roles and responsibilities. The successful completion of a training program requires the active participation of the claimant, RC and OWCP staff.

(1) Role of the RS. The RS is responsible for ensuring that an appropriate facility is selected for the approved training and that the necessary approval documentation is issued. The RS will monitor RC reports and training documentation. If the RC communicates any instances of non-cooperation by the claimant, the RS will report this to the CE promptly so that appropriate action can be taken.

(2) Role of the RC. The RC assists the claimant with registration and obtaining the needed supplies for approved training. The RC provides guidance and counseling during training and maintains contact with the claimant at regular intervals. If needed, the RC can interact with the training institution and other parties to resolve any issues which arise. The RC also obtains transcripts, certificates, or other documentation of successful training progress and completion.

(3) Role of the CE. The CE reviews RC's reports and monitors the claimant's progress in training. If non-cooperation occurs, the CE issues the appropriate warning letters and sanction decisions. See paragraph 17 of this chapter for more information on non-cooperation. Any medical issues which arise during training should be addressed and resolved by the CE.

(4) Role of the claimant. The claimant should have been made aware of what is expected during training because his/her responsibilities are laid out when the plan is developed. The claimant is required to be responsive to RC communication and to show up for any scheduled meetings. During training, the claimant is also expected to maintain a "C" average in all classes and provide documentation of grades, certificates, etc. Regular attendance is required at all approved training programs.

c. Time Frames. The length of the training phase will vary depending on the type of training pursued.

d. At the completion of the approved training plan, the claimant will be provided with 90 days of placement services.

9. Placement with New Employer (PNE). Placement New Employer is the phase of vocational rehabilitation during which an injured worker is provided services aimed at obtaining work with a different employer, other than the original EA, usually in the private sector (though another federal employer may also be an option). PNE services may be offered when no training has been conducted or after an approved training plan has ended. It is the phase of vocational rehabilitation where the actual job search is implemented in accordance with the approved vocational rehabilitation plan that was created in Plan Development.

a. Services offered during this phase include, but are not limited to:

- (1) Assistance with developing a resume.
- (2) Counseling on proper interview appearance and behavior.
- (3) Provision of job leads.
- (4) Assisted reemployment funds, when appropriate. See paragraph 10 of this chapter for more information on Assisted Reemployment.

b. Roles and Responsibilities. Like all other phases of vocational rehabilitation, in order for placement with a new employer to be successful, active participation by the claimant, RC, and OWCP staff is crucial.

(1) Role of the RS. The RS oversees the implementation of the approved placement plan, ensuring that all aspects are in accordance with OWCP standards and procedures. This includes the following:

- (a) Managing the RC by evaluating progress and requesting changes in the plan, as necessary.
- (b) Reviewing reports and bills submitted for reimbursement.
- (c) Acting as a mediator, should differences arise between the RC and the injured worker.
- (d) Communicating any instances of non-cooperation or other factors that may impede the return-to-work effort to the CE.

(2) Role of the RC. The RC is responsible for providing job search services to the claimant, which may include the following:

- (a) Providing job leads to the claimant and contacting potential employers on behalf of the claimant.

(b) Actively assessing the claimant's job search and identifying obstacles and problems the injured worker is having with his or her search; providing constructive counseling and guidance to assist the claimant in overcoming these obstacles.

(c) Counseling the claimant about interview appearance and behavior; conducting mock interviews or videotaped practice interviews to help the claimant develop interviewing skills.

(d) Assisting with resume writing and tailoring it to particular jobs.

(e) Ensuring the claimant is complying with the placement efforts by following up on job leads provided and appropriately participating in scheduled interviews.

(f) Promptly reporting any non-cooperation to the RS while continuing to provide placement services for the allotted 90 days. The RC should counsel the claimant on the importance of reemployment and the possible consequences of failure to do so. The RC should make sure that the claimant understands his or her responsibilities in the placement phase.

(g) Recommending assisted reemployment benefits, when appropriate.

(3) Role of the CE. The CE participates in this phase in the following ways:

(a) At the beginning of placement new employer, the CE should advise the claimant that OWCP will provide 90 days of placement assistance and that his or her LWEC probably will be based on the job for which placement is being attempted. The 90 days is calculated from the date of the OWCP-3 (or equivalent) approving placement with a new employer.

(b) The CE should monitor the claimant's return-to-work progress and promptly respond to requests for intervention from the RC and RS throughout the 90 days of placement services.

(c) If new medical evidence is provided by the claimant, the CE needs to evaluate it promptly and notify the RS if there is a change in the weight of the medical evidence that affects the vocational rehabilitation efforts currently in progress.

(d) Arranging for a conference with appropriate parties if it is determined that one would be helpful.

(4) Role of the Claimant. The claimant is required to cooperate fully with the RC and adhere to the approved rehabilitation plan by:

(a) Being responsive to the RC. This includes returning phone calls, appearing for scheduled meetings, and responding to requests for information.

(b) Performing all job search activities presented by the RC. This can include contacting the job leads provided, keeping a log of job search activities, attending job fairs, scheduling and attending interviews, and other related activities.

c. Time Frames. The PNE phase usually lasts for 90 days. This period may be extended, if agreed upon by the CE and RS, if the claimant is motivated and granting such an extension is likely to lead to job placement.

d. Upon completion of placement services, one of two things will occur. If the claimant has obtained a job through placement, the vocational rehabilitation effort will move to Employed status and the RC will follow the claimant's progress for 60 days to ensure a successful return to work. If the claimant fails to obtain employment, the CE will issue a pre-reduction notice for a constructed loss of wage-earning capacity.

10. Assisted Reemployment. Assisted reemployment is a subsidy, used during PNE, designed to encourage employers to choose qualified rehabilitated workers whom they might otherwise not hire.

Disabled Federal workers with skills transferable to jobs within the general labor market may prove difficult to place due to economic factors in both the Federal and private employment sectors. Assisted reemployment is designed to increase the number of permanently disabled employees who successfully return to the labor force by providing wage reimbursement to potential employers.

a. General Provisions.

(1) Assisted reemployment will allow for up to three years of partial reimbursement of salaries to employers, other than the original employer, who reemploy disabled FECA claimants. The program allows reimbursement, on a quarterly basis, to the new employer of salary paid to the claimant up to 75% the first year, up to 50% the second year, and up to 25% the third and final year.

(2) These wage subsidies to the employer plus the LWEC payment to the claimant shall never exceed the amount of compensation which would be paid to the claimant if there were an absence of employment. Similarly, if basic compensation is being paid, i.e., the claimant has no dependents, the subsidy rate may not exceed 66 2/3 percent.

(3) Should compensation be terminated (e.g., because work-related disability ceases), wage subsidies to the employer should also be discontinued.

(4) The RS and RC will consider jobs which correspond to the claimant's educational background and employment history.

(5) The CE will ensure that the employment under consideration conforms to the medical limitations imposed by the residuals of the work injury and any concurrent conditions.

b. Cooperative Agreement. Once an employer has agreed to hire the claimant under this program, a cooperative agreement between OWCP and the new employer must be drafted and signed by the RS. The title of the job, the job duties, the salary to be paid, and the wage subsidy rate will all be specified in the cooperative agreement.

c. Approval.

(1) Concurrence of CE. The CE should review the job offer to be sure it meets the following elements:

(a) The offer must be in writing;

(b) It must conform to the claimant's work limitations and be suitable within the meaning of Section 8106(c) of the FECA; and

(c) It must support an LWEC rating, i.e., the earnings must fairly and reasonably represent the claimant's wage-earning capacity.

The CE must concur with the cooperative agreement and this concurrence should be documented in the case file. The cooperative agreement should be forwarded to the Lead Vocational Rehabilitation Specialist for preliminary review. If no changes are needed, the Lead Vocational Rehabilitation Specialist will forward the cooperative agreement to the Rehabilitation Supervisor for final review and signature.

(2) Approval of the Rehabilitation Supervisor. The cooperative agreement signed by the Rehabilitation Specialist and Claims Examiner will be forwarded to the Lead Vocational Rehabilitation Specialist for preliminary review and then to the Rehabilitation Supervisor for final review and signature. If the Rehabilitation Supervisor approves the subsidy, the approval should be reflected in the file. Assisted reemployment cannot commence until the agreement is approved by the Rehabilitation Supervisor.

d. Payment of Compensation.

(1) To eliminate the possibility of an overpayment, the CE should remove the case from the periodic roll as soon as the beginning date of work is known.

(2) Any additional entitlement to compensation on the basis of temporary total disability should be paid on the daily roll until the employment commences.

(3) If the claimant is entitled to compensation on the basis of a LWEC after returning to employment, the CE should set up payment using the Shadrick formula. After the claimant has successfully worked for 60 days, the CE should review the case to issue a formal LWEC decision (including formal findings of no LWEC).

11. Employed. If a claimant finds employment with either the previous employer or a new employer, the vocational rehabilitation effort moves to Employed status in order to ensure that the claimant successfully works the position for 60 days. This phase allows OWCP to provide follow-up services, in recognition that this initial period is a period of readjustment and often determines the success or failure of the rehabilitation effort.

The RC should contact the claimant at the end of the first day, first month, and second month on the job to check on the adjustment to the workplace and the position. The RC should remain available to the claimant to assist with the readjustment by providing counseling and support.

During the Employed phase, the RC will obtain all documentation pertaining to the new position, such as the name and address of the employer, the job title, the Dictionary of Occupational Titles code (if applicable), the starting date, hours per week, etc. If the claimant does not want the RC to follow up with the new employer regarding job information and/or the claimant's return to work, all information must be obtained from the claimant.

The RC should notify the RS immediately when any situation arises that jeopardizes the claimant's successful return to work. The RC should provide counseling and work with the claimant and the employer (if authorized by the claimant) to solve the problems. The RC can provide services such as job site analysis, ergonomic assessment, and the provision of adaptive equipment during this phase. If the claimant and employer arrive at an impasse, the RC may recommend a conference call with OWCP staff to resolve any issues surrounding the new position.

12. Medical Rehabilitation. Medical Rehabilitation refers to those medical and related services necessary to correct, minimize or modify the impairment caused by a disease or injury so that the injured worker can return to an adequate level of function and employment. Thus, it is distinguished from actual medical treatment to cure or relieve the effects of the injury.

a. Various medical services can be provided during this phase:

(1) Intensive services provided in catastrophic claims. This can be done in coordination with the FN and can include setting up home health care, arranging for medical transport, etc.

(2) Functional Capacity Evaluations (FCE), work hardening, or any other physical therapy program aimed at producing work tolerance limitations. These are also referred to as Occupational Rehabilitation Programs (ORP). These programs should only be provided as part of vocational rehabilitation services if there is an expectation that they will lead to restrictions which can then be used for a return-to-work effort. FCEs can be offered outside of vocational rehabilitation under FN direction or CE case management. See part b in this section for more information on ORPs.

(3) Speech therapy, orthotics, prosthetics, or other assistive devices that would make the claimant employable.

(4) Psychiatric counseling, drug addiction counseling, pain management clinics. OWCP may approve treatment for addiction to drugs (legal or illegal) that is not specifically work-related, if the addiction is impeding the claimant's return to work. See paragraph 16 of this chapter for more information on substance abuse during vocational rehabilitation.

Aside from drug addiction treatment, OWCP is not responsible for medical costs associated with conditions unrelated to the work injury. Nevertheless, the RC may still encourage the claimant to seek treatment.

(5) Housing and vehicle modifications can be provided under the vocational rehabilitation program. See FECA PM 2-1800, Housing and Vehicle Modifications, for further details.

b. Occupational Rehabilitation Programs. Services which help the injured worker return to work through the use of abbreviated workdays or altered job duties are known as Occupational Rehabilitation Programs (ORPs).

(1) Kinds of ORPs. There are two kinds of ORPs.

(a) Return-to-work (RTW) ORPs are intended for claimants who were injured more than 60 days ago, have not worked for at least 30 days, and are returning to a particular job and employer with defined duties, including transitional duties. RTW ORPs are highly structured, job oriented, goal-directed, individualized, and interdisciplinary. They are intended to maximize the claimant's ability to return to work. Real or simulated work activities are used in conjunction with graded conditioning tasks to aid the transition between acute care and return to work.

(b) Work Readiness (WR) ORPs are used when no specific job is available with a known employer. Services provided have the potential to improve the claimant's work options. They are designed to evaluate and treat the claimant's physical, behavioral, and vocational functions. These programs include real or simulated job-specific work tasks with modifications. The WR ORP uses many of the tests, evaluations, and restorative services used in the RTW ORP, but the job skill requirements under this category are less well defined. The goal in most cases is to maximize potential job options rather than prepare for a specific job. Sometimes, however, the goal is to document the claimant's job potential, and/or measure ability to improve physical tolerance, productivity, and work behavior.

(2) Referral for ORPs. CEs should refer cases meeting the criteria stated in paragraph 5 of this chapter to the RS for an ORP assessment. The RS may also initiate an ORP placement. Also, the RS will notify the responsible CE in any case already open for vocational rehabilitation which, in his or her opinion, may benefit from this type of service.

(3) Initial RS Actions. The RS opens for rehabilitation those cases referred by the CE that meet the basic criteria. The RS refers the case to a RC for a screening interview and the scheduling of a FCE to determine the type and nature of the ORP most suited to the claimant's needs.

(4) Authorization of ORP. When the FCE is completed, the RS authorizes the kind of ORP most suitable for the claimant. Once the claimant is enrolled in the ORP, the RS notifies the treating physician, employer (when available), the RC, and the CE that the program has been authorized.

(5) Obstacles to Completion. Medical or other issues which could delay or terminate the ORP, such as the emergence of non-work related conditions, recurrences, complaints of high levels of pain, etc. must be reported immediately to the RS and CE. When the ORP is interrupted, the RC

notifies the RS immediately, carefully detailing the reason(s) for the interruption. The RS communicates this fact to the CE and recommends an appropriate course of action based on the circumstances of the case.

(6) Outcomes. The following outcomes are based on the results of a completed ORP:

(a) Where the claimant cannot perform the duties of the previous employment or the targeted jobs, the RS may place the case in Plan Development, with the concurrence of the CE, to consider other rehabilitation solutions.

(b) Where the claimant can perform the duties of the date of injury job, the RS should notify the CE immediately.

(7) Reports. The ORP facility must submit at least two reports. The FCE report is the basis for the ORP program plan. The final report should contain the following:

(a) The present and potential status of the claimant for each of the elements reported in the FCE or the ORP plan, including the positive or negative changes that have occurred during the program, as well as information on the claimant's attendance, efforts, attitude, and general condition.

(b) Specific information on the vocational and functional status of the claimant and relationship to the targeted job(s) and fitness for return to work.

(c) Any issues related to work site safety, accommodations, ergonomics, transportation, etc.

(d) Any additional relevant information, such as recommendations for maintenance of work capacity, improvement in functional status, considerations for alternative occupations, and need for continued monitoring and support.

c. Medical rehabilitation services can be offered at any time in the life of a claim if they are deemed appropriate. The rehabilitation effort may begin with this phase if an FCE is scheduled and there is an expectation of work restrictions at the end. On the other hand, if a claimant requires drug addiction counseling after the rehabilitation effort has already begun, this phase could follow placement efforts with the previous employer or even plan development.

d. Ideally, medical rehabilitation leads to the identification of work restrictions that can be utilized for a return-to-work effort. However, depending on the reason for referral, there can be several outcomes from medical rehabilitation.

(1) If medical rehabilitation is utilized for coordination of care in catastrophic injuries or for coordinating housing or vehicle modifications, then the rehabilitation efforts will be closed once these services have been provided.

(2) If the medical rehabilitation services result in work restrictions which can be used for a return-to-work effort, then the case will either move to Placement or Plan Development.

(3) If the period of medical rehabilitation occurred during an approved plan and the resulting work restrictions do not rule out the jobs previously targeted, then the rehabilitation effort can resume in whatever stage is appropriate. If new restrictions result, a new rehabilitation plan may be needed.

(4) If medical rehabilitation fails to result in work restrictions that can be used for a return-to-work effort, the rehabilitation file should be closed or, if deemed appropriate by the RS and CE, placed in Interrupt status.

13. Interrupt. During vocational rehabilitation intervention, issues may arise which can be resolved in a relatively short period of time. Instead of closing the vocational rehabilitation file, there are options which allow the RC to remain active in the claim while other interventions are undertaken.

Interrupt status is used when rehabilitation action is suspended temporarily but is expected to resume in a short time, e.g. a delay until a training course begins, recovery from surgery, etc.

In order for the RS to consider this status, there must be a significant probability of eventual rehabilitation, the postponement should generally be expected to last six months or less, and any changes in the claimant's medical condition must be reviewed with the CE.

a. When a case is placed in Interrupt status, the RC will maintain regular but limited contact with the claimant. Substantial services will not be offered because of limitations on the allowable hours for the RC to work on the case. If services are appropriate, another phase must be considered.

b. If the reason for the interruption is medical in nature, a determination must be made by the CE and the RS whether medical rehabilitation is appropriate. (See paragraph 12 in this chapter.)

In instances where medical rehabilitation is not appropriate, such as the need for the CE to schedule a referee examination to resolve a medical conflict, then the Interrupt status will end as soon as the medical issue is resolved. The case will either move into a rehabilitation phase which offers services or be closed, depending on the outcome of the medical management of the claim.

c. A case may be placed in Interrupt status if a training plan is approved but there is a delay before school begins. As soon as the approved training program begins, the case will move from Interrupt status to the Training phase.

d. Interrupt status should not last for more than six months. At that time, the CE and the RS should review the case and determine whether further services are warranted or rehabilitation closure is appropriate.

14. Communication Among the CE, RS, RC, and Claimant. For rehabilitation efforts to be successful, the CE, RS, RC, and claimant must have frequent and clear communication.

a. Cooperative Effort. Communication pertaining to any issues relevant to rehabilitation should flow between all parties as needed. Rehabilitation is a team effort that includes the claimant, CE, RS, and RC. It is essential for all members of this team to remain informed of the progress of the case throughout the course of rehabilitation.

The CE should receive periodic reports from the RS on Form OWCP-3 (or equivalent) whenever the status of rehabilitation changes or a significant event occurs. While a vocational rehabilitation program may last for several months or more than a year, counselors are required to report monthly or bimonthly, depending on the phase of vocational rehabilitation efforts. It is imperative that the CE stay informed of the progress by reading the RC reports. Since late RC reporting requires RS action, the CE should request a status report from the RS at any point the CE is aware that the RC reporting is delinquent, or there is a question about the current status. Often this can be done in person, or by sending a short memo to the RS. The CE and RS should be in active communication if it is unclear why the rehabilitation process has exceeded the time frames set forth in the previous paragraphs of this chapter.

The CE and RC are encouraged to discuss issues as needed, but they must remember to include the RS in, or inform the RS of, the discussion. An important limitation to keep in mind is that it is the responsibility of the RS, not the CE, to direct RCs to change vocational rehabilitation statuses, and to approve or terminate services.

b. Change in Medical Status during Vocational Rehabilitation. The work tolerance limitations identified by the CE to the RS may change during the vocational rehabilitation effort; if this happens, the CE should advise the RS of the change as soon as possible. The RC may contact the claimant's physician and discuss the work limitations, if authorized by the CE directly or through the RS. If the physician recommends a change in work limitations, whether stricter or lighter, the RC should submit these work limitations to the CE through the RS. It is the CE, and not the RS or RC, who determines the accepted work limitations. It is important that the CE evaluate any new medical evidence and advise all parties of the current weight of medical evidence in the case or the need for additional medical development. See paragraph 15 of this chapter for more information on managing medical issues during vocational rehabilitation.

c. Non-cooperation. The RC should notify the CE and RS of any instances of non-cooperation so that the CE may act promptly. See paragraph 17 of this chapter for more information on the procedures for responding to instances of non-cooperation.

d. Conferences. A conference is an especially useful tool to bring multiple parties together to resolve issues, and is an excellent tool to discuss, coordinate and move cases forward in the rehabilitation process. This can occur when issues arise unexpectedly that could possibly delay or derail the process, or at set points during the rehabilitation process when a conference can help facilitate understanding, resolve misunderstandings, or provide information where a dialogue would be more productive.

Since it is critical to keep all parties informed, and to ensure that all parties hear the same information at the same time, any rehabilitation-related conference should usually include the RS and/or the RC. (The only exception to this is if the CE chooses to conduct a conference just prior

to the rehabilitation referral to help the claimant understand what to expect in a general way once the referral is made). Even if the RS or the RC is not present at the conference, the absent party should receive a copy of the subsequent conference documentation. See FECA PM 2-0500 for a discussion of formal conferences and 2-0600-12 for a discussion of informal conferences.

Situations that can benefit from a rehabilitation-related conference, though not limited to these topics, are:

- (1) Initial referral: to explain the process to the claimant in a general way.
 - (2) Job Offer: if a job offer is pending and the claimant has not signed the offer or returned to work, or the claimant indicates concerns with the offered position.
 - (3) Training plan: if concerns have arisen regarding the viability of the plan or the willingness of the claimant to fully participate; or if the plan being considered is greater than \$20,000. While rare, it is important to conduct a conference when considering such a costly plan to help determine whether the claimant has intentions of fully participating with the end goal of obtaining employment.
 - (4) Medical concerns: any time medical issues arise that have the potential to delay or derail full participation. The earlier these issues are addressed, the more effective rehabilitation can be.
 - (5) Non-cooperation: to explain to the claimant the responsibilities and consequences for non-cooperation. This occurs in conjunction with a warning letter, if warranted.
 - (6) Placement: at or near the time when placement services start, in order to explain to the claimant the process and the services available through placement. The conference can also be used to explain what will occur at the end of placement, whether or not a job is obtained (see FECA PM 2-0814).
 - (7) Employment: if the claimant accepts a position which does not accurately reflect his or her wage-earning capacity (such as accepting part-time work when capable of full-time employment).
 - (8) Retirement/OPM election: whenever the claimant brings this issue up, so the CE can assess the claimant's intentions and explain the process and the claimant's rights, responsibilities, and consequences if non-cooperation occurs prior to an election of OPM benefits.
- e. Change in Case Status. The CE should notify the RS by short memo of any change in case status, such as the termination or suspension of compensation, or any information in the record which may directly affect the rehabilitation effort (e.g., medical evidence establishing no work-related residuals). The RS will then provide guidance to the RC.
- f. Inquiries from Claimants. Claimants will sometimes query the RS or the RC about matters in the domain of the CE, such as compensation entitlement or medical authorization. Similarly, the CE may receive inquiries about vocational rehabilitation matters. Both rehabilitation and claims

personnel are responsible for referring the claimant to the proper individual when issues arise which are not in the domain of the party addressed. No attempt should be made to address questions outside one's own area of expertise and responsibility.

15. Managing Medical Issues During Rehabilitation. When a case is in vocational rehabilitation, many different types of medical issues may arise throughout the process which can impede the rehabilitation effort on a temporary or long-term basis. Although the vocational professionals (RC and RS) play an important role in the rehabilitation effort, medical issues are within the purview of the CE. Since a claimant may provide new medical documentation to an RC which may impact the rehabilitation program, it is important that all parties communicate with one another during the vocational rehabilitation effort to quickly and efficiently resolve outstanding medical issues.

a. CE Responsibilities. The CE has overall charge of the case and makes decisions based on the medical evidence of record and the professional recommendations of the RS and RC.

(1) Once a case is referred to vocational rehabilitation, the CE should continue to monitor the medical evidence and medically manage the claim. The CE should advise the RS immediately if there is a change in the claimant's medical status, particularly if it will have an impact on the vocational rehabilitation effort.

(2) The CE should read RC reports and query the RS if the reports demonstrate that the RC is focusing on vocational goals which do not appear to be in line with the claimant's medical limitations.

(3) The CE should promptly address medical issues raised by the RS, RC, or injured worker which will delay the development or continuation of a rehabilitation plan. In particular, the CE must act quickly when impediments to rehabilitation are reported. Examples of this include a change in the claimant's work restrictions or the development or treatment of a concurrent condition which interferes with the rehabilitation process.

(4) The RS and RC will generally not supervise extensive medical programs, with the exception of ORPs and substance abuse programs. Therefore, it is the CE's responsibility to monitor and promptly develop the medical evidence, as appropriate, including any changes in work limitations, changes in the weight of the medical evidence, the acceptance of consequential or additional medical conditions, or the scheduling of second opinion and/or referee medical examinations.

b. RC Responsibilities.

(1) The RC should immediately notify the CE and RS if the claimant indicates a change in his or her medical condition.

(2) The RC should provide the CE and RS with a copy of any new medical documentation that the claimant provides, paying particular attention to medical evidence that may change the established work tolerance limitations and the direction of the rehabilitation effort. Under certain

circumstances the RC may contact the claimant's treating physician to discuss work limitations in order to expedite any necessary clarification needed to move forward. However, it is ultimately the CE who determines whether changes to the accepted work tolerance limitations are warranted based on the medical evidence of record.

(3) The RC should notify the CE and RS of any instances of non-cooperation based on medical issues so that the CE may act promptly to resolve potential impediments to the rehabilitation process.

c. RS Responsibilities.

(1) The RS should monitor RC reports for changes in the claimant's medical status and inform the CE, via OWCP-3 memo, a Rehabilitation Action Report, or similar documentation, if clarification of the medical evidence is needed at any time during the rehabilitation effort.

(2) The RS should provide guidance to the RC on how to handle a change in the claimant's medical status. Since the CE is the final authority on the weight of medical evidence, the RS must counsel the RC to ensure that the RC does not unnecessarily stall the rehabilitation effort unless the CE has determined that the new evidence establishes a significant change to the work tolerance limitations.

(3) The RS should promptly communicate to the CE any medical issues raised by the RC so that action may be taken to resolve such issues as quickly as possible.

d. Urgency of Actions. The rehabilitation effort could be delayed unnecessarily if the CE does not address and resolve medical issues quickly and thoroughly. The CE should act promptly to resolve issues identified by the RS or RC that are impeding the rehabilitation effort. Such issues include, but are not limited to, the following: the claimant's medical situation (work-related or non-work-related) appears to have changed significantly, or the claimant stops work after being reemployed because of a change in medical condition brought on by the return to work.

e. Effectively Resolving Medical Issues. The RS must defer to the CE on medical issues, and make sure that the RC does the same, in order to avoid creating conflicts in the medical evidence.

(1) Work limitations will be provided to the RC (or obtained in the course of an ORP) and should be used as a basis for planning the rehabilitation effort. Unless specifically authorized to contact the attending physician by an indication on the referral, the RC must refer any questions about work limitations to the CE.

(2) If the injured worker reports a recurrence of disability, introduces more severe restrictions, or provides other medical information (e.g., pregnancy, the need for physical therapy or other treatment, the emergence of a non-work-related medical condition or surgery) which would ultimately affect the rehabilitation plan, the RC should tell the injured worker to provide a medical report, and notify the district office. Rehabilitation should proceed on schedule unless the CE agrees that the medical situation has changed. If this occurs, the CE and RS can discuss

whether to interrupt the rehabilitation effort or begin medical rehabilitation (see paragraphs 12 and 13 of this chapter).

(3) The CE should appropriately develop any questions regarding the nature and extent of injury-related disability, work limitations, or medical treatment plans with the attending physician, or a second opinion or referee specialist, if necessary, until a resolution is obtained. Formulation of direct and appropriate medical questions to the appropriate medical provider is crucial to this effort.

(4) If a second opinion or referee examination is arranged during the vocational rehabilitation effort, the CE should advise the RS. Also, the CE should immediately advise the RS of any change in the weight of medical evidence, as it affects work limitations or injury-related disability.

16. Effects of Substance Abuse. Inappropriate use of drugs, whether legal or illegal, may complicate recovery from other medical conditions and hinder a claimant's return to work. Substance abuse may come to light from medical reports, contacts with the FN or RC, or through direct communication with the claimant. Actions to be taken, regardless of whether the Office has accepted it as work-related, are outlined below.

a. Treatment. Where substance abuse or addiction prevents a claimant from entering a vocational rehabilitation program, continuing with such a program once it has begun, or returning to work, the RC or RS may recommend participation in a drug treatment plan. The CE (not the RS or RC) is responsible for authorizing such care where necessary based on the medical evidence of record (e.g., the recommendation of the attending physician).

Such a program may be approved even if the Office has not accepted the substance abuse as related to employment.

(1) 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 (see FECA PM 3-0400). The facility selected should be within 25 miles of the claimant's residence wherever feasible.

(2) Outpatient treatment may be recommended by itself or as a follow-up measure to inpatient care. Such treatment may be authorized when recommended by the attending physician, as may medications prescribed to alleviate the effects of addiction. Likewise, counseling in a group setting may be undertaken at OWCP expense.

b. Effect on Vocational Rehabilitation. The CE, or the RS on request of the CE, should advise the claimant of the terms of the referral before treatment begins. In particular, the claimant should be notified that non-completion of the program, or continued abuse of the substance after the treatment ends, may result in suspension of compensation benefits under 5 U.S.C. 8113 at the salary level of the job which is the goal of the vocational rehabilitation plan. Any suspension of benefits will continue until the claimant reenters a program and/or discontinues use of the substance.

If the effort is not successful, the claimant's compensation should be determined in accordance with paragraph 17 of this chapter, according to the claimant's status in the vocational rehabilitation process.

17. Non-Cooperation and Sanction Decisions. Section 8104 of the FECA provides the authority for OWCP to direct an individual to undergo vocational rehabilitation, and section 8113 allows the Office to prospectively reduce compensation in accordance with a claimant's wage-earning capacity if he or she refuses, without good cause, to undergo vocational rehabilitation. The sanction remains in effect until the individual in good faith complies with the rehabilitation effort.

20 C.F.R. §10.519 prescribes what action OWCP will take if an employee refuses to undergo vocational rehabilitation. If a suitable job has been identified, OWCP will reduce compensation "...based on the amount which would likely have been his or her wage-earning capacity had he or she undergone vocational rehabilitation." If a suitable job has not been identified, "...in the absence of evidence to the contrary, OWCP will assume that the vocational rehabilitation effort would have resulted in a return to work with no loss of wage-earning capacity, and OWCP will reduce the employee's compensation accordingly."

A claimant may fail to cooperate with vocational rehabilitation efforts in various ways. General examples of non-cooperation include lack of response to letters or phone calls from the RS or RC; failure to show up for appointments, interviews, or testing (e.g., vocational testing, functional capacity evaluation) arranged by the RC; and failure to attend an approved training program.

The RC must fully document any non-cooperation on the part of the injured worker and submit reports to the RS for immediate handling. The RS will inform the CE via OWCP-3 (or equivalent) of the claimant's non-cooperation. When an injured worker refuses or impedes the rehabilitation process, the CE must intervene (e.g., issuance of warning letter, conference call, or both). The type of intervention depends on the current stage of the vocational rehabilitation effort.

a. Refusing or Impeding Placement Previous Employer. An RC may be asked to work with the EA to determine if the agency will be able to identify work within the injured worker's limitations.

If the claimant impedes the rehabilitation process prior to a job being offered, the CE will treat this as non-cooperation with the rehabilitation process. Examples of this include failing to meet with the RC, refusing to show up for a scheduled FCE, etc.

If the injured worker refuses or impedes the rehabilitation process during this early phase, and the medical evidence indicates that the claimant does have the ability to work, the CE should issue a letter to the injured worker, advising that failure to cooperate with the vocational rehabilitation effort will result in a reduction of monetary compensation benefits. This letter should provide the claimant with 30 days to begin cooperating with the vocational rehabilitation

effort or show good cause for refusing to cooperate. Release of this letter satisfies the requirement to issue a pre-reduction notice to the claimant.

If 30 days have passed since the warning letter was issued and no response is received, or if the injured worker does not begin or resume a good-faith effort to cooperate, the CE should issue a formal decision reducing compensation to zero under 5 U.S.C. 8113(b) and 20 C.F.R. §10.519(c), which states in part that "...in the absence of evidence to the contrary, OWCP will assume that the vocational rehabilitation effort would have resulted in a return to work with no loss of wage-earning capacity, and OWCP will reduce the employee's compensation accordingly."

If an offer of suitable employment has been made and the claimant refuses to accept the position, this is not failure to cooperate with vocational rehabilitation efforts. This is failure to accept a suitable job, subject to sanctions under section 8106 of the FECA. The CE should refer to FECA PM 2-0814 for appropriate action to take in this situation.

b. Refusing or Impeding Plan Development. Specific instances of non-cooperation during this phase of vocational rehabilitation include: failure to appear for the initial interview; failure to attend meetings with the RC; failure to undergo an FCE, including failure to put forth optimum effort during the FCE; failure to undergo vocational testing and other work evaluations, including lack of response or inappropriate response to directions during testing; and failure to respond to the RC's telephone calls or written notices. Non-cooperation also includes failure to begin or continue pre-vocational training, such as English lessons for those who lack command of the language, or classes for a General Equivalency Diploma (GED) for those without a high school education.

If the claimant is in plan development and the file contains the documentation needed in order to make a determination on the claimant's wage-earning capacity, compensation should be reduced based on the claimant's ability to earn wages at the time of the sanction decision. If the CE is unsure about whether the evidence of record is sufficient, the RS should be requested to provide a recommendation on the claimant's WEC based on the evidence of record.

If this documentation is not yet of record and/or the RS is unable to provide it, then the compensation should be reduced to zero.

In either case, the CE will release a letter to advise the injured worker to begin or resume a good-faith effort to cooperate with the RS, or show good cause for refusing, within 30 days. (See e. below regarding evaluating reasons for non-cooperation.) This letter also satisfies the requirement to provide a 30-day pre-reduction notice.

c. Refusing or Impeding Training. Specific instances of non-cooperation during this phase of vocational rehabilitation include: failure to attend classes; failure to apply appropriate effort to succeed in such classes; failure to maintain a "C" average; and failure to undergo training after a training program has been approved.

If the claimant refuses or impedes rehabilitation training, the CE shall notify the injured worker, in writing, of the provisions of 5 U.S.C. 8113(b) and direct the injured worker to apply for, participate in, or resume participation in the training program. The letter should advise the injured worker to comply or provide a written explanation of his or her failure to comply within 30 days, or the provisions of 5 U.S.C. 8113(b) will be applied and benefits will be reduced based on the jobs targeted in the approved training plan. This letter satisfies the requirement to provide a 30-day pre-reduction notice.

d. Refusing or Impeding Placement New Employer. When placement efforts with a new employer are to begin, the CE should advise the injured worker by letter that OWCP will provide 90 days of placement assistance and that at the end of that 90-day period his or her WEC will be based on either (1) earnings from the new position; or (2) earnings for the job for which placement was attempted. (The 90 days is calculated from the date placement services begin as documented by the RS.)

It is important to note that non-cooperation with vocational rehabilitation during the placement stage does not generally result in a sanction decision under 5 U.S.C. 8113(b). If non-cooperation occurs during placement, the RS should request that the RC submit a final report and list the jobs for which placement was being attempted (i.e., provide updated labor market surveys, if necessary, including current pay information). Continuing placement services for the full 90-day period is not required if the claimant has not cooperated. Upon receipt of this information, the CE should prepare a pre-reduction notice determining the injured worker's WEC prospectively pursuant to 5 U.S.C. 8115 [not 8113(b)] based on one of the selected positions. This notice should be completed within 30 days of receipt of the OWCP-3 (or equivalent) from the RS, verifying that the selected positions are available in sufficient numbers. After considering any response to the pre-reduction notice, the CE should issue a final decision, if appropriate.

If the injured worker elects OPM benefits in lieu of cooperating with the vocational rehabilitation effort, the final decision reducing compensation based on prospective earnings must still be issued (see paragraph 18 of this chapter). It is necessary for the CE to establish the level of compensation entitlement in accordance with 5 U.S.C. 8115 so that any future, retroactive compensation will be paid at the proper established WEC instead of at the rate for total disability. The WEC decision will stand unless the injured worker meets one of the three valid reasons for WEC modification (see FECA PM 2-0814).

e. Evaluating Reasons for Lack of Cooperation. Given the variety of reasons which injured workers may offer for non-cooperation, and the variety of circumstances in which these reasons may be offered, it is impossible to establish a definitive list of acceptable and unacceptable reasons for lack of cooperation. In general, however, the injured worker is expected to treat the vocational rehabilitation effort as seriously as employment, and reasons for lack of cooperation should be considered in this light. A situation which would be considered a valid reason for absence from work (e.g., an illness) may be considered good cause for failure to cooperate with vocational rehabilitation for a reasonable period of time.

The specificity of the reasons offered and the injured worker's diligence in advising the RC of the problem should also be considered in evaluating reasons offered. Moreover, the CE must

consider how much the specific instance(s) of failure to cooperate will affect the overall success of the vocational rehabilitation effort.

The injured worker may cite a change in his or her medical condition as a reason for not cooperating. In this situation, the CE should act promptly to resolve any potential medical issues that may affect the vocational rehabilitation effort (see paragraph 15 of this chapter).

f. Issuing Sanction Decisions under 5 U.S.C. 8113(b). As noted earlier in this section, the appropriate sanction for refusing a suitable job offer from the previous employer comes under 5 U.S.C. 8106, and the appropriate decision for a claimant who refuses or impedes rehabilitation during the placement new employer (PNE) phase is a rating of the claimant's WEC under 5 U.S.C. 8115. Otherwise, sanctions for failure to cooperate in the rehabilitation process come under 5 U.S.C. 8113 (b), discussed below.

Note: Decisions issued under 8106(b) and 8115 are different in that promises of "cooperation" after one of these decisions will not alter the final decision once it has been issued, and the grounds for reversal of those decisions are based on suitability of the job under 8106 and whether the WEC under 8115 should be modified.

Decisions issued under 5 U.S.C. 8113(b) can be affected if the claimant demonstrates cooperation after the decision is issued. If 30 days have passed since the warning letter was issued and no response is received, or if the injured worker does not begin or resume a good-faith effort and fails to provide good cause, the CE shall issue a formal decision reducing compensation under 5 U.S.C. 8113(b) and reduce compensation as of the date of the final decision. Application of sanction decisions under 5 U.S.C. 8113(b) will result in suspension or reduction of compensation unless, and until, the claimant demonstrates cooperation with vocational rehabilitation efforts. This is true even when the next opportunity for actual cooperation will not occur for several months and the injured worker has stated that he or she will, in fact, comply with OWCP's requirements.

The decision should be tailored to the specific stage of the vocational rehabilitation process (e.g., plan development or training) and it should address the following:

- (1) The nature of the specific failure or impedance;
- (2) The contacts or dialogue among all parties, including the injured worker, the RC, the RS, the CE, and the vocational entity in question (e.g., the testing facility or company where the injured worker had an interview);
- (3) The contents and date of the warning letter;
- (4) Any reasons advanced by the injured worker for failure to cooperate. Each reason should be evaluated according to the criteria discussed in paragraph (e) above;
- (5) An explanation why the injured worker's failure to cooperate was without good cause, and that either:

- (a) The rehabilitation effort would have resulted in a return to work with no loss in WEC; or
- (b) Cooperation with the rehabilitation effort would probably have substantially increased the injured worker's earnings.

The case status should remain PR, even if compensation is reduced, since no formal rating of the claimant's WEC has been issued.

If the injured worker later complies with the Office's direction to undergo vocational rehabilitation after a formal decision has been issued reducing compensation under Section 8113(b), compensation should be reinstated prospectively at the previous rate. Health benefits and life insurance coverage, if applicable, should be reinstated *retroactively* to the date of termination and the premiums due for the period of reduction should be deducted from the continuing compensation beginning with the date of reinstatement.

The effective date of reinstatement of the previous rate of compensation should be the date the injured worker indicates in writing his or her intent to comply. However, the intent to cooperate must be confirmed by the RS or RC (e.g., the injured worker has actually contacted the RC or RS to begin or resume vocational rehabilitation efforts, or has scheduled and/or attended interviews or testing, etc.) before compensation is reinstated.

g. Multiple Instances of Non-Cooperation. An injured worker who fails to cooperate with OWCP more than once during the course of the vocational rehabilitation process should not be rated for an LWEC (unless the criteria are met for an 8115 decision as noted earlier in this paragraph). Rather, he or she should be given progressively more serious sanctions for the second and subsequent instances of non-cooperation if he or she does not resume cooperation after issuance of a warning letter and good reasons for failure to cooperate are not provided.

Example: Early in January, the injured worker repeatedly, and without explanation, fails to appear for vocational testing, and, after appropriate warning and assessment of the response, compensation is suspended to zero at the end of February. In mid-March, the injured worker professes willingness to cooperate, and actually does undergo the testing as directed, beginning in April. The CE, as a result, reinstates compensation retroactively to mid-March, after the testing is completed.

A plan is developed, and OWCP approves a one-year training program for the injured worker to begin in September. The injured worker misses the deadline for registration, and, again, after appropriate warning and assessment of the response, compensation is reduced in October (at the rate for partial disability, reflecting the job for which the training program is to prepare the injured worker). In mid-November, the injured worker again expresses willingness to resume cooperation, but compensation is not reinstated until the CE receives confirmation that the injured worker has registered for the semester in January of the following year. The date of reinstatement of compensation (at the rate of total disability) is the date the injured worker registered for the course, not before.

In February, one month after school begins, the RC reports to OWCP that the injured worker has been absent from classes for two weeks without explanation. A warning letter is issued, but the injured worker does not reply to it, and compensation is once again reduced (to the partial disability rate) in March 2011. The injured worker immediately contacts OWCP, promises to resume attendance, and promptly does so. Instead of accepting the return to school as a demonstration of cooperation, however, OWCP determines that in light of previous instances of non-cooperation, the injured worker must complete the semester (which ends in April) before compensation payments are resumed (at the rate of total disability).

18. Election of OPM (Office of Personnel Management) Benefits During Vocational Rehabilitation. OWCP is a return-to-work program and not a retirement program; however, if eligible, the claimant may have a right under law to choose retirement benefits in lieu of OWCP benefits (FECA PM 2-1000). When reviewing instances of non-cooperation in conjunction with an OPM election during the vocational rehabilitation process, it is important to focus on the behavior and level of non-cooperation. Sanctions may apply to the non-cooperative behavior but not to the choice to elect OPM.

a. A conference may be helpful any time retirement is brought up during the rehabilitation process. The CE should consider scheduling a conference to assess the claimant's actual intent, since many times the claimant may be simply exploring options. Other times the claimant may not understand that OWCP is a return-to-work program and not a retirement program. A conference provides the opportunity to create a plan of action for both the claimant and the CE. After the conference, an election offer should be issued if the claimant states this is his or her choice.

Despite issuing an election letter, the CE should pursue case management and rehabilitation to its logical conclusion. Sending the election letter does not guarantee OPM election. Until the claimant actually submits a signed election form choosing OPM benefits, he or she is required to participate fully in rehabilitation or be subject to the sanction process.

b. If the claimant continues to cooperate until the actual election form is signed and received by OWCP, the election is at the temporary total disability (TTD) amount.

c. If the claimant does not cooperate during the election process, any behavior which is deemed to be non-cooperation will be subject to sanctions pursuant to 5 U.S.C. 8113. A non-cooperation sanction under 5 U.S.C. 8113 may not be initiated once a claimant has officially elected OPM benefits. It may only be finalized following an OPM election if the warning letter was issued while the claimant was in receipt of FECA benefits.

If a sanction is applied prior to receipt of the actual election, the election is at the reduced amount pursuant to the sanction. When a warning is issued before the claimant elects OPM benefits, and the claimant continues to be uncooperative up to the point of the election, it is appropriate to issue the final sanction under 5 U.S.C. 8113, even if it is issued after the election is signed. In the decision, the CE should focus on the reasons that the claimant's behavior was determined to be non-cooperative and must document the selection of a zero or reduced LWEC

rating, taking into consideration the claimant's condition and not the choice to elect OPM benefits.

If the claimant later decides through a subsequent election to resume OWCP benefits, he or she returns to OWCP at the zero or reduced rate (suspension amount) for the retroactive period and only at TTD prospectively at the point in which cooperation resumes (effective the date the injured worker indicated in writing his or her intent to comply).

Note: If the evidence warrants, the CE should consider issuance of a WEC in accordance with 5 U.S.C. 8115, rather than a sanction under 5 U.S.C. 8113. See below.

d. If the claimant fails to participate during Placement, the election is offered at the TTD amount with an explanation of the WEC decision to follow. The CE should then pursue resolution with a Notice of Proposed Reduction and a formal constructed LWEC decision pursuant to 5 U.S.C. 8115 with appeal rights.

Any future retroactive compensation, if the claimant later chooses to elect OWCP benefits once again, would be payable at the WEC rate. If a final WEC decision pursuant to 8115 is issued, it can only be modified for one of the three established criteria outlined in PM 2-0814.

19. Possible Outcomes of Vocational Rehabilitation. The goal of the vocational rehabilitation effort is to ultimately return all injured federal employees to some form of gainful work, with the previous employer or in the private sector. However, there are times when vocational rehabilitation efforts are not successful and do not result in a return to work. In some situations, appropriate sanctions must be applied because the injured worker refused a suitable job or failed to cooperate with rehabilitation efforts (see FECA PM 2-0814 and paragraph 17 of this chapter). In other situations, the claimant's WEC must be determined on the basis of a position deemed suitable but not actually held. (See FECA PM 2-0814 for more specific details on issuing WEC decisions). No matter the situation, the CE should issue appropriate entitlement decisions whenever possible to complete the rehabilitation process.

a. Return to Work with the Previous Employer. When the employee cannot return to the DOI job because of disability due to the work-related injury or disease, he or she may return to alternative or limited duty employment with the previous employer. After the claimant has been working for 60 days, the CE should determine whether the claimant's actual earnings fairly and reasonably represent his or her WEC. If so, a formal decision should be issued within 90 days of the date of return to work.

b. Refusal of Suitable Work with the Previous Employer. Section 5 U.S.C. 8106(c) provides a severe penalty against workers who refuse offers of suitable work, or who abandon suitable work without good cause. After appropriate warning letters have been provided to the claimant, and the refusal of suitable work continues, the CE should prepare a formal decision which provides full findings of facts as to why claimant's reasons for refusing the job are deemed unacceptable and terminate compensation as of the date of the final decision. Such a decision should not be modified even if the claimant's medical condition later deteriorates and he or she claims a recurrence of total disability.

c. Return to Work with a New Employer (other than the EA). Sometimes the claimant will return to work but not with the original employer. After the claimant has been working for 60 days, the CE will determine whether the claimant's actual earnings fairly and reasonably represent his or her WEC. If so, a formal decision should be issued within 90 days of the date of return to work. If not, the CE should consider whether a constructed WEC decision is appropriate.

d. Constructed WEC Decisions. If the claimant does not locate employment at the end of the vocational rehabilitation process, or if the claimant's actual earnings are not representative of his or her capacity to earn wages, further determination must be made based on the claimant's ability to work in a selected position. The test for making this type of decision is whether the claimant's WEC based on the selected job appears reasonable, giving due regard to the factors specified in 5 U.S.C. 8115 (i.e., the nature of the injury; the degree of physical impairment, including impairment resulting from both injury-related and pre-existing conditions; the claimant's usual employment; the claimant's age; qualifications for other employment, including education, previous employment, and training as well as work limitations imposed by the injury-related and pre-existing impairments; and the availability of suitable employment.)

e. Other Outcomes of Rehabilitation.

(1) Where rehabilitation services are under way and the CE determines that injury-related disability has ceased, it is proper to issue a pre-termination notice. As the claimant's response may overcome the initial determination to terminate compensation, OWCP should continue rehabilitation services during the notice period until a formal decision is issued. Pre-termination notices and formal decisions are discussed in PM Chapter 2-1400.

(2) Specific sanctions for non-cooperation with rehabilitation efforts may be applied as detailed in paragraph 17 of this chapter.

(3) The severity of the claimant's medical condition (work-related or non-work-related) may change or worsen during the rehabilitation process. If the medical limitations from the accepted injury-related condition(s) and any pre-existing medical condition(s) subsequently prohibit a return to all gainful employment, the CE's concurrence with the infeasibility of continued reemployment efforts is needed for closure of rehabilitation efforts.

(4) A claimant may elect OPM at any time during the rehabilitation process. The CE should consider the specific stage of the rehabilitation effort and refer to paragraph 18 of this chapter for detailed guidance concerning further actions that should be taken in each instance.

2-0813 Exhibit 1: Physical Demand Definitions

The Program has adopted the following definitions from the Selected Characteristics of Occupations Defined in the Revised Dictionary of Occupational Titles (where applicable), which should be used when comparing the established work restrictions to the physical requirements of positions identified in the Dictionary of Occupational Titles. These definitions indicate the absence or presence and frequency of the physical demand components requested on the OWCP-5b and OWCP-5c.

1. STRENGTH LEVEL

Sedentary Work - Sedentary Work involves exerting up to 10 pounds of force occasionally or a negligible amount of force frequently to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs may be defined as Sedentary when walking and standing are required only occasionally and all other Sedentary criteria are met.

Light Work - Light Work involves exerting up to 20 pounds of force occasionally or up to 10 pounds of force frequently, or a negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Work. Even though the weight lifted may be only a negligible amount, a job/occupation is rated as Light Work when it requires: (1) walking or standing to a significant degree; (2) sitting most of the time while pushing or pulling arm or leg controls; or (3) working at a production rate pace while constantly pushing or pulling materials even though the weight of the materials is negligible. (The constant stress and strain of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.)

Medium Work - Medium Work involves exerting 20 to 50 pounds of force occasionally or 10 to 25 pounds of force frequently or an amount greater than negligible and up to 10 pounds constantly to move objects. Physical demand requirements are in excess of those for Light Work.

Heavy Work - Heavy Work involves exerting 50 to 100 pounds of force occasionally, or 25 to 50 pounds of force frequently, or 10 to 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Medium Work.

Very Heavy Work - Very Heavy Work involves exerting in excess of 100 pounds of force occasionally, or in excess of 50 pounds of force frequently or in excess of 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Heavy Work.

<u>Limits of Weights Lifted/Carried/Pushed/Pulled</u>			
<u>Rating</u>	<u>Occasionally</u>	<u>Frequently</u>	<u>Constantly</u>
Sedentary	* - 10	*	N/A
Light	* - 20	* - 10	*
Medium	20 - 50	10 - 25	* - 10
Heavy	50 - 100	25 - 50	10 - 20
Very Heavy	100 +	50 +	20 +

* = negligible weight; N/A = Not Applicable

The range excludes the lower number and includes the higher number, i.e., the range 10 - 25 excludes 10 (begins at 10 +) and includes 25.

Presence and/or Frequency of Other Physical Demands

This chart should be referenced to determine the frequency of demands for the remaining physical components of a given job.

<u>Presence and/or Frequency of Other Physical Demands</u>			
<u>Code</u>	<u>Frequency</u>	<u>Definition</u>	<u>Max hrs./8 hr. day</u>
N	Not Present	Activity/condition does not exist	0
O	Occasionally	Activity/condition exists up to 1/3 of the time	2 hrs. 40 min.
F	Frequently	Activity/condition exists from 1/3 to 2/3 of the time	5 hrs. 20 min.
C	Constantly	Activity/condition exists 2/3 or more of the time	8

2. REACHING

Extending hand(s) and arm(s) in any direction, including overhead reaching or reaching above shoulder level.

3. TWISTING

Turning, twisting, contorting, or flexing the torso in any direction towards the right or left.

4. BENDING/STOOPING

Bending body downward and forward by bending spine at the waist, requiring full use of the lower extremities and back muscles.

5. OPERATING A MOTOR VEHICLE AT WORK

Driving any vehicle during the performance of one's duties.

6. REPETITIVE MOVEMENTS OF ELBOWS (HANDLING)

Seizing, holding, grasping, turning, or otherwise working with hand or hands using the whole arm.

7. REPETITIVE MOVEMENTS OF WRISTS (FINGERING)

Picking, pinching, or otherwise working primarily with fingers and wrists rather than the whole arm as in handling.

8. SQUATTING (CROUCHING)

Bending body downward and forward by bending legs and spine.

9. KNEELING

Bending legs at knees to come to rest on knee or knees.

10. CLIMBING

Ascending or descending ladders, stairs, scaffolding, ramps, poles, and the like, using feet and legs or hands and arms. Body agility is emphasized.

2-0813 Exhibit 2: Environmental Conditions Definitions

The Program has adopted the following definitions from the Selected Characteristics of Occupations Defined in the Revised Dictionary of Occupational Titles, which should be used when comparing the established work restrictions to the environmental conditions for positions identified in the Dictionary of Occupational Titles. These definitions indicate the absence or presence and frequency of the environmental components requested on the OWCP-5b.

Presence and/or Frequency of Environmental Condition Components

This chart should be referenced to determine the frequency of exposure to the listed environmental components.

Presence and/or Frequency of Environmental Condition Components			
<u>Code</u>	<u>Frequency</u>	<u>Definition</u>	<u>Max hrs./8 hr. day</u>
N	Not Present	Activity/condition does not exist	0
O	Occasionally	Activity/condition exists up to 1/3 of the time	2 hrs. 40 min.
F	Frequently	Activity/condition exists from 1/3 to 2/3 of the time	5 hrs. 20 min.
C	Constantly	Activity/condition exists 2/3 or more of the time	8

1. EXPOSURE TO TEMPERATURE EXTREMES

Exposure to outside atmospheric conditions and/or non weather-related hot and/or cold temperature.

2. EXPOSURE TO AIRBORNE PARTICLES

Exposure to such conditions as dusts, smoke, and poor ventilation that affect the respiratory system, eyes, or the skin.

3. EXPOSURE TO GASES/FUMES

Exposure to such conditions as fumes, noxious odors, mists, and gases that affect the respiratory system, eyes, or the skin.

4. EXPOSURE TO ELECTROMAGNETIC RADIATION

Exposure to electromagnetic radiation that affects cardiovascular devices.

Chapter 2-0814, Job Offers and Return to Work

1. Purpose and Scope. Injured workers who are medically able to return to work are expected to return to gainful employment when work is made available. The Office of Workers' Compensation Programs' (OWCP) goal is to return each disabled employee to work as soon as he or she is medically able. An injured worker who does not work when employment is made available within the established work restrictions is not entitled to disability compensation under the Federal Employees' Compensation Act (FECA).

This chapter explains the procedures for reviewing job offers for suitability, determining when employment has been abandoned, and evaluating temporary light duty assignments.

Disability Management is discussed in PM Chapter 2-0600.

Vocational Rehabilitation is discussed in PM Chapter 2-0813.

Determining wage-earning capacity upon return to work is discussed in PM Chapter 2-0815.

2. Statutory and Regulatory Provisions.

a. 5 U.S.C. §8106(c) of the FECA outlines that, "A partially disabled employee who-

(1) refuses to seek suitable work; or

(2) refuses or neglects to work after suitable work is offered to, procured by, or secured for him; is not entitled to compensation."

b. 20 CFR §10.5(f) defines disability as "the incapacity, because of an employment injury, to earn the wages the employee was receiving at the time of injury. It may be partial or total."

c. 20 CFR §10.500 provides the basic rules governing continuing receipt of compensation benefits and return to work.

"(a) Benefits are available only while the effects of a work-related condition continue. 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. For example, 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. (The penalty provision of 5 U.S.C. 8106(c)(2) will not be imposed on such assignments under this paragraph.)

(b) Each disabled employee is obligated to perform such work as he or she can. OWCP's goal is to return each disabled employee to work as soon as he or she is medically able. In determining what work qualifies under 5 U.S.C. 8115 for determining the wage-earning capacity for a particular disabled employee, OWCP considers all relevant factors, including the employee's current physical limitations, whether the work is available within the employee's demonstrated commuting area and the employee's qualifications to perform such work.

(c) 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.

(d) Payment of medical benefits is available for all treatment necessary due to a work-related medical condition."

d. 20 CFR §10.508 describes when relocation expenses can be paid for an employee who would need to move to accept an offer of reemployment.

"If possible, the employer should offer suitable reemployment in the location where the employee currently resides. If this is not practical, the employer may offer suitable reemployment at the employee's former duty station or other location. Where the distance between the location of the offered job and the location where the employee currently resides is at least 50 miles, OWCP may pay such relocation expenses as are considered reasonable and necessary if the employee has been terminated from the agency's employment rolls and would incur relocation expenses by accepting the offered reemployment. OWCP may also pay such relocation expenses when the new employer is other than a Federal employer. OWCP will notify the employee that relocation expenses are payable if it makes a finding that the job is suitable. To determine whether a relocation expense is reasonable and necessary, OWCP shall use as a guide the Federal travel regulations for permanent changes of duty station."

e. 20 CFR §10.516 describes how an employee will know if the OWCP considers a job to be suitable.

"OWCP shall advise the employee that it has found the offered work to be suitable and afford the employee 30 days to accept the job or present any reasons to counter OWCP's finding of suitability. If the employee presents such reasons, and OWCP determines that the reasons are unacceptable, it will notify the employee of that determination and that he or she has 15 days in which to accept the offered work without penalty. At that point in time, OWCP's notification need not state the reasons for finding that the employee's reasons are not acceptable."

f. 20 CFR § 10.517 outlines the penalties for refusing to accept a suitable job offer.

"(a) 5 U.S.C. 8106(c) provides that a partially disabled employee who refuses to seek suitable work, or refuses to or neglects to work after suitable work is offered to or arranged for him or her, is not entitled to compensation. An employee who refuses or neglects to work after suitable work has been offered or secured for him or her has the burden to show that this refusal or failure to work was reasonable or justified.

(b) After providing the two notices described in §10.516, OWCP will terminate the employee's entitlement to further compensation under 5 U.S.C. 8105, 8106, and 8107 as of the date of the final decision on all claims where the injury occurred prior to the termination decision, as provided by 5 U.S.C. 8106(c)(2). However, the employee remains entitled to medical benefits as provided by 5 U.S.C. 8103."

3. Policy. The OWCP will make every reasonable effort to arrange for employment of a partially disabled claimant with the Employing Agency (EA) first. This effort will take into account both medical conditions which pre-existed the injury and those which arose afterwards. The partially disabled claimant is viewed as a whole person when considering suitability of potential employment.

If the EA is unable or unwilling to accommodate the partially disabled claimant, vocational rehabilitation services should be initiated to determine the claimant's wage-earning capacity by alternative means. See PM Chapters 2-0815 and 2-0816 for more information on determining wage-earning capacity.

If the claimant remains out of work but no longer suffers from work-related disability, or has the ability to perform his/her date of injury position without restriction, compensation should be terminated in lieu of any attempts to return the claimant to gainful employment. See PM Chapter 2-1400 for more information on issuing termination decisions.

4. Offers of Employment. If the EA can provide alternative employment to a partially disabled employee who cannot perform his/her date of injury position, it will make an offer of light duty to the claimant (this may also be identified as limited duty) and provide a copy to the OWCP. A job offer may be solicited by the Rehabilitation Specialist (RS), Rehabilitation Counselor (RC), Staff Nurse (SN), Field Nurse (FN), Claims Examiner (CE), or by the claimant.

When an offer of employment is made, and the position is not temporary, the job offer can be evaluated under the auspices of 5 U.S.C. §8106(c). See exception at c(5) in this paragraph, which pertains to workers who held temporary positions at the time of injury. If the offer is for temporary work only, and the employee was not a temporary worker at the time of injury, see paragraph 9 in this chapter.

a. Job Offers from the EA.

(1) Any such offer must be in writing and include the following information:

- (a) A description of the duties to be performed;
 - (b) The specific physical requirements of the position and any special demands of the workload or unusual working conditions;
 - (c) The organizational and geographical location of the job;
 - (d) The date on which the job will first be available;
 - (e) The claimant's work schedule (including telework);
 - (f) Pay rate (salary) information; and
 - (g) The date by which a response to the job offer is required.
- (2) If the job offer is for a site outside of the claimant's residential area, the EA must document that it first searched for suitable employment in the claimant's geographic area before it settled for a position outside of it. The EA must provide this information to the OWCP.
- (3) The EA should not include any information in the job offer regarding election of benefits from the Office of Personnel Management (OPM), since obtaining an election is solely the responsibility of the OWCP.
- (4) A copy of the job offer should be sent to the OWCP, along with the medical evidence used as the basis for the offer (if the OWCP does not already have a copy).
- b. If the claimant accepts the job offer and returns to work without OWCP involvement, no suitability determination is necessary, but compensation should be promptly terminated or reduced, as appropriate. A letter should be issued to the claimant explaining the basis for reducing or terminating his/her compensation.

The CE should make a preliminary assessment of the position and then monitor the case so that a wage-earning capacity (WEC) determination can be made after the claimant has worked sixty (60) days, if appropriate. See PM Chapter 2-0815.

Note - If a formal LWEC decision has been previously issued, the CE should review the guidance set forth in PM 2-1501-3 and 2-1501-5.

c. If the claimant does not accept the offer, or accepts the offer but does not return to work, a formal suitability determination is needed. The CE must consider each of the following items to determine if the job offer is suitable for purposes of an 8106(c) sanction.

- (1) Ideally, a job offer should be made for the number of hours for which a claimant has been released to work.

(2) When this is not possible, the EA may offer a job for fewer hours than the claimant was actually released to work. As long as the job offer is for at least half of the total hours for which the claimant has been released to work, the job offer can be found suitable.

Note: This change is intended as a recognition of the concept embodied in the legislative history of the 1916 Act that an "employee is bound to do what work he can." For additional details, see FECA Transmittal 13-09.

If the EA cannot accommodate the full number of hours for which the claimant has been released to work, the EA must provide written verification that it is unable to provide work for the full number of hours for which the claimant has been released to work. If this written verification is on file, a position with less than that number of hours can be found suitable as noted above. However, any job offer of less than 2 hours per day (or totaling less than 20 hours per pay period) will always be considered unsuitable for purposes of an 8106(c) sanction.

(a) Example 1: A claimant was previously employed in an 8-hour per day job and has been permanently restricted to working no more than 3 hours per day. In this situation, a 3-hour per day job offer could be considered suitable for purposes of an 8106(c) sanction.

(b) Example 2: A claimant was previously employed in an 8-hour per day job and now has permanent restrictions which limit his physical activities but continue to allow him to work 8 hours per day. The EA is able to offer a 4-hour per day job which would accommodate the claimant's permanent work restrictions. In this situation, a 4-hour per day job offer could be considered suitable for purposes of an 8106(c) sanction.

(c) Example 3: A claimant was previously employed in an 8-hour per day job and now has permanent restrictions which limit his physical activities but continue to allow him to work 8 hours per day. The EA is able to offer a job that accommodates the claimant's permanent work restrictions with the following schedule: Monday, Wednesday and Friday 8 hours per day in week one of the two week pay period, and Tuesday and Thursday 8 hours per day in week two of the two week pay period. In this situation, the job offer could be considered suitable for purposes of an 8106(c) sanction because it provided work for at least half of the hours for which the claimant was released to work (40 hours within one complete pay period).

(d) Example 4: A claimant was previously employed in an 8-hour per day job and has been permanently restricted to working no more than 6 hours per day. The EA is able to offer a 2-hour per day job. In this situation, a 2-hour per day job offer could not be considered suitable for the purpose of an 8106(c) sanction because the job offer is not for at least half of the total hours per day that the claimant has been released to work. In order to be considered suitable for the purpose of an 8106(c) sanction in this example, the EA must offer at least a 3-hour per day job.

(3) If the medical evidence substantiates that a gradual return to work is necessary, the job offer must specify the dates of the increased hours commensurate with the claimant's prescribed restrictions.

(4) A job which represents seasonal employment will generally be considered unsuitable unless the claimant was a career seasonal or temporary employee when injured. In locations where year-round jobs are scarce, however, a seasonal position may be considered suitable for an employee who previously held a year-round job. In either case, the job must reasonably represent the claimant's WEC.

(5) A temporary job will be considered unsuitable for the purposes of 8106(c) unless the claimant was a temporary employee when injured, and the temporary job reasonably represents the claimant's WEC. Even if these conditions are met, a job which will terminate in less than 90 days will be considered unsuitable. See M.C., Docket No. 09-1889 (issued May 4, 2010) (although the modified mechanic position was temporary in nature, this was permissible as appellant's date-of-injury job was temporary and the modified mechanic position would not expire in less than 90 days).

(6) The weight of medical evidence must establish that the claimant is physically capable of carrying out any physical requirements of the job. If the claimant has an emotional condition, there may be other requirements that must be met for the position to be deemed suitable (e.g., not working in a particular environment).

(7) If medical reports in the file document a condition which has arisen or worsened since the compensable injury, and this condition disables the claimant from the offered job, the job will be considered unsuitable (even if the subsequently acquired condition is not work-related). As noted previously, the claimant must be taken as a whole person. If a non work-related condition results in work restrictions, those must be considered. The CE may need to develop this evidence with the claimant and seek an OWCP directed examination, if necessary, to delineate the severity of any such restrictions. See E.G., Docket No. 11-1730 (issued October 14, 2011).

Note - Where the weight of the medical evidence establishes that the claimant can work in at least a sedentary capacity due to the work injury, but is more severely restricted from work due to a non employment-related condition which post-dates the injury, the CE should document the file with medical evidence that establishes the claimant's work tolerance limitations based on the accepted work-related conditions and any pre-existing conditions. A referral for vocational rehabilitation services should then be made solely for the purpose of determining the claimant's capacity to earn wages in the open labor market based on the restrictions attributable to the work injury and any pre-existing medical conditions. A constructed wage-earning capacity decision would then be issued. See FECA PM 2-0813-5j.

(8) The claimant must be vocationally able to perform the duties of the offered position. This is usually not an issue, since the EA will have greater knowledge of the claimant's vocational skills and abilities than the OWCP based on the claimant's initial application and work experience, and/or would be able to provide any training necessary to perform the job; therefore, no specific assessment of this criteria is necessary unless there is evidence in the file suggesting a vocational inability to perform the job or an objection is raised by the claimant, in which case it must be developed/addressed with the EA.

(9) If the medical and/or vocational suitability of an offered position is in question, a limited referral for vocational rehabilitation services may be appropriate so that a RC may assist the EA in preparing a job description and identifying equipment which may be needed in order for the claimant to perform the specific duties of an offered position. As necessary, the RC may also arrange for ergonomic or other job site analysis, vocational testing, and/or vocational evaluation to assess the medical and/or vocational suitability of the offered position. See FECA PM 2-0813-6.

(10) Ideally the job offer should clearly state whether the offered position is temporary or permanent in nature.

If it is not clear whether the offer of employment is permanent or temporary in nature, the EA should be asked to clarify in writing the nature of the offer, since an offer of a temporary light duty assignment cannot be deemed suitable (unless the worker was temporary at the time of injury), and the provisions of Section 8106(c) will not apply. See paragraph 9 of this chapter regarding temporary light duty assignments.

Job offers with provisions that are conditional in nature, or place restrictions on continuing availability, may be indicators that further clarification is required as to whether the offer is temporary in nature.

(11) If the offered position involves mandatory telework, the CE should consider whether the claimant teleworked previously. If the employee had already been teleworking, then a job offer that involves telework should be acceptable. If the claimant had not previously teleworked, the additional factors to consider are:

(a) Whether the claimant has an appropriate work space (including any necessary furniture) available. If not, the offer should include the EA's intention to purchase any equipment deemed necessary.

(b) Whether the claimant has the necessary technological capacity (i.e. internet connectivity, computer, etc.). If not, the offer should include the EA's intention to purchase any equipment deemed necessary.

(c) Whether the claimant will be able to perform any necessary training remotely.

A limited referral for vocational rehabilitation services may be necessary if the claimant alleges that any of the above factors have not been met. However, any refusal to cooperate with the RC assigned to confirm or arrange for the necessary accommodations should be pursued under 8113(b), not under 8106(c). See PM 2-0813.

d. Advising the Claimant. After assessing the position and determining that it is a suitable offer of employment, the CE must confirm with the EA that the job remains open and available to the claimant. This must be documented in the file.

(1) The CE should then advise the claimant in writing that:

(a) The job is considered suitable. The CE should explain how s/he determined that the job is suitable and identify the medical evidence which represents the weight of medical opinion with respect to the claimant's work capacity.

(b) The job remains open and available for the claimant.

(c) The claimant will be paid compensation for the difference (if any) between the pay of the offered job and the pay of the claimant's date of injury job.

(d) The claimant can still accept the job with no penalty.

(e) The claimant has 30 days from the date of the CE's letter to either accept the job offer or provide a written explanation of the reason(s) for refusing it.

(f) A claimant who unreasonably refuses an offer of suitable employment is not entitled to any further compensation benefits (with the exception of medical expenses for treatment of the accepted condition). The letter should cite the specific language of §8106 of the FECA ("a partially disabled employee who refuses to seek suitable work, or refuses or neglects to work after suitable work is offered to, procured by, or secured for him, is not entitled to compensation.").

(g) The claimant must also be advised whether relocation expenses will be paid if the job offer is not within the claimant's commuting area. See paragraph 7 of this chapter.

(h) If a formal LWEC is already in place, the 30-day notice must also contain language proposing the modification of the existing LWEC determination with supporting rationale. See paragraph 5d of this chapter.

(2) Whenever the penalty provision of §8106 is invoked, the CE must send out this 30-day notice, advising the claimant that the offered position is suitable and that s/he has 30 days to accept the job offer.

(3) The claimant's authorized representative, if applicable, should also receive a copy of this notice, since it is a notice prior to a final determination (if the claimant does not return to work). See 20 C.F.R. §10.127 ("If the employee has a designated representative before OWCP, a copy of the decision will also be mailed to the representative."); and see, S.T., Docket No. 11-723, issued December 16, 2011 (The ECAB held that the OWCP did not properly issue the termination decision because it did not send a copy of that decision to the authorized representative on that date). See PM Chapter 2-1200 for further information on corresponding with authorized representatives.

(4) The foregoing is the responsibility of the OWCP and cannot be delegated to the EA, but the EA should receive a copy of the notice.

e. Claimant's Response.

(1) If the claimant subsequently accepts the job offer and returns to work, compensation should be promptly reduced or terminated, as appropriate. A letter should be issued to the claimant explaining the basis for reducing or terminating his/her compensation. The return to work should be monitored by the CE so that a WEC determination can be made after the claimant has worked sixty (60) days, if appropriate. See PM Chapter 2-0815.

Note - If a formal LWEC decision has been previously issued, the CE should review the guidance set forth in PM 2-1501-3 and 2-1501-5.

(2) If the claimant does not accept the job offer and/or does not return to work, the CE must evaluate the response, if any, as outlined in paragraph 5 of this chapter. If no response is received, a final decision should be issued invoking the penalty provisions of §8106. See paragraph 6 of this chapter.

5. Job Offer Refusal. If the claimant submits evidence and/or reasons for refusing the offered position, the CE must carefully evaluate the claimant's response and determine whether the claimant's reasons for refusing the job are valid.

a. Acceptable Reasons for Job Offer Refusal. Reasons which may be considered acceptable for refusing the offered job include (but are not limited to):

(1) The offered position was withdrawn.

(2) The claimant found other work which fairly and reasonably represents his or her earning capacity (in which case compensation should be reduced or terminated based on actual earnings, and a formal decision determining the claimant's WEC should be made after 60 days of reemployment). If a WEC has already been issued, see 5d below.

(3) The medical evidence establishes that the claimant is unable to travel to the job because of residuals of the injury. However, if necessary, a claimant who is able to travel but requires special arrangements to do so may be referred for vocational rehabilitation services on a limited basis to determine the least expensive transportation alternative. (Once established and approved, the claimant may request reimbursement for the travel using Form OWCP-957, or equivalent.)

(4) The claimant provides evidence that his or her refusal was based upon the attending physician's advice, and that such advice included medical rationale in support of the opinion.

(a) If the reemployment effort was based upon the attending physician's work restrictions and the physician has now changed his/her opinion, the CE can develop the issue further with the attending physician by providing a copy of the job offer and seeking an opinion regarding the claimant's ability to perform the job. After seeking this clarification, if the attending physician determines that the claimant can perform the position, a new 30-day notice is not needed and the CE can proceed with issuing a final 15-day notice. However, a copy of any new medical evidence obtained should be included with this notice. See sub-paragraph 5e(3) of this paragraph for further discussion regarding the 15-day notice.

(b) If the reemployment effort was based upon the attending physician's work restrictions and the physician has now changed his/her opinion regarding the claimant's work tolerance ability, the CE may decide that a second opinion examination is warranted. If the CE seeks a second opinion and ultimately finds that the weight of medical evidence supports that the offered position is suitable, a new 30-day notice (as outlined in paragraph 4) is required. The claimant will have an opportunity to review the new medical evidence with his or her attending physician if desired.

(c) If the reemployment effort was not based upon the attending physician's work restrictions but rather a prior second opinion physician's findings, and the CE has already weighed the opinions of the attending physician and the second opinion examiner, and the opinion submitted by the attending physician does not alter the weight of medical evidence determination as provided in the 30-day notice, the CE can proceed with the 15-day notice. See sub-paragraph 5e(3).

(d) If the attending physician states that the claimant cannot perform the duties of the offered position and a second opinion specialist states that the claimant can perform those duties, and both opinions are of equal weight, then a conflict in the medical evidence exists and a referral to an impartial medical specialist for a referee examination is necessary. If the CE seeks an impartial medical examination and ultimately finds that the offered position is suitable, a new 30-day notice (as outlined in paragraph 4 above) is required.

(e) If the reemployment effort was based upon a prior referee examination from an impartial medical specialist, and the attending physician was on one side of the conflict which resulted in such examination, no additional development is generally necessary. See Kathryn E. Demarsh, Docket No. 05-269, issued August 18, 2005 and M.B., Docket No. 07-522, issued September 18, 2007 (Submitting a report from a physician who was on one side of a medical conflict that an impartial specialist resolved is generally insufficient to overcome the weight accorded to the report of the impartial medical examiner or to create a new conflict). The CE can proceed with the 15 day notice. See sub-paragraph 5e(3).

b. Acceptable Reasons for Job Offer Refusal When the Claimant is No Longer on the Agency's Rolls. A claimant may be simultaneously on both the EA's rolls as a matter of employment status and the OWCP's rolls for purposes of compensation payment. For claimants no longer on the EA's rolls (those who have been separated by formal personnel action), the following are also considered acceptable reasons for refusing the offered job:

(1) The claimant will lose health insurance coverage by accepting the job. (If the offered job is not classified at the same grade level as the date of injury job and the EA will not be making insurance deductions, the EA should be asked to offer the job at a pay rate lower than the date of injury job so that compensation will be payable and the OWCP can retain the claimant's health insurance enrollment.)

(2) The claimant is already working and the job fairly and reasonably represents his or her WEC (whether or not a formal Loss of Wage-Earning Capacity (LWEC) decision is already in place).

(3) The claimant has moved and a medical condition (either pre-existing or subsequent to the injury) of the claimant or an immediate family member (spouse or minor child) contraindicates a return to the area of residence at the time of injury.

c. Unacceptable Reasons for Job Offer Refusal. Reasons which are not considered acceptable for refusing the offered job include (but are not limited to):

(1) The claimant's preference for the area in which s/he currently resides.

(2) The claimant's personal dislike of the position offered or the work hours scheduled. See Fred L. Nelly, 46 ECAB 142 (1994); see also George E. Wills, Docket No. 97-0646, issued October 22, 1998 (It is well established that a claimant's preference for the area in which he currently resides, or personal dislike of the position offered, are not acceptable reasons for refusing an offered position).

(3) The lack of potential for promotion or a lack of job security. See Jerry Inman, Docket No. 03-476, issued April 24, 2003 (The claimant alleged that co-workers had treated him poorly when he returned to the previous light duty position and that the employing establishment failed to provide him with information regarding his status in the event of a reduction-in-force. The ECAB held that issues of job security were not acceptable reasons for refusing an offered position).

(4) The claimant indicates that s/he is retired. See Stephen R. Lubin, 43 ECAB 564 (1992) (The ECAB noted that the employee's election to receive retirement benefits was not a valid reason for refusing an offer of suitable work). See also B.C., Docket No. 08-1274, issued May 11, 2009 ("To the extent that appellant refused the position because she was pursuing a disability retirement, the Board notes that retirement is not an acceptable reason for refusing an offer of suitable work").

(5) The claimant is participating in an OWCP sponsored vocational rehabilitation program (including training).

d. Unacceptable Reasons for Job Offer Refusal if a Previous LWEC Decision is in place. The existence of an established LWEC decision alone is not a valid reason for refusing suitable work in all instances. However, the CE must carefully evaluate the prior LWEC decision to determine if it can be modified. (See PM 2-1501, if the claimant accepts the offered position.)

(1) Claimant Not Working. If a claimant refuses a job offer and is not currently working but a LWEC decision is in place, the CE should first review the record to determine whether the claimant's medical condition has improved such that he/she can now work a greater number of hours or perform more strenuous duties.

If the CE determines that the offered job is suitable AND that the LWEC is in posture for modification on the basis of an improved medical condition, the CE should prepare the 30-day notice in accordance with paragraph 4(d) above. However, the 30-day notice must also contain language proposing the modification of the existing LWEC determination with supporting

rationale. Because the OWCP is proposing modification, it has the burden of proof to modify the LWEC.

(a) If no reply is received from the claimant, the CE should prepare a formal decision which terminates any further compensation for wage loss, as well as any entitlement to a schedule award, under Section 8106(c) of the Act as of the date of the final decision. However, the decision must also contain language indicating the prior LWEC is modified and explain the evidence supporting this determination. The claimant's entitlement to payment of medical expenses for treatment of the accepted condition is not terminated. See paragraph 6 of this chapter.

(b) If the claimant does provide a response, the CE must carefully evaluate the claimant's response. If the continued refusal is deemed unjustified and the suitable work remains available to the claimant after 30 days, the CE should review the file and send the 15-day letter as appropriate. See paragraph 5e(3).

After the expiration of 15 additional days, if refusal continues and the suitable work is still available, the CE should issue the 8106(c) sanction decision and terminate compensation as of the date of the final decision consistent with paragraph 6 below. However, the decision must also contain language indicating the prior LWEC is modified and explain the evidence supporting this determination.

(c) If the claimant returns to work, and a formal LWEC decision has been previously issued, the CE should review the guidance set forth in PM 2-1501-3 and 2-1501-5.

(2) Claimant Working. If the claimant is working, the CE should determine whether the actual earnings fairly and reasonably represent the claimant's WEC prior to proceeding with the sanction.

(a) If the earnings do fairly and reasonably represent the claimant's WEC, a sanction cannot be issued. It is not appropriate for the OWCP to invoke section 8106(c) where a claimant has actual earnings and the office has found those earnings to be a fair and reasonable representation of wage-earning capacity. Michael E. Moravec 46 ECAB 492 (1995).

Note - The claimant's earnings do not have to be in the position for which the LWEC decision was issued for earnings to fairly and reasonably represent the claimant's WEC. See PM 2-815 for a discussion of WECs.

(b) If the earnings do NOT fairly and reasonably represent the claimant's WEC because the claimant's condition has improved such that he/she can now work a greater number of hours or perform more strenuous duties, the CE may proceed with modification of the WEC and a sanction decision on that basis as described above in paragraph 5d(1).

(3) If the CE determines that the LWEC cannot be modified because the claimant's medical condition has not improved, an 8106(c) sanction decision may not be issued and the CE should advise the agency of such in writing. Absent clear evidence that the prior LWEC was issued in

error, there is no other basis for modifying a prior LWEC because modification on the grounds that the claimant has been vocationally rehabilitated requires actual employment in a new position for a period of at least 60 days.

e. Further Action.

(1) If the refusal is deemed justified, the CE should notify both the claimant and the EA in writing. The claimant will continue receiving compensation benefits while the CE (or FN or RC) contacts the EA concerning further attempts at reemployment. The CE can also refer the case for vocational rehabilitation services, if an RC is not already assigned, for assistance with the placement effort.

(2) If it is not possible to determine whether a claimant's reason for refusal is justified without further development of the issues, the CE should contact the claimant or EA for clarifying information and follow up promptly until the issue is resolved. The EA should be contacted again and asked to keep the job open and available during this period. If the EA is unable or unwilling to do this, the CE must discontinue any further consideration of applying the sanction provided by Section 8106(c), and the claimant should be notified in writing of this determination. However, after development of the issues, if the CE still finds that the position is suitable and the job remains available, a new 30-day notice is not needed and the CE can proceed with issuing a final 15-day notice. See 5e(3) below.

See sub-paragraph 5a(4) if the case requires further medical development.

(3) If the claimant's refusal of the offered job is not deemed justified, the CE must advise the claimant and allow 15 additional days for him or her to accept the job (see Maggie L. Moore, Docket No. 90-1291, issued March 8, 1991). The notice need not include the reason for finding the claimant's refusal unjustified. However, if new relevant evidence has been obtained, it should be included with this notice.

6. Issuing a Final 8106(c) Decision. If the claimant does not accept the job and return to work during the 15-day period (or does not accept the job and return to work after the original 30-day notice and does not submit any response at all), the CE should issue a formal decision in accordance with FECA PM 2-1400 and terminate compensation as of the date of the final decision. The final decision should generally contain:

a. A brief case summary, including a discussion of the opinion of the attending physician, as well as any referrals to a second opinion or referee examiner and the results of such, if indicated.

b. Identification of the medical evidence accepted as bearing the weight that indicates that the claimant's condition is stable and establishes well-defined limitations.

c. A description of the offered position, including the physical requirements and a discussion as to how the position is medically suitable to the claimant's disabling condition.

d. Confirmation that the 30-day notice was provided and a thorough discussion of any evidence received in response (and the results of any additional development that was undertaken).

e. Full findings of fact as to why the claimant's reasons for refusing the job are deemed unacceptable.

f. Confirmation that the 15-day notice was issued, if one was necessary.

g. Notice that compensation, including any entitlement to a schedule award, has been terminated under Section 8106(c). See PM 2-0808.12 for more information regarding schedule award entitlement and refusal of suitable work.

h. If a formal LWEC is in place, the decision must also contain language indicating the prior LWEC is modified and explain the evidence supporting this determination.

A formal termination resulting from failure to accept a suitable job offer should not be modified even if the claimant's medical condition later deteriorates and s/he claims a recurrence of total disability. The pertinent factor is whether the evidence supports that the offered position was suitable at the time it was offered, not at a later period in time.

7. Relocation Expenses. 20 CFR §10.508 provides that an injured employee who relocates to accept a suitable job offer after termination from the EA rolls may receive payment or reimbursement of moving expenses from the compensation fund. This provision further states that Federal travel regulations addressing permanent change of duty station (PCS) moves will be used to determine whether expenses claimed are reasonable and necessary.

a. Criteria for Payment. Relocation expenses are payable only to claimants who are no longer on the EA rolls. They are payable whether the claimant still resides in the locale where s/he last worked and is offered employment in another area, or whether the claimant has moved away from the locale where s/he was employed and is offered employment in either the original area or a different one. Expenses may be paid for relocation to a temporary job as long as it is expected to lead to a permanent assignment, but may not be paid for relocation to a temporary job which is not expected to lead to a permanent assignment. The distance between the two locations must be at least 50 miles, but the claimant is not required to demonstrate financial need for relocation expenses to be paid.

b. Responsibilities.

(1) The OWCP District Office staff will adjudicate all requests for relocation. The EA, however, has an advisory role with respect to the amounts payable.

(2) Where relocation is approved, the EA will be asked to assist with all arrangements for the move (e.g., have a moving company transport the employee's household goods to the new duty station). The EA will also be asked to ensure that the types of expenses and the actual amounts are allowable according to GSA travel regulations and according to what the EA would authorize

for any other employee making a PCS move. The CE is not expected to determine the kinds of expenses and the amounts payable.

(3) The OWCP is responsible for resolving any dispute between the claimant and the EA as to allowable costs in accordance with GSA regulations. Any formal denial will be accompanied by appeal rights.

c. Adjudication of the Request. The CE should ask the EA to send a copy of the job description to the Office before making the job offer so that suitability of the job and entitlement to payment of relocation expenses can be determined. If the offered job is found suitable, medically and otherwise, the CE may proceed to consider whether relocation expenses may be paid.

The CE should evaluate the request for payment of relocation expenses and make a recommendation to the Supervisory Claims Examiner (SCE) concerning payment. The SCE's concurrence should be documented in the file.

d. Advising the Parties.

(1) If relocation expenses are approved, the OWCP should notify the claimant and EA in writing. The letter to the claimant should note that GSA regulations require employees whose moving expenses are paid by the Federal government to remain in Federal employment for one year after the move. Should the claimant cease working for a reason unacceptable to the Office (see paragraph 5 above), the relocation expenses may be declared an overpayment by the EA.

(2) If relocation expenses are approved, the EA should include a description of the claimant's entitlement to relocation expenses and a statement that relocation expenses are payable in the job offer.

(3) If the claimant does not accept the job offer, the CE should again notify the claimant, in the letter notifying the claimant that the offered job has been found suitable, that such expenses are payable. See paragraph 5 in this chapter.

e. Payment/Reimbursement of Relocation Expenses.

(1) Where relocation is approved, the EA will pay or reimburse authorized expenses to the claimant in accordance with its procedures.

(2) An EA which is unable to pay relocation expenses may request that the OWCP pay such expenses under 20 CFR § 10.508.

A claimant who has paid for relocation expenses from his or her own funds will be directed to submit copies of the bills and travel vouchers to the EA for examination to ensure that the amounts claimed are in accordance with GSA travel regulations. The bills and vouchers should then be forwarded to the OWCP for reimbursement to the claimant. Should the claimant cease working as described in paragraph d(1) above, the relocation expenses will be declared an overpayment by the OWCP and handled according to the usual procedures (see PM Part 6).

8. Abandonment of a Suitable Job. If a claimant returns to work and then stops working and submits a claim for compensation, the CE must make a finding of suitability (as discussed in paragraph 4 of this chapter), unless a formal LWEC decision has been issued.

- a. If a formal LWEC determination has been made, the CE must develop the evidence to determine whether modification of that LWEC is appropriate. See PM Chapter 2-1501.
- b. If a formal LWEC has not been issued, the CE should evaluate any evidence submitted and the reasons for the work stoppage.

If the evidence of file is insufficient to establish a recurrence (see FECA PM 2-1500), and the CE has determined that the job is suitable (see paragraph 4 and 5 of this chapter), the CE must advise the claimant that the job is suitable and that refusal of the job offer may result in application of the penalty provision of 5 U.S.C. §8106(c), and allow the claimant 30 days to submit his or her response. The claimant should also be advised simultaneously of the evidence necessary to establish a recurrence of disability.

(1) If the claimant then returns to work, a letter should be issued to the claimant explaining the basis for his/her ongoing compensation, if any. The employment should be monitored by the CE so that a WEC determination can be made after the claimant has worked sixty (60) days, if appropriate. See PM Chapter 2-0815.

(2) If no reply is received from the claimant, the CE should prepare a formal decision which terminates any further compensation for wage loss, as well as any entitlement to a schedule award, under Section 8106(c) of the Act, and terminate compensation as of the date of the final decision. The claimant's entitlement to payment of medical expenses for treatment of the accepted condition is not terminated. See paragraph 6 of this chapter.

(3) If the claimant does provide a response, the CE must carefully evaluate the claimant's response.

(a) The CE should first evaluate whether a recurrence has been established in accordance with FECA PM 2-1500. If the claim meets the criteria necessary to establish a recurrence of disability, the claim should be accepted and no further action should be taken with regard to abandonment of suitable work.

(b) If a recurrence of disability is not established, the CE must evaluate the reasons given for the work stoppage. See paragraph 4 and 5 of this chapter for guidance on determining whether the reasons provided are sufficient. Insufficient reasons for job abandonment include the following:

(i) Where the claimant elected to receive disability retirement rather than continue working in suitable employment. See Roy E. Bankston, 38 ECAB 380 (1987) (The ECAB affirmed the OWCP's termination of compensation where the claimant voluntarily retired two and a half years after he returned to work, and there was no evidence to indicate that he retired because of disability or health reasons).

(ii) Where the claimant resigned a modified light duty position without good reason. See Arquelio Pacheco, 40 ECAB 277 (1988) (The ECAB affirmed the OWCP's termination of compensation where the claimant voluntarily resigned from his modified part-time position in order to move to Puerto Rico, and there was no evidence to indicate that his relocation was due to disability or health reasons).

(iii) Where the claimant resigned from his light duty position to go back to college. See Donald A. Reynolds, Docket No. 00-2682, issued August 17, 2001 (At the time of his work stoppage, appellant indicated that he was resigning his position because he desired to finish his degree).

(c) If it is not possible to determine whether a claimant's reason for abandonment is justified without further development of the issues, the CE should take action as outlined in paragraph 5 of this chapter.

(d) If the abandonment is deemed justified, the CE should notify both the claimant and the EA. The claimant will be entitled to TTD compensation benefits while the CE (or FN or RC) contacts the EA concerning further attempts at reemployment. The CE can also refer the case for vocational rehabilitation services, if an RC is not already assigned, for assistance with the placement effort.

(e) If a recurrence has not been established, and the abandonment of the job is not deemed justified, the CE must advise the claimant (also notifying the EA) and allow him or her 15 additional days to return to work, as outlined in paragraph 5d(3) of this chapter.

(i) If the claimant then returns to work, a letter should be issued to the claimant explaining the basis for his/her ongoing compensation, if any. The return to work should be monitored by the CE so that a WEC determination can be made after the claimant has worked sixty (60) days, if appropriate. See PM Chapter 2-0815.

(ii) If the claimant does not return to work after the 15-day notice, the CE should issue a formal decision which terminates compensation under Section 8106(c) and terminate compensation as of the date of the final decision as described in paragraph 6 of this chapter. The CE should also include a description of the initial return to work and subsequent work stoppage, a detailed discussion of any development actions taken and any evidence received in response to such actions, and an explanation as to why the evidence received was insufficient to establish both a recurrence of disability and an inability to perform the duties of the position. Such a decision should not be modified even if the claimant's medical condition later worsens and s/he claims a recurrence of total disability.

9. Temporary Assignments. There may be occasions when the EA is only able to provide a temporary light duty assignment to the claimant even though the claimant held a permanent job at the time of injury. In these instances, the penalty language of Section 8106(c) cannot be applied.

The claimant is, however, expected to work, as 20 CFR §10.5(f) defines disability as "the incapacity, because of an employment injury, to earn the wages the employee was receiving at

the time of injury. It may be partial or total." If the claimant is provided with a temporary light duty assignment within his or her restrictions, total disability for the period of the assignment is not substantiated.

Note - If the claimant held a temporary position at the time of injury, a temporary offer of at least 90 days can be found suitable. See paragraph 4c(5) of this chapter.

a. 20 CFR §10.500(a) provides the following:

"Benefits are available only while the effects of a work-related condition continue. 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. For example, an employee is not entitled to compensation for any wage loss claimed on Form CA-7 to the extent that evidence contemporaneous with the period claimed on the CA-7 establishes that the employee had medical work restrictions in place; that light duty within those restrictions was available; and that the employee was previously notified in writing that such duty was available. Similarly, an employee receiving continuing payments for periodic 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. (The penalty provision of 5 U.S.C. 8106(c)(2) will not be imposed on such assignments under this paragraph.)"

b. When the Claimant is Not on the Periodic Roll. A claim for wage-loss compensation may be received on a Form CA-7 where a temporary light duty assignment has been provided by the EA. If a formal LWEC decision has been issued, the CE must develop the evidence to determine whether modification of that LWEC is appropriate. See PM Chapter 2-1501. If a formal LWEC has not been issued, and a CA-7 is received, the CE should follow the procedures below.

(1) Requirements.

(a) If the evidence establishes that injury-related residuals continue and result in work restrictions; that light duty within those work restrictions was available; and that the employee was notified in writing that such light duty was available, then wage-loss benefits (effective the date of the written notification of light duty availability) are not payable for the period covered by the available light duty assignment. Such benefits are payable only for any periods during which an employee's work-related medical condition prevent him or her from earning the wages earned before the work-related injury. The light duty assignment may include or consist of telework.

(b) Entitlement to schedule award or medical benefits is not affected by this determination.

(2) Developing the Claim for Compensation. If a claim for wage-loss compensation is made where the weight of the medical evidence establishes that the claimant has been cleared to return to light duty work activities, the CE should determine whether light duty work was available within the claimant's medical restrictions during the period for which compensation was claimed.

Upon receipt of the claim for wage-loss compensation, the CE should send out a development letter to the claimant, advising him/her of the standards set forth in §10.500(a) and of the medical evidence required to substantiate the claim for compensation. Thirty days should be provided for the submission of evidence.

The CE should also obtain documentation from the EA that written notification of light duty availability was provided to the claimant, if not already in the file.

(3) Adjudicating the Claim for Compensation.

(a) If the claimant submits evidence that light duty work was not available to him/her for the period for which wage-loss compensation was claimed, or that the light duty work assignment was not within his/her restrictions, then s/he is entitled to compensation for said period.

(b) If the evidence of record establishes that light duty work within the claimant's restrictions was in fact available to the claimant for the period claimed (and written notification of the light duty assignment had been provided to the claimant), there is no entitlement to wage-loss compensation. A formal decision should be issued denying the claim for compensation. The decision should only deny wage-loss compensation for the period claimed; the decision should not terminate all future entitlement to wage-loss compensation.

(c) When making a determination that an employee was not prevented from earning the wages earned before the work-related injury, the CE should refrain from making a suitability finding, since the denial of wage-loss compensation pursuant to §10.500 is different from the penalty provision of §8106.

The CE should instead reference the language in §10.500(a) in the decision denying wage-loss compensation for the period claimed: "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..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."

(4) If an employee is offered a part-time, temporary light duty assignment, the same basic rules outlined above should be followed. The CE should not pay for the hours when light duty within the claimant's work restrictions was available if there is evidence that the claimant was previously performing light duty or was notified in writing that such light duty was available.

c. When the Claimant is on the Periodic Roll (PR). The general premise regarding medically appropriate light duty assignments offered to claimants while on the PR under 20 CFR 10.500(a) is that the assignments in these instances are temporary in nature. For instance, a temporary light duty assignment may be provided to the claimant during a period of recovery while the claimant's work restrictions are temporary in nature. A temporary assignment may also be provided to the claimant when s/he has stable and well defined or permanent restrictions and the

EA is actively pursuing permanent employment opportunities to accommodate those restrictions. If necessary, temporary assignments provided in these situations allow for OWCP vocational rehabilitation assistance in identifying and securing auxiliary aids in the event they are necessary (through such tools as transferable skills analyses, ergonomic assessments and/or job site analyses). Even if a FN is assigned to the case during the claimant's period of recovery, an RC can still be assigned to assist with the reemployment effort as part of disability management Dual Tracking. See PM Chapter 2-0600.

(1) Requirements.

(a) If the evidence establishes that injury-related residuals continue and result in work restrictions; that light duty within those work restrictions is available; and that the employee was notified in writing that such light duty was available, then wage loss benefits are not payable for the duration of light duty availability, since such benefits are payable 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.

(b) When a claimant is in continuous receipt of wage-loss compensation on the periodic roll (PR), there is an expectation of continued payment. Therefore, the notification and due process burden when a temporary light duty assignment is offered is greater than when the claimant is not on the PR. A pre-termination notice must be issued if the CE is removing the claimant from the PR and ceasing his/her wage loss compensation payments (a pre-reduction notice should also be issued if the CE is proposing to reduce the claimant's compensation). See PM Chapter 2-1400 for a discussion of pre-termination and pre-reduction notices.

(c) Entitlement to schedule award or medical benefits is not affected by this determination.

(d) When a temporary light duty assignment ends (or the work is no longer available), the claimant is entitled to compensation and should be placed back on the PR immediately, as long as medical evidence supports any disabling residuals of the work-related condition.

No development is typically needed prior to reinstating the claimant on the PR and resuming wage-loss compensation. See paragraph 9c (11) of this chapter.

(2) Basic Criteria for Applicability.

(a) A temporary light duty assignment based on permanent restrictions can be provided for a specified period of time with an end date, but it can also be provided for an indefinite period of time with no end date specified. If the EA's notification is clear that the assignment is for a given period (for example, 120 days), a denial of compensation for a PR recipient will only extend for that closed period. The light duty assignment may consist of or include telework as a component of the assignment.

(b) The light duty assignment must take into account the claimant's work-related condition(s), as well as any pre-existing medical conditions and any conditions which have arisen since the

compensable injury. A light duty assignment that does not consider all such conditions will not be considered appropriate.

(c) If the EA is only able to provide a temporary light duty assignment when the claimant has permanent work restrictions, the EA must provide written verification that it is unable to provide a permanent job offer. If this written verification is on file, a temporary light duty assignment can be considered appropriate. If this verification is not on file, the CE should request this verification in writing from the EA.

If the claimant's work restrictions are temporary in nature, such written verification is not needed from the EA. Written confirmation/verification is only needed when the claimant's work restrictions are permanent in nature.

(d) Ideally, a light duty assignment should be provided for the number of hours for which a claimant has been released to work. In some instances, when this is not possible, the EA may provide a light duty assignment for fewer hours than the claimant was actually released to work. As long as the light duty assignment is for at least half of the total hours that the claimant has been released to work, the light duty assignment can be considered appropriate. However, a light duty assignment of less than 2 hours per day (or totaling 20 hours a pay period) cannot be considered appropriate.

If the EA cannot accommodate the full number of hours for which the claimant has been released to work, the EA must provide written verification that it is unable to provide work for the full number of hours for which the claimant has been released to work. If this written verification is on file, a light duty assignment with less than that number of hours can be considered appropriate. If this verification is not on file, the CE should request this verification in writing from the EA.

See paragraph 4c in this chapter for examples of hourly/weekly schedules that may be considered appropriate when the claimant is offered work for less than the number of hours for which he/she was released to work. The same examples would also apply to temporary light duty assignments.

(e) If the medical evidence substantiates that a gradual return to work is necessary, a light duty assignment must specify the dates of the increased hours commensurate with the claimant's prescribed restrictions.

(f) The light duty assignment should be in the location where the employee currently resides. If this is not practical, the EA may provide light duty at the employee's former duty station if that station is within the claimant's commuting area. Reemployment at any other location may only be considered where the distance between the location of the light duty assignment and the location where the employee currently resides is no greater than 50 miles and the employee is physically capable of performing the commute entailed. Special travel arrangements through vocational rehabilitation will not be pursued for temporary assignments.

(3) Notice of a Temporary Light Duty Assignment. When the EA provides a temporary light duty assignment to the claimant, a copy should also be sent to the OWCP. The claimant's

response should be forwarded to the OWCP when it is received by the EA. A temporary light duty assignment for a claimant on the PR must be in writing and contain the following essential elements:

- (a) A description of the duties to be performed;
 - (b) The specific physical requirements of the assignment, including any special demands of the workload or unusual working conditions;
 - (c) The organizational and geographical location of the assignment;
 - (d) The date on which the assignment will be first available and the end date of the assignment, if any;
 - (e) The claimant's work schedule (including telework);
 - (f) Pay rate (salary) information; and
 - (g) The date by which a response to the notice of the light duty assignment is required.
- (4) If the employee accepts the light duty assignment, the CE should calculate the claimant's entitlement to compensation in accordance with his or her actual earnings. See FECA PM 2-0815. A letter should be issued to the claimant explaining the basis for reducing or terminating his/her compensation, but no formal determination on the appropriateness of the light duty assignment is necessary.

Even after 60 days of employment, the CE should not consider the case for a WEC determination, since the light duty assignment was only temporary. There can be no determination that the position fairly and reasonably represents the claimant's WEC.

- (5) If the employee declines the offered assignment, or fails to return to work after accepting the assignment, the CE should review the light duty assignment in light of the factors identified above in sub-paragraphs 9c(2) and 9c(3) of this chapter.

If the assignment is considered appropriate based on the evidence of record, the CE should issue a notice of proposed termination or reduction of compensation for the duration of the temporary assignment, whether specified or indefinite, and provide the claimant with 30 days to respond.

The claimant should be advised in writing of the requirements of §10.500 and that:

- (a) A light duty assignment (identified by name/date) has been provided that accommodates the claimant's current work restrictions. (The medical evidence used to make this determination should be identified and a copy should be included with the notice.);
- (b) The light duty assignment is available effective the start date of the assignment and remains open through the end date of the assignment, or will remain available indefinitely;

(c) The claimant will be paid compensation for the difference (if any) between the pay of the offered assignment and the pay of his/her date of injury job; and

(d) The claimant can still accept the light duty assignment without penalty.

(6) Actions AFTER a notice of proposed termination or reduction of compensation has been issued:

(a) If the claimant then accepts the light duty assignment, compensation should be reduced or terminated, as outlined above. Also, a letter explaining the basis for this action should be issued to the claimant, and he/she should be advised to file a CA-2a (Notice of Recurrence) if further wage loss compensation is claimed either due to a change in the medical condition or a withdrawal of the light duty assignment.

(b) If no reply is received from the claimant and the claimant does not return to work, the CE should prepare a formal decision as outlined in paragraph 9c(7) below.

(c) If the claimant submits reasons for declining the light duty assignment within the 30-day period, the CE should carefully evaluate the claimant's reasons and determine if they are valid.

i. Acceptable reasons include (but are not limited to): the claimant is physically unable to travel to the job site (see paragraph 9c.2(f) above); the medical evidence establishes that the claimant cannot perform the duties of the light duty assignment; and the claimant is in an OWCP sponsored vocational rehabilitation program and a placement or training plan has been approved.

ii. Unacceptable reasons include (but are not limited to): the claimant's preference for a permanent position, or personal dislike of the light duty assignment (or the hours scheduled).

iii. If it is not possible to determine whether a claimant's reason for declining the light duty assignment is justified without further development of the issues, the CE should contact the claimant or EA for clarifying information and follow up promptly until the issue is resolved. The EA should be contacted and asked to keep the light duty assignment open and available during this period and/or to extend the period of the temporary assignment. If the EA is unable or unwilling to do this, the CE must discontinue any further consideration of the light duty assignment.

iv. If the claimant's reason for declining the light duty assignment is deemed justified, the CE should notify both the claimant and the EA that the claimant will continue to receive wage-loss compensation on the PR while the CE continues disability case management activities. Reference PM Chapter 2-0600 for more information regarding disability management.

v. If the claimant's reason for declining the light duty assignment is not justified, the CE should prepare a formal decision as outlined in paragraph 9c(7) below after confirming with the EA that the temporary assignment is still available.

(7) Formal Denial of Compensation. If the temporary light duty assignment meets the criteria outlined in this paragraph, and the claimant has been provided with a pre-reduction or pre-termination notice, a final reduction or termination decision should be issued and compensation should be reduced or terminated as of the date of the final decision. Final reductions and terminations are described in PM Chapter 2-1400.

(a) Because the denial of compensation under 20 C.F.R. §10.500(a) is not a termination of benefits for refusal to accept suitable work, a formal denial of compensation under the auspices of 20 C.F.R. §10.500(a) should:

i. Deny compensation for wage loss, or reduce compensation based upon the expected WEC had the light duty assignment been accepted, for the duration of the assignment or indefinitely (depending on whether the light duty assignment was for a specific period of time or was to be provided indefinitely);

ii. Clearly indicate that the claimant's entitlement to medical care or eligibility for a schedule award for his/her accepted condition is not affected by the decision; and

iii. Advise the claimant that s/he may file a Form CA-2a, Notice of Recurrence, at the end of the temporary assignment period (if applicable) to claim further wage-loss compensation, and that compensation will be paid only if the light duty assignment was withdrawn or the claimant's medical condition has worsened.

(b) When making a determination that an employee was not prevented from earning the wages earned before the work-related injury, the CE should refrain from making a suitability determination, since the denial of compensation pursuant to §10.500(a) is different from the penalty provision of §8106.

The CE should instead reference the language in §10.500(a): "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... 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."

(8) Continuing Payment After a Denial. If there still would have been wage loss if the claimant had accepted the light duty assignment, the claimant remains entitled to compensation benefits based upon the temporary actual earnings WEC calculation (just as if he/she had accepted the light duty assignment).

(9) Any modification of compensation should be preceded by a 30-day notice and then be made prospectively so that no overpayment results.

(10) When a temporary light duty assignment ends or the work is no longer available, the claimant should submit Form CA-2a through the EA (or Form CA-7 with verification from the

EA that work is no longer available). In such circumstances, as long as medical evidence supports that any disabling residuals of the work-related condition still exist, the claimant is entitled to be placed back on the PR immediately.

No development is typically needed prior to placing the claimant back on the PR and resuming wage-loss compensation, and payment should not be unnecessarily delayed, as 20 C.F.R. §10.5 (x) defines a recurrence of disability as "...an inability to work that takes place when a light-duty assignment made specifically to accommodate an employee's physical limitations due to his or her work-related injury or illness is withdrawn, or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations."

Note - A recurrence of disability does not apply when a light-duty assignment is withdrawn for reasons of misconduct or non-performance of job duties.

Chapter 2-0815, Determining Wage-Earning Capacity Based on Actual Earnings

1. Purpose and Scope. An employee that is unable to return to his/her date of injury (DOI) job because of disability due to work-related injury or disease may instead return to alternative employment. This chapter explains the procedures for determining entitlement to compensation after such reemployment. It also provides guidance on making a determination as to whether the alternative employment fairly and reasonably represents the employee's wage-earning capacity (WEC) and presents procedures for issuance of the formal loss of wage-earning capacity (LWEC) decision.

2. Statutory and Regulatory Provisions/Case Law.

a. Section 8106 of the FECA provides for a reduction in compensation to reflect a LWEC when the disability for work is partial.

The method of computing compensation for wage loss due to partial disability is set forth in Section 8106(a), which states that if the disability is partial, the United States shall pay the employee during the disability monthly monetary compensation equal to $66\frac{2}{3}$ (or 75) percent of the difference between his monthly pay and his monthly WEC after the beginning of the partial disability, which is known as his/her basic compensation for partial disability.

b. Section 8115(a) of the FECA states that in determining compensation for partial disability, except permanent partial disability compensable under Sections 8107-8109 of this Title, the WEC of an employee is determined by his/her actual earnings if his actual earnings fairly and reasonably represent his/her WEC.

c. 20 C.F.R. §10.402 states that an injured employee who cannot return to the position held at the time of injury (or earn equivalent wages) due to the work-related injury, but who is not totally disabled for all gainful employment, is considered to be partially disabled.

d. 20 C.F.R. § 10.510 states that a light duty position that fairly and reasonably represents an employee's ability to earn wages may form the basis of a LWEC 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.

e. Shadrick Formula. In the early landmark decision of Albert C. Shadrick, 5 ECAB 376 (1953), ECAB directed that the LWEC of the partially disabled employee be determined by comparing the wages of the position s/he is currently able to perform with the current wages of the position s/he held when injured. See paragraph 4b.

3. Initial Fiscal Actions. Upon notification that an injured employee has returned to work, the Claims Examiner (CE) should take the following actions:

a. If the injured employee has been receiving compensation on the periodic roll (whether for total disability or partial disability based on actual earnings without a formal LWEC determination), the CE should delete the payment record as soon as possible. If the deletion can be made effective the current roll period, a supplemental payment may be made to pay any additional compensation due. Any compensation paid for total wage loss subsequent to the date of return to work should be declared an overpayment (see FECA PM Part 6 – Debt Management).

If a formal LWEC decision has been previously issued, the CE should review the guidance set forth in PM 2-1501-3 and 2-1501-5.

b. If the injured employee is entitled to compensation for partial wage loss after return to work, the CE should compute entitlement using the Shadrick formula (see paragraph 4 in this chapter). If the injured employee's earnings are fixed, the CE may authorize compensation on a 28-day payment cycle. If the injured employee's earnings are variable, the CE may authorize payment on the daily roll as earnings records are received. In either case, the CE should make every effort to avoid interruption of income to the injured employee.

(1) For part-time work, compensation should be computed using the Shadrick formula. The only exception to this rule is when the return to work is with the employing agency and the injured employee had a fixed DOI work schedule. In such cases, the injured employee may be compensated for hours lost without applying the Shadrick formula.

(2) For seasonal and temporary employment, the annual salary of the job selected must be divided by 52 to obtain a weekly pay rate. The figure obtained should then be compared, using the Shadrick formula, to the weekly pay for the grade and step of the job held when injured, and

the result should be applied to the pay rate for compensation purposes. However, when a career seasonal employee is rated in a career seasonal job, the salary of the current job should be annualized before the Shadrick formula is applied, so that a true LWEC will be obtained.

(3) Where the injured employee has earnings of a sporadic or intermittent nature, the CE should obtain actual earnings for each pay period and compensate the injured employee on the daily roll using the Shadrick formula.

(4) Where the Office learns of actual earnings that span a lengthy period of time (e.g., several months or more), the compensation entitlement should be determined by averaging the earnings for the entire period, determining the average pay rate, and applying the Shadrick formula (comparing the average pay rate for the entire period to the pay rate of the DOI job in effect at the end of the period of actual earnings).

For example, the Office learns on October 1, 2012 that the employee, injured on June 5, 2006, returned to work on September 1, 2007 and worked intermittently through September 1, 2011 when he ceased work. On September 1, 2011 the pay rate for the employee's DOI job was \$500 per week. The employee grossed \$40,000 during the four years (208 weeks) he worked from September 1, 2007 through September 1, 2011, or an average of \$192.30 per week (\$40,000 / 208). When using the Shadrick formula, the pay rate of \$192.30 would be compared to the pay rate of \$500.

c. Advise the injured employee in writing that compensation will be paid based on actual earnings, and that the s/he remains entitled to payment of medical expenses for treatment of the accepted condition(s). This letter does not constitute a formal decision and should have no appeal rights attached.

4. Computing Entitlement to Compensation. This paragraph addresses the elements specific to computing payments for LWEC.

a. Compensation for Partial Disability. Where residuals of the accepted work injury prohibit the employee from returning to the employment held at the time of injury, or from earning equivalent wages, but do not render him/her totally disabled for all gainful employment, the employee is considered partially disabled and is entitled to compensation for LWEC.

(1) The partially disabled employee shall be paid compensation equal to $66 \frac{2}{3}$ (or 75) percent of the difference between the employee's pay and his/her WEC. To satisfy this requirement, compensation for partial disability is computed using the formula described in paragraphs b. and c. below.

(2) A formal LWEC determination is based on the employee's actual wages if they fairly and reasonably represent his/her WEC. If they do not, or if the employee has no actual earnings, the OWCP may reasonably determine the employee's WEC giving due consideration to the factors enumerated in Section 8115 of the FECA. For further discussion on the determination of WEC based on a constructed position, see FECA PM 2-0816.

(3) In a doubled case, the CE should determine which case file number should be used. In cases where compensation is being paid in one of the cases, that file number should be used. In cases where compensation is not being paid and a claim for retroactive partial disability is received, the CE should use the file number of the injury that represents the predominate cause of the claimed disability. This is not necessarily the master file number.

b. Shadrick Formula. The method for computing the compensation payable where an injured employee has actual earnings or a WEC is called the Shadrick formula, as it reflects the principles set forth in Albert C. Shadrick, 5 ECAB 376. In that decision, the ECAB found that Section 5 U.S.C. 8106(a) does not state that compensation is to be based upon the difference between the employee's earnings at the time of injury and whatever variable dollar income the employee may have in the future. Rather, it is to be based upon the loss of capacity to earn wages. The ECAB stated:

Although capacity to earn and not wages received is the proper test under the law, an employee's actual wages may constitute compelling evidence of his capacity to earn and in a proper case may be used as a yardstick in determining an injured employee's diminished earning capacity.

However, in applying this standard, the ECAB held:

...wages received 2, 5 or 10 years after an employee has sustained an injury and during which period changes in business conditions have caused wages to double due to a business boom or to be cut in half due to a depression cannot be used as a conclusive factor in determining a claimant's diminished wage-earning capacity after he has been injured.

The ECAB concluded, "Actual dollar earnings received several years after injury may be used to determine wage-earning capacity only after they have been converted into terms of actual dollar earnings received at the time of injury."

The Shadrick formula is as follows:

- (1) Pay rate when:
 - (a) injured ()
 - (b) disability began ()
 - (c) compensable disability recurred. () \$ _____
- (2) Current pay rate for job and step when injured \$ _____
- (3) () (a) is capable of earning
 () (b) has actual earnings of \$ _____
- (4) WEC [item (3) divided by item (2)] \$ _____ %

- (5) WEC [item (4) times item (1)]. \$ _____

- (6) Loss of WEC [item (1) minus item (5)] \$ _____

- (7) Compensation [item (6) times () $\frac{2}{3}$ or () $\frac{3}{4}$] \$ _____
- (8) CPI (expressed in decimal terms)
- (a) Item (7) times 1. * = \$ _____
 (rounded)
- (b) Item (8a) times 1. * = \$ _____
 (rounded)
- (c) Item (8b) times 1. * = \$ _____
 (rounded)

c. Computation. The CE should confirm any pay information necessary to complete the Shadrick formula by letter, secure e-mail with the employing agency to and from a government network, or by telephone call and document the file accordingly. Further guidelines on computation are noted below.

(1) Item (1) in the Shadrick formula above should represent the weekly pay rate of record (as established per PM 2-0900).

(2) Item (2) in the Shadrick formula above should represent the current weekly pay rate for the job and step when injured. In traumatic injury cases, "when injured" is considered to be the DOI. In occupational disease cases, "when injured" is considered to be the date of the last exposure to causal employment factors. "Current" may be any date as long as actual or constructed weekly earnings are computed as of the same effective date.

(a) In cases involving irregular employment, Item (2) should be computed by dividing the actual annual earnings used to establish the pay rate by the hourly wage in effect on the date when injured. This figure which represents the average hours worked one year prior to the date when injured should then be multiplied by the current hourly wage for the grade/step when injured.

For example, the employing agency reported that a Part-Time Flexible Letter Carrier who filed an occupational disease claim earned \$30,000 during the year prior to the date of last exposure to causal employment factors. Also, on that date, the employee was a Grade 1, Step J Carrier earning \$15 per hour. Therefore, on the date of last exposure, the employee had worked 2000 hours (\$30,000 / \$15) during the year prior or an average of 38.46 hours per week ($2000/52 = 38.46$). If the "current" hourly salary for a Grade 1, Step J Carrier was reported as \$20.00, then the current pay rate for job and step when injured would be computed as $\$20.00 \times 38.46 = \$769.20$ per week.

(b) In cases where the DOI position has since been formally reclassified by the employing agency the grade/step "when injured" should be the grade/step of the reclassified position.

(3) Item (3) in the Shadrack formula above should represent the injured employee's actual or constructed weekly earnings.

The comparison of wage rates in Items (2) and (3) need not be made as of the beginning of the period of disability (but see sub-paragraph e.(2) below concerning Rural Letter Carriers). Any convenient date may be chosen for this comparison, as long as the two wage rates are in effect on the date used for the comparison.

For example, an employee files an occupational disease claim for carpal tunnel syndrome. After surgery, he returns to work part-time on 05/01/2012, four hours per day. The CE should ask the employing agency to provide the date of last exposure to employment factors and the job grade and step as of that date. The agency indicates that this occurred on 03/01/2011, the day before the employee accepted a limited duty job assignment. On this date, the employee was a Grade 5, Step 1 Accountant. If the CE has computed actual earnings in the new position effective 05/01/2012, then the salary of a Grade 5, Step 1 Accountant should be requested as of 05/01/2012.

d. Additional Elements of Pay. When the job held at injury included additional elements of pay (such as night differential), which would also be included in the pay rate for compensation purposes, the additional pay should be reflected in the "current pay rate for job and step when injured," which is Item (2) of the Shadrack formula. This adjustment should be made by increasing the additional pay elements by the same percentage as the original base pay was increased.

(1) Only premium pay received in the job held when injured is considered. It is not relevant, for example, if the employee receives premium pay as of the date of recurrence. The receipt of premium pay should only be verified as of the DOI (traumatic injury cases) or date of last exposure to causal employment factors (occupational disease cases).

(2) In occupational disease cases, "when injured" is defined as the date of last exposure to employment factors. As such, where premium pay is involved, the CE should obtain the base salary as well as weekly premium pay amounts as of the date of last exposure. This information will then be used to compute the percentage, which will be applied to the "current" salary for the grade/step when injured.

For example, in an occupational disease case, an employee was last exposed to the accepted causal factors of employment on 01/01/2012, the last day he worked his regular job before accepting a modified assignment. As of that date, the employing agency reported that the employee earned \$500 per week base pay with a night differential of \$14.82 per week, or .03 percent of the base pay (\$14.82/\$500), for a total pay rate of \$514.82. The employing agency reported the "current" base pay for the same job is \$600 per week. The CE should increase the current base pay for that job, \$600 per week, by .03 percent, or \$18.00 (\$600 x 0.03), resulting in \$618.00 as the current pay for the same job to be used in the Shadrack computation.

e. Special Determinations.

(1) Locality Pay or "COLA" Pay. When an injured employee is reemployed in a new locale with a lower percentage of locality pay than the job held on the DOI, or without the "COLA" (cost-of-living allowance), the employee may be paid less than previously even if reemployed at the same grade and step. However, the "current pay rate for the job and step when injured" should reflect the pay in the new locale, not the original one. The employee is not losing net pay if reemployed at a lower locality pay rate, or without COLA pay, since the cost of living is less in the new location as represented by the difference in locality pay or COLA pay.

For example, an employee sustains a traumatic injury while employed as a GS-5, Step 1 Economist in Washington, DC. She moves to Jacksonville, FL and obtains new employment with a loss in WEC. In this case, the CE should request the "current" pay rate for a GS-5, Step 1 Economist in the Jacksonville, FL locality, not the Washington, DC locality.

(2) Rural Letter Carriers. While the salaries for these employees may vary over the life of the claim due to reevaluations of the employee's route, the only salary that affects the pay rate for compensation purposes is the pay rate on the DOI, when disability began, or at the time of a qualifying recurrence. The highest of the three is used to compute compensation.

(a) Changes in route evaluations which occur after a final LWEC decision is issued do not alter that decision.

(b) A Rural Carrier who returns to work but whose hours are restricted due to the effects of the job-related injury is entitled to compensation for any LWEC.

(c) A Rural Carrier who returns to full duty but whose route was reduced during the period compensation was received is not entitled to continuing compensation, since the reduction is not due to injury-related disability.

(d) The "current pay of job held when injured" is defined according to whether the boundaries of the Carrier's route have changed:

If so, the DOI job no longer exists. Therefore, the current hourly rate for the grade and step when injured should be multiplied by the number of hours representing the route's evaluation at the time of injury.

If not, the current annual salary provided by the Postal Service should be used.

(3) Performance-Based Alternative Pay Systems (Pay Banding). Some agencies have adopted performance-based pay systems (also known as pay banding), which link individual base pay and bonuses to performance. Instead of a set of distinct grades and steps, broad pay bands are used, and managers have more flexibility in setting the pay for new and current employees. Most options do not provide for any automatic pay increases. For example, the 15 General Schedule grades could be collapsed into four bands which cover GS-1 through 5, GS-6 through 11, GS-12

through 13 and GS-14 through 15. Once the bands are defined, an agency may hire an employee at any pay amount within a band and determine how employees move within and across bands.

(a) If the DOI position salary was based on a set grade and step, and the "current" employing agency pay scale is banded, the CE should determine the "current" pay rate for the DOI grade and step, following procedure consistent with paragraph (c)(2) and paragraph (d) above. The fact that the employing agency has subsequently switched to pay banding is not relevant.

For example, if the employee was a GS-5, Step 1 on DOI 01/01/2009, and the "current" salary is needed as of 01/01/2012, the CE should obtain the salary for a GS-5, Step 1 effective 01/01/2012.

(b) If the employing agency pay scale was banded on the DOI, and remains banded "currently" the CE will first need to determine the injured employee's DOI pay rate as a percentage of the appropriate band. Once that percentage has been established, the current pay rate for the DOI job (as entered in Item (2) of the Shadrack formula) will be the same percentage of the current pay range for the band in which the employee was being paid on the DOI.

For example, if the employee was hired in the second band (with a range of \$28,085 through \$60,049) at a salary of \$50,000, then s/he earns 69% of the total range. If the current range of the band in which s/he was being paid on the DOI is \$35,000 through \$72,000, then \$60,530 will be the current salary since it is 69% of the new range. When calculating the percentage of the pay band range, normal rounding rules apply.

i. The steps for determining the percentage of the band on the DOI are as follows:

- Determine the range of the DOI pay band by deducting the lowest salary from the highest salary within that band. (In the example above, $\$60,049 - \$28,085 = \$31,964$)
- Deduct the salary at the low end of the band from the actual salary paid to the employee. ($\$50,000 - \$28,085 = \$21,915$)
- Take the amount from step 2 and divide it by the amount from step 1. This will give the percentage of the salary range that the employee earned on the DOI ($\$21,915$ divided by $\$31,964 = 69\%$). The CE must document the case record with this calculation.

ii. The steps for determining the current salary for the DOI job are as follows:

- Determine the range of the current salaries for the DOI pay band by deducting the lowest salary from the highest salary within that band. (In the example given, $\$72,000 - \$35,000 = \$37,000$)
- Multiply the amount from step 1 by the percentage of the band that the employee was earning on the DOI. ($\$37,000 \times 69\% = \$25,530$)
- Add the number obtained in the second step to the lowest salary in the current range for the appropriate band. This will give you the current pay rate for the job held when injured. ($\$25,530 + \$35,000 = \$60,530$)

Once the current pay rate for the job held when injured is calculated according to the above instructions, it can be entered into Item (2) of the Shadrick formula so that compensation for LWEC can be paid to the injured employee. The CE must document the case record with the Form CA-816 or equivalent.

(c) If the salary of the DOI position was based on a pay band, and the "current" employing agency pay scale has reverted to a set grade and step (i.e. GS), the CE should take the following steps:

- Determine the employee's DOI pay rate as a percentage of the appropriate band for the job held when injured as described in 4e(3)(b)i.
- Then use "steps" 1 through 10 of the corresponding GS Grade scale as provided by the agency for an employee currently doing that job as the range for the "current" pay band and calculate the current dollar amount of the DOI job as described in 4e(3)(b)ii.
- Identify the current grade and step whose associated annual salary is just greater than, or equal to, the dollar amount obtained above. This amount should not be less than the amount obtained above unless the maximum Step 10 amount within the Grade has been exceeded.
- The annual salary of the grade and step just identified should be used as the current pay rate for the job held when injured.

f. Reinjury. When a formal LWEC determination has been issued for a reemployed claimant and s/he subsequently sustains a new injury, s/he continues to be entitled to receive compensation for the LWEC on the basis of the first injury, as well as compensation for temporary total disability for the second injury. The pay rate for the job held at the time of the second injury should be used to compute compensation for disability resulting from that injury. If the injured employee was only working on a part-time basis at the time of the second injury, the part-time salary should form the basis of the calculation of the pay rate for the job held at the time of the second injury.

For example, a full-time employee working 40 hours per week sustains a traumatic injury. He returns to work four hours per day with stable work restrictions for over 60 days and the CE issues a formal LWEC determination. One year later, the employee sustains a new traumatic injury and is rendered totally disabled. At the time of the new injury, the employee is working 20 hours per week and the employing agency reports an annual salary (based on full-time work) of \$52,000. The employee would continue to receive his LWEC compensation on the original claim, and if compensable, also receive total disability compensation on the new claim. The pay rate for total disability would be based on the part-time, 20 hour per week work schedule, or $\$52,000 / 52 = \$1000 \times (20/40) = \$500$ per week. Keep in mind, however, that the employee may never receive more than 40 hours per week in disability compensation between the two claims.

5. Determination of Whether Earnings are Representative of the WEC.

This paragraph outlines the criteria that a CE should use to determine whether the injured employee's actual earnings fairly and reasonably represent his/her WEC. While a formal decision cannot be issued until the injured employee has completed 60 days of employment, the CE should still review the evidence promptly following the return to work so that disability

management actions can continue if it is determined that the actual earnings do not fairly and reasonably represent the WEC.

a. Standard of Review. The ECAB has consistently held that, generally, wages actually earned are the best measure of a WEC and in the absence of evidence showing they do not fairly and reasonably represent the injured employee's WEC, must be accepted as such measure. Clarence D. Ross, 42 ECAB 556 (1991); Lee R. Sires, 23 ECAB 12 (1971).

It is the responsibility of the CE to review the case record for evidence that earnings do not fairly and reasonably represent the injured employee's WEC. In reviewing the file, the CE should not consider the factors set forth in 5 U.S.C. § 8115(a) 1-7, as they should be addressed only when rendering a constructed LWEC (see PM 2-0816). See Monique L. Love, 48 ECAB 378 (1997) (ECAB held that it was only appropriate for OWCP to consider the factors enumerated in section 8115(a) when it has been shown that actual wages do not fairly and reasonably represent WEC).

b. Medical Evidence. The medical evidence of record should indicate that the injured employee's condition is stable. Well-defined work restrictions should be indicated.

c. Alternative employment within the Federal government. 20 C.F.R. § 10.510 provides that:

A light duty position that fairly and reasonably represents an employee's ability to earn wages may form the basis of a LWEC 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.

(1) Type of Appointment. To determine whether the injured employee's work fairly and reasonably represents his/her WEC, the CE should consider whether the kind of appointment and tour of duty are at least equivalent to those of the job held on the DOI. If they are not, the CE should not consider the work representative of the injured employee's WEC unless one of the exceptions noted in sub-paragraphs (a) or (b) below apply.

(a) Temporary or Casual Employment. Reemployment of a temporary or casual worker in another temporary or casual position is proper, as long as it will last at least 90 days.

(b) Part-Time Positions.

(i) A part-time position may form the basis for a WEC if the employee was a part-time worker at the time of injury.

(ii) A part-time position may form the basis for a WEC for an employee who was a full-time employee on the DOI if his/her stable, established work restrictions limit him/her to part-time work. This policy change is consistent with the statutory purpose of 5 U.S.C. 8115 which anticipates LWEC determinations for partial disability based on actual earnings where those earnings fairly and reasonably represent the injured employee's WEC.

For a part-time position to fairly and reasonably represent the WEC of an employee who was a full-time employee on the DOI, the position should involve the number of hours the employee is capable of working as indicated in the current, stable work restrictions.

Note: The rationale for this policy change in the FECA program is articulated more fully in FECA Transmittal No. 13-09.

(2) When Reemployment May Not Be the Basis of WEC. Reemployment may not be considered representative of the injured employee's WEC when:

(a) The job is odd-lot, makeshift or sporadic in nature. (See paragraph 5(c)(3) of this chapter for a discussion of classified positions.)

(b) An injured employee who has been released to full-time work is working less than full-time hours.

(c) The job represents permanent seasonal employment in an area where year-round employment is available (unless the employee was a career seasonal or temporary employee when injured).

However, in locations where year-round jobs are scarce, a seasonal position may represent the WEC of an employee who previously held a year-round job.

(d) The job is temporary where the employee's job when injured was permanent.

(i) A job is considered temporary when expressly stated in the job offer, position description, or other supporting documentation.

(ii) If the language in the job offer is ambiguous, the CE should ask the employer if the position represents temporary work and document the file accordingly.

(iii) If the employee was a temporary employee on the DOI, a temporary position may reasonably represent the employee's WEC, so long as the position will last for 90 days or more.

(3) Classified Position. In order for a Federal position to be representative of an injured employee's WEC, it should be a "classified position." See 20 C.F.R. §10.510. A formal WEC decision may not be based on an odd-lot or makeshift position, or one that is sporadic in nature.

In determining whether a given job is make-shift or odd-lot, the ECAB has looked to such factors as whether the job has detailed work duties and a set schedule. A.J., Docket No. 10-619 (issued June 29, 2010). See, B.B. Docket No. 10-24 (issued December 23, 2010) (ECAB found the job appellant obtained at a company owned by a friend, who accommodated his restrictions, to be sheltered employment.); M.H. Docket No. 09-2349 (September 2, 2010) (ECAB found appellant's receptionist job for a family owned company constituted sheltered employment, as the restricted work was self-paced without a set schedule.); William Emory, 47 ECAB 365, 368 (1996) (finding babysitting for grandchildren not a proper basis for a LWEC determination; the factors particular to the case indicated a position designed for his particular needs); Elizabeth E.

Campbell, 37 ECAB 224 (1985) (ECAB held the position was makeshift, as it allowed the use of a partner to lift cartons and was eliminated when the employee was laid off.).

The case file should therefore contain evidence of a formal job title, established work schedule, and written position description. A detailed description of duties and physical limitations of the position should also be in the record. The physical limitations of the position should not exceed the injured employee's work tolerances.

Required evidence not in the file should be requested from the employing agency. If the totality of the evidence is ambiguous following any applicable development, the CE should seek clarification from the employing agency.

d. Return to Work Outside the Federal Government. When evaluating whether alternative employment obtained outside the Federal government fairly and reasonably represents the injured employee's WEC, the CE may need to compare the employee's work capacity and actual earnings to the constructed wage which an expert in vocational rehabilitation has determined best represents the employee's capacity to earn wages in his/her local labor market. See PM 2-0816 for additional information on constructed wage-earning capacity determinations.

Generally, wages earned on a part-time basis where the injured employee was medically released to full-time employment will not be considered representative of his/her WEC unless the average weekly wage earned on a part-time basis is greater than, or approximately equal to, the average full-time weekly wage supported by a labor market survey. Conversely, wages earned on a full-time basis can usually be considered representative of the injured employee's WEC unless the average weekly wage earned on a full-time basis is notably less than the average weekly wage supported by a labor market survey.

If an injured employee has returned to alternative employment in the private sector, the CE should consider the number of hours actually being worked in relation to the number s/he is medically capable of working and review both the nature of the occupation and the actual wages earned in the new position to determine whether the earnings fairly and reasonably represent the WEC.

(1) If the injured employee has no loss of wage-earning capacity, the CE may generally presume that the earnings fairly and reasonably represent the WEC.

(2) If the injured employee is reemployed with a loss of wage-earning capacity through OWCP Vocational Rehabilitation, the CE should compare the actual earnings to the minimum constructed wage at the capacity the employee is capable of working for the job classification(s) selected by the Rehabilitation Counselor. If the actual earnings are greater than, or approximately equal to, the minimum constructed wage, the CE may generally presume that earnings fairly and reasonably represent the WEC.

For example, an injured employee who is capable of working full-time is reemployed part-time at the rate of \$400 per week. A labor market survey indicates that the minimum full-time wage of a medically and vocationally suitable position is \$420 per week. In this case, the part-time work

fairly and reasonably represents the WEC even though the employee is capable of working full-time.

Conversely, an injured employee is reemployed full-time at the rate of \$400 per week. A labor market survey indicates that the minimum full-time wage of a medically and vocationally suitable position is \$600 per week. In this case, the work would not fairly and reasonably represent the WEC because the employee is clearly capable of earning a higher weekly wage.

(3) If the injured employee is reemployed with a loss of wage-earning capacity without OWCP Vocational Rehabilitation intervention, the CE should make a task-based referral to vocational rehabilitation to determine whether the employee is capable of earning more than the actual wages given his/her work restrictions and vocational background. Once complete, the CE should take actions consistent with sub-paragraph (2) above. Note that, depending on the outcome and the circumstances of the case, additional vocational rehabilitation actions may be necessary to pursue training, placement, etc. in a position that represents the employee's WEC. See PM 2-0813.

If the injured employee previously underwent OWCP Vocational Rehabilitation and was subsequently reemployed over one year from the date of the labor market surveys (i.e. Form OWCP-66 or equivalent), the CE should make a task-based referral to vocational rehabilitation to obtain updated OWCP-66 forms and then proceed with actions consistent with sub-paragraph (2) above.

e. Further Actions.

(1) If it is determined that the injured employee's actual earnings fairly and reasonably represent his/her WEC, the CE should proceed with the issuance of a formal LWECD decision once the employee has worked in the position for 60 days (see paragraph 6 below).

(2) Where the injured employee has actual earnings which do not fairly and reasonably represent a WEC, a formal LWECD decision should not be issued, but compensation payable for the period during which the employee has earnings should be reduced to reflect those earnings. The reduction in compensation is not permanent but covers only the period of earnings.

In these cases, active disability management should continue. Reference PM 2-0600.

6. Issuance of Decision. If the CE has determined that the injured employee's actual earnings fairly and reasonably represent his/her WEC in accordance with paragraph 5 above, a formal decision should be issued. See FECA PM 2-1400 for additional guidance on the issuance of formal decisions.

a. As long as there is no work stoppage due to the accepted condition(s), the decision should be issued following 60 calendar days from the date of return to work.

Any work stoppage due to the accepted work injury should be further evaluated by the CE. If a recurrence of disability is accepted during the first 60 days after the return to work, a WEC may

not be issued and the actual earnings should be reevaluated following any subsequent return to work.

Note – Time spent solely in a training program prior to actually starting work in a new position should not be counted when assessing whether the employee has worked in the job for 60 days.

b. The CE will determine the employee's monetary entitlement using the Shadrick formula (see paragraph 4 above). The CE should confirm the respective pay rates by letter, secure e-mail with the employing agency to and from a government network, or by telephone call and document the file accordingly. Any convenient date may be chosen for the comparison of the pay rates of the DOI job and the new job, as long as the two wage rates are in effect on the same date.

c. If the employee returns to work at a retained pay rate, and therefore incurs no wage loss, the CE should still issue a formal LWEC decision. Wages lost because step increases and/or cost-of-living increases were not applied to the retained pay rate do not constitute a LWEC, and claims based on this premise should be denied (see Paul D. Farnsley, 46 ECAB 341 (1994); Joseph D. Musolino, Docket No. 89-1765, issued March 12, 1991).

d. A formal actual earnings LWEC decision should generally contain:

(1) A brief case summary pertaining to the injured employee's return to work.

(2) An identification of the medical evidence that indicates the injured employee's condition is stable and that establishes well-defined work limitations.

(3) A notation the employee has worked in the position for at least 60 days.

(4) An explanation of the computation of compensation.

(5) In cases where the reemployment was within the Federal government, the decision should also include the following.

(a) A discussion of the evidence supporting that the position is classified. The CE should cite (and explain, where necessary) the evidence supporting a formal job title, established work schedule, written position description, description of duties, and physical limitations of the alternative work.

(b) An indication that the type of appointment and tour of duty are at least equivalent to the job held when injured (unless otherwise medically restricted).

(c) If the employee was a full-time employee on the DOI, and the actual earnings LWEC is based on part-time work because the stable work restrictions limit the employee to part-time work, the CE should clearly identify the medical evidence and explain the medical basis for finding the part-time work representative of the WEC (see paragraph 5(c)(1)(b) above).

(d) An indication that the physical requirements of the alternative work do not exceed the work limitations.

(6) In cases where the reemployment was outside of the Federal government, the CE need not make a specific determination on medical suitability; however, the decision should include the following:

(a) A wage-comparison analysis consistent with paragraph 5(d)(2) above as appropriate.

(b) An indication that the job was obtained through an OWCP Vocational Rehabilitation effort, if applicable.

e. The LWEC decision should also include language formally awarding compensation based on actual earnings for the period beginning on the date of return to work through the date of issuance of the formal LWEC decision. (e.g., "It is hereby determined that the claimant is entitled to compensation from DATE to DATE based upon his actual earnings."). This is necessary because the employee was never provided with a formal decision concerning entitlement based on actual earnings following the CE's reduction in compensation upon the employee's return to work.

If the employee was overpaid compensation based on actual earnings from the date of the return to work through the effective date of the formal LWEC decision, the usual overpayment procedures should be followed. See PM Part 6.

7. Retroactive Determinations. If the injured employee is no longer working in the alternative position upon which a rating is being considered, the CE may consider a retroactive LWEC determination. This, however, is rare.

a. Such a decision should only be made if:

(1) The employee had worked in the position for at least 60 days;

(2) The CE has determined that the employment fairly and reasonably represented the WEC as discussed in paragraph 5 above; and

(3) The subsequent work stoppage or change in alternative positions did not occur because of any change in the employee's injury-related condition affecting his/her ability to work.

Before proceeding with a LWEC determination, the CE should ensure that current medical evidence is on file that establishes that the injury-related condition does not prevent the employee from performing the position upon which the LWEC determination is being considered.

b. Any retroactive LWEC decision should clearly address these factors (1) through (3) above. See M.P., Docket No 06-1126 (issued September 27, 2006) (ECAB found that a retroactive WEC determination was inappropriate when the employee had submitted medical evidence that his

injury-related condition had progressed such that his work hours were restricted.); William M. Bailey, 51 ECAB 197 (1999) (ECAB held that it was inappropriate to issue a retroactive WEC determination when there is a pending claim for compensation).

c. In cases where the injured employee has stopped work and filed for compensation, the CE should render a decision on the recurrence and/or compensation claim as applicable, addressing how the work stoppage was not due to the injury. The CE may concurrently proceed with a retroactive LWEC determination. One formal decision may be rendered addressing both issues; the CE need not issue two separate formal decisions.

Chapter 2-0816, Determining Wage-Earning Capacity Based on a Constructed Position

1. Purpose and Scope. In some situations, vocational rehabilitation (VR) efforts do not succeed, and the claimant's wage-earning capacity (WEC) must be determined on the basis of a position deemed suitable but not actually held. In making this determination, the test is whether the claimant's WEC based on the selected job appears reasonable, giving due regard to the factors specified in 5 U.S.C. §8115 of the Federal Employees' Compensation Act (FECA) as described in paragraph 3 below.

FECA PM 2-0813 explains the procedures for referring partially disabled workers for VR services and describes the services which may be provided. This chapter explains the procedures for reducing monetary compensation when the worker is unable to secure new employment through such services. This includes determining the suitability of positions not actually held and whether those positions fairly and reasonably represent the claimant's WEC. This chapter also outlines procedures for issuance of the formal loss of wage-earning capacity (LWEC) decision.

2. Statutory and Regulatory Provisions.

a. 5 U.S.C. §8106 of the FECA provides that, "If the disability is partial, the United States shall pay the employee during the disability monthly monetary compensation equal to 66 2/3 percent of the difference between his monthly pay and his monthly wage-earning capacity after the beginning of the partial disability, which is known as his basic compensation for partial disability."

b. 5 U.S.C. §8115 of the FECA outlines that, "If the actual earnings of the employee do not fairly and reasonably represent his wage-earning capacity or if the employee has no actual earnings, his wage-earning capacity as appears reasonable under the circumstances is determined with due regard to--

- (1) the nature of his injury;
- (2) the degree of physical impairment;

- (3) his usual employment;
- (4) his age;
- (5) his qualifications for other employment;
- (6) the availability of suitable employment; and
- (7) other factors or circumstances which may affect his wage-earning capacity in his disabled condition."

c. 20 C.F.R. §10.402 provides that, "An injured employee who cannot return to the position held at the time of injury (or earn equivalent wages) due to the work related injury, but who is not totally disabled for all gainful employment, is considered to be partially disabled."

d. 20 C.F.R. §10.403 establishes that,

(a) 5 U.S.C. 8115 outlines how compensation for partial disability is determined. If the employee has actual earnings which fairly and reasonably represent his or her WEC, those earnings will form the basis for payment of compensation for partial disability. (See §§ 10.500 through 10.521 concerning return to work.) If the employee's actual earnings do not fairly and reasonably represent his or her WEC, or if the employee has no actual earnings, OWCP uses the factors stated in 5 U.S.C. 8115 to select a position which represents his or her WEC, which include 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. However, OWCP will not secure employment for the employee in the position selected for establishing a WEC.

(b) Compensation for partial disability is payable as a percentage of the difference between the employee's pay rate for compensation purposes and the employee's WEC. The percentage is $66\frac{2}{3}$ percent of this difference if the employee has no dependents or 75 percent of this difference if the employee has at least one dependent.

(c) The formula which OWCP uses to compute the compensation payable for partial disability employs the following terms: pay rate for compensation purposes, which is defined in § 10.5(s) of this part; current pay rate, which means the salary or wages for the job held at the time of injury and at the time of the determination; and earnings, which means the employee's actual earnings, or the salary or pay rate of the position selected by OWCP as representing the employee's WEC.

(d) The employee's WEC in terms of percentage is computed by dividing the employee's earnings by the current pay rate. The comparison of earnings and "current" pay rate for the job held at the time of injury need not be made at the beginning of partial disability. OWCP may use any convenient date for making the comparison as long as both wage rates are in effect on the date used for comparison.

(e) The employee's WEC in terms of dollars is computed by first multiplying the pay rate for compensation purposes by the percentage of WEC. The resulting dollar amount is then subtracted from the pay rate for compensation purposes to obtain the employee's LWEC.

3. Factors Considered. In accordance with §8115, a WEC is reasonable under the circumstances as determined with due regard to the claimant's:

a. Nature of injury. This is determined by the medical opinion which the Claims Examiner (CE) has deemed to bear the weight of the medical evidence. It may be the opinion of the attending, Second Opinion or Referee physician.

b. Degree of physical impairment. This includes impairments resulting from any injury-related conditions as well as all pre-existing conditions. Conditions which post-date the injury need not be considered. See, T.K., Docket No. 08-914 (issued January 14, 2009) ("Any incapacity to perform the duties of the selected position resulting from subsequently acquired conditions is immaterial to the loss of wage-earning capacity that can be attributed to the accepted employment injury and for which appellant may receive compensation.").

c. Usual employment. The physical requirements of the claimant's regular employment should be considered before determining that the claimant can not return to the position held at the time of injury. If the accepted medical restrictions do not preclude the claimant's return to full, regular duty, action should be taken to terminate compensation for wage loss as the claimant is no longer disabled within the meaning of the FECA. Refer to FECA PM 2-1400 for additional guidance regarding disallowances.

d. Age. Age alone does not determine WEC. Rather, it is one part of a reasonableness standard, which takes into account all factors described in §8115. See P.S., Docket No. 06-1029 (issued March 26, 2007) and I.N., Docket No. 09-0823 (issued December 7, 2009).

e. Qualifications for other employment. This is evaluated by an assigned Rehabilitation Counselor (RC) who obtains educational and employment histories and performs transferable skills analysis (TSA) or vocational testing to assess such.

f. The availability of suitable employment. This is established by a Labor Market Survey (LMS) conducted by the RC and confirmed by the Rehabilitation Specialist (RS).

g. Other factors or circumstances which may affect WEC. These are case-specific special determinations which may include the area in which the claimant currently resides or whether the claimant is in prison.

The nature of injury and degree of physical impairment are discussed in greater detail in paragraph 4 of this chapter, Medical Suitability. The claimant's usual employment and age should require no additional explanation. The claimant's qualifications for other employment and the availability of suitable employment are addressed further in paragraph 5 of this chapter, Vocational Suitability. Other factors or circumstances affecting WEC are discussed in paragraph 7 of this chapter, Special Determinations.

4. Medical Suitability. This paragraph addresses the evidence necessary to establish that a selected position is medically suitable given the claimant's injury-related and pre-existing impairments.

a. In cases where the claimant has undergone vocational rehabilitation (VR), the RC will submit a final report to the RS summarizing why VR was unsuccessful and listing two (or more) jobs which are medically and vocationally suitable for the claimant. Where no VR services were provided, the RS provides this report. The report will include the corresponding job numbers from the Dictionary of Occupational Titles (DOT) (or OWCP specified equivalent) and pay ranges in the relevant geographical area. The RC will also include the DOT's description (or OWCP specified equivalent) of the duties and physical requirements of each job. The positions listed may be those in which placement was attempted. The RS will indicate to the CE, using an OWCP-3 or equivalent, that a WEC determination may be based on this report.

b. The CE is then responsible for determining whether the medical evidence establishes that the claimant is able to perform the selected jobs, taking into consideration medical conditions due to the accepted work-related injury or disease (including those accepted under other claims which may or may not have been doubled/combined with the instant case file), and any pre-existing medical conditions. The medical evidence of record should indicate that the claimant's condition is stable. Well-defined work restrictions should be of record, and if a Functional Capacity Evaluation and/or a work hardening program were completed in an effort to establish work restrictions, these should be considered and consistent with the limitations imposed by the determining physician.

c. Medical conditions arising subsequent to the work-related injury or disease should not be considered. Claimants who could otherwise engage in active VR services, but for a non-employment-related condition which post-dates the injury, should be referred for limited VR services as appropriate. For additional information regarding conditions that post-date the injury, see FECA PM 2-0813.5.j (3).

d. A wage-earning capacity determination must be based on a reasonably current medical evaluation. See M.A., 59 ECAB 624 (2008) and cases cited therein. See Carl C. Green, Jr., 47 ECAB 737, 746 (1996) (six-month-old medical reports are reasonably current for purposes of wage-earning capacity determination); Anthony Pestana, 39 ECAB 980 (1988) (a three-year-old medical evaluation is not reasonably current for wage-earning capacity determination).

Additionally, the medical evidence upon which the OWCP relies must provide a detailed description of the claimant's condition. See, John D. Jackson, 55 ECAB 465 (issued April 8, 2004). In certain situations, a medical evaluation may be considered reasonably current where an attending physician continued to provide follow up examinations but kept the same work restrictions. See M.A., 59 ECAB 624 *supra*.

Therefore, if the medical evidence is not clear and unequivocal, or is old enough to be considered stale (generally greater than eighteen months old), the CE should seek clarification from the attending physician, Second Opinion or Referee specialist as appropriate. Refer to FECA PM 2-0810.6 for further discussion related to weighing medical evidence.

e. Once current, stable and well-defined work restrictions are established, the CE should evaluate the physical requirements of the selected positions. This should include a review of all of the individual physical demands of the position and not just the overall demand level. Each of the physical requirements of the selected position should not exceed the accepted work tolerance limitations. See FECA PM 2-0813, Exhibits 1 and 2, which should be used when comparing the established work restrictions to the physical requirements of positions identified in the DOT. While the CE should have completed a similar review at the time the VR plan was approved, a final review should be conducted at the time of closure to confirm that the claimant's medical conditions have not changed.

f. If the initial position selected is eventually determined to be medically unsuitable, the CE should consider the other position(s) listed by the RC and proceed as outlined above. If the CE concludes that no position can be identified which is within the claimant's work tolerance limitations, the CE should return the case to the assigned RS and request that VR efforts be renewed to identify medically, vocationally and otherwise suitable positions for which additional placement services should be offered. If the RS is unable to do so, the claimant will be deemed to have no current WEC. In this situation, the CE should prepare a memorandum for the file explaining the circumstances and recommending that efforts to establish a WEC be suspended until such time as the medical evidence establishes the claimant's condition(s) has improved. See FECA PM Chapters 2-0600 and 2-0812.

Once the CE has determined that the selected position is medically suitable for the claimant's disabling condition, the CE should consider whether the position is vocationally suitable as well.

5. Vocational Suitability. This paragraph outlines the criteria that a CE should use to determine whether the claimant is vocationally capable of performing the selected position. The fact that a claimant is not successful in securing employment does not establish that the selected position is not vocationally suitable. See Lawrence D. Price, Docket No. 02-1541 (issued May 19, 2003) 54 ECAB 590 (2003).

a. In addition to the DOT's description (or OWCP specified equivalent) of the duties and physical requirements of each job, the final report of the RC or RS should describe how requirements for Specific Vocational Preparation (SVP) were achieved. This should include a discussion of how the claimant's past employment experience and/or education qualify him or her to perform the selected position on at least an entry level basis. A summary of this information may be found on Form OWCP-66 or equivalent.

b. The CE may need to choose between two or more identified positions and should be able to justify such selection based on the claimant's SVP. Factors or circumstances to consider may include the employee's other skills, aptitude for acquiring new skills, mental alertness, general appearance, personality factors, and ability to adjust to the disability; also, the need for a license, and the industrial realities in the area where the employee is to be rated.

Unless documentation is of record supporting that the claimant is capable of earning more, the entry level wage of the selected position (as indicated by the current LMS) should be used as the basis of the claimant's WEC. A higher WEC may be considered if the RC has documented that

the claimant's SVP would qualify him or her to earn greater than the entry level wage. If the claimant's SVP qualifies him or her for all identified positions, justification for the job and wage selected should still be provided.

If the selected position is determined to be both medically and vocationally suitable, the CE should confirm that the job is reasonably available within the local labor market.

6. Reasonable Availability. The job selected for determining WEC must be a job reasonably available in the general labor market in the commuting area in which the claimant lives. See Dim Njaka, Docket No. 96-1950 (issued June 18, 1999) 50 ECAB 425 (1999) (finding that a 120-mile daily commute was reasonable and customary based on the conclusions of the RS). This paragraph describes how reasonable availability is established.

a. The final report from the RC or RS will also include a statement which addresses reasonable availability of the selected jobs in that area. The RC uses professional experience and knowledge of the job market to document that the jobs which are medically and vocationally suitable for the claimant are also available in sufficient numbers in the local labor market. The RC will have conducted a survey of the local labor market and documented availability of targeted jobs by citing sources such as the local State employment service, the local Chamber of Commerce, employer contacts, and actual job postings. A summary of this information may be found on Form OWCP-66 or equivalent. Such labor market surveys should be conducted within one year of the OWCP's decision or otherwise be considered stale. In R.H., Docket No. 10-807 (issued January 4, 2011), ECAB held that labor market surveys conducted within one year of the OWCP's decision were not stale. If the most recent LMS is greater than one year old, the case should be returned to the RS so that a current survey may be obtained.

b. The RS will have evaluated the selected positions to ensure that the RC has adequately documented availability, etc. and confirmed that the jobs are performed in sufficient numbers in the claimant's local labor market. Because the RC and RS are experts in the field of VR, the CE may rely on their opinion as to whether the job is reasonably available and vocationally suitable. See W.D., Docket No. 09-188 (issued August 21, 2009).

c. Lack of current job openings does not equate to a finding that the position was not performed in sufficient numbers to be considered reasonably available. See T.W., Docket No. 10-937 (issued March 28, 2011). Broad unemployment figures are not particularly relevant to whether the selected positions are being performed in sufficient numbers within a commuting area so as to be considered reasonably available. See S.C., Docket No. 10-243 (issued August 18, 2010).

7. Special Determinations. When necessary, the CE should consider the following factors:

a. A Federal or other civil service position in which the claimant is not actually employed may not be considered reasonably available and may not be used to make an LWEC decision. See J.E., Docket No. 08-1582 (issued March 3, 2009) (ECAB held that it was inappropriate for OWCP to base a claimant's WEC on a state or government position as there is no evidence to establish that such positions are available in the general labor market).

b. The availability of the employment is usually evaluated with respect to the area where the claimant resides at the time the determination is made, rather than the area of residence at the time of injury. However, when the claimant voluntarily moves to an isolated locality with few job opportunities, the question of availability should be applied to the area of residence at the time of the injury. This is true even if the move was due to a spouse's relocation or job transfer. For a discussion of isolated areas and other relevant issues, see R.H., Docket No. 10-807 (issued January 4, 2011); Joyce W. Thurman, Docket No. 05-1537 (issued December 7, 2005); and Purvis Nettles, Docket No. 99-2038 (issued April 26, 2001).

c. If health conditions which were caused by the injury, or which pre-dated the injury, require the claimant to move to a certain area, isolated or otherwise, the issue of availability must be considered with respect to the new area of residence. See R.H., Docket No. 10-807 (issued January 4, 2011); Richard L. Semple, 33 ECAB 757 (1982); Sidney Kawalick, 19 ECAB 272 (1968).

d. If the claimant can work only part-time or at a sub-sedentary level the position must be reasonably available on the associated basis in the local labor market. A general finding of reasonable availability is not sufficient because a position which can be obtained on a full-time basis may not be available on a part-time basis. See W.M., Docket No. 06-1311 (issued February 23, 2007). Similarly, if the claimant is released to sub-sedentary employment, the LMS must establish that the sedentary position is reasonably available on a sub-sedentary basis. See P.A., Docket No. 10-1907 (issued June 17, 2011).

Either of these special determinations may be established via basic field research with eligible employers to determine whether the position is available part-time or that certain jobs listed as sedentary in the DOT can actually be performed at sub-sedentary levels of demand.

e. When suitable year-round employment is not available, a seasonal job may be selected for WEC purposes. The file must support the finding that the job is performed on a seasonal basis in sufficient numbers so as to be reasonably available. A seasonal job in the private sector should not ordinarily be used to rate a claimant who is not working and who resides in an area where year-round work is generally performed. The reasons for using a seasonal job should be explained in a memorandum for the file.

f. Claimants in Prison. Pursuant to § 8148(b) of the FECA, benefits of individuals imprisoned as a result of a felony conviction shall be suspended as of the date of imprisonment. The implementing regulations (20 C.F.R. § 10.18) provide that the convicted individual forfeits all rights to compensation during the period of incarceration. See D.D., Docket No. 07-126 (issued May 15, 2007) and Michael Johnson, 54 ECAB 553 (2003). However, during periods that a claimant's compensation is suspended under section 8148(b) for a felony conviction, the claimant's dependents are entitled to a percentage of his/her compensation. See Cheri Cortinas, guardian of Savannah Speiser, Docket No. 02-363 (issued April 21, 2003). See also PM Chapter 2-1400.18.

Claimants not convicted of felonies do not lose entitlement to compensation payments simply because they are imprisoned. Such cases are handled according to the same criteria as any other case, insofar as possible.

(1) The employing agency (EA) should be asked to provide a copy of the claimant's employment application, resume and SF-171, when available, as well as a copy of the claimant's employment record by job title with inclusive dates. A description of any training certifications earned by the claimant should also be requested.

(2) If necessary, prison authorities may be asked to provide information on the claimant's work activities and training. Work performed in prison, and training received there, should be considered in assessing the claimant's physical capability to perform a job and his or her job skills along with other factors in the claimant's background to determine a suitable job on which to base an estimated earning capacity.

(3) The case should be referred to VR on a limited basis solely for the purpose of determining the claimant's capacity to earn wages based on the restrictions attributable to the work injury and any pre-existing medical conditions. Since prison is not an open labor market and the claimant is considered to be confined as the result of a voluntary misdeed, job selection should be based upon availability in the area which would apply if the claimant were not imprisoned.

Based on the RS's recommendation, the CE will select the position best suited to the claimant in accordance with the factors defined in section 8115.

8. Issuance of Decision. After selecting a position from those listed by the RS/RC, and after determining that the job is suitable and reasonably available, the CE should provide the claimant with a notice of proposed reduction as described in FECA PM 2-1400. This action should be taken within 30 days of receipt of the RC's or RS's final report.

a. The CE will determine the claimant's proposed monetary entitlement using the Shadrick formula. See FECA PM 2-0815.4. As described in paragraph 5 above, the CE should use the minimum entry level wage as the amount that the claimant is capable of earning in Item 3 of the Shadrick unless the evidence of record supports a higher wage.

b. The notice of proposed reduction decision should generally contain:

(1) A brief case summary, including a discussion of the opinion of the attending physician, as well as any referrals to a Second Opinion or Referee examiner and the results of such, if indicated;

(2) An identification of the medical evidence accepted as bearing the weight that indicates that the claimant's condition is stable and establishes well-defined limitations;

(3) A summary of any training provided and the claimant's resultant success rate, including any certificates or diplomas obtained;

(4) A discussion of the placement assistance provided, including any extensions authorized, and the claimant's cooperation level during this phase. If placement ceased prior to the full 90-day period provided due to the claimant's non-cooperation or election of OPM benefits, this should also be discussed and an explanation provided as to why a proposed reduction is still being pursued. See FECA PM 2-0813.17 and 18;

(5) A complete discussion of the job selected as being both medically and vocationally suitable, including the applicable position description and the physical requirements of such. This may be done in the narrative of the decision or as an attachment;

(6) An explanation as to why that particular position was selected, including a discussion of the claimant's transferable skills and vocational and/or educational preparation where necessary;

(7) An identification of the wage selected as reasonably representing the claimant's WEC and an explanation as to how it was determined, including a discussion of the claimant's qualifying SVP in support of anything greater than the minimum entry level wage. If the final wage provided by the RC or RS differs from the original wage estimated for the same position at the time of plan approval this should also be discussed;

(8) Confirmation that the job is reasonably available; i.e. that it is performed in sufficient numbers in the claimant's local labor market as verified by the RC and/or RS including a reference to the date of the LMS supporting this assertion; and

(9) Attached copies of the medical report upon which the proposed reduction is based and the proposed compensation calculations. A copy of the applicable position description and the physical requirements of such should also be included.

Refer to FECA PM 2-1400, Disallowances, for additional information regarding formal decisions.

c. If the claimant does not respond within 30 days of the notification of proposed reduction, the CE should issue a formal decision determining the claimant's WEC and reduce compensation as of the date of the final decision.

d. If the claimant does respond to the notification of proposed reduction, the CE should consider the response and proceed with any further development necessary or finalize the decision as indicated in paragraph c. above. Any physician to whom the claimant is referred during such development should be specifically asked to provide an opinion on the claimant's ability to work the position selected. Any questions regarding the vocational suitability or reasonable availability should be referred to the RS for additional input.

e. Tentative constructed LWEC determinations will not be made under any circumstances. When a claimant is receiving compensation for total disability and evidence shows that he or she is partially disabled, benefits must be paid at the rate for total disability until a proper job selection can be made.

f. If the CE provides a written recommendation that efforts to determine a WEC should be suspended on the basis of new evidence, case management should continue in accordance with procedures described in FECA PM Chapters 2-0600 and 2-0812 as long as the claimant is in receipt of compensation for total disability.

9. Retroactive Determinations. The Board has approved retroactive LWEC determinations using either actual earnings or a selected position, in appropriate cases, pursuant to the regulatory authority provided in 20 CFR §10.403. See Barnell R. Coufal, Docket No. 97-1305 (issued April 2, 1999). Retroactive constructed LWEC determinations should be considered only when the evidence clearly shows that partial, rather than total, disability existed prior to adjudication, and that no compensation has been paid for the period of disability in question. While this situation is rare, it may occur when retroactive compensation is claimed and payable, but the evidence of record shows that the claimant had demonstrated an ability to earn wages during the period of entitlement.

a. In cases meeting these criteria, the CE must first determine whether the claimant has had any actual earnings. If so, the CE should consider whether such earnings fairly and reasonably represent the claimant's WEC as described in FECA PM 2-0815. See Bridgett T. Davis, Docket No. 96-1951 (issued June 23, 1999) (ECAB remanded the retroactive WEC based on a selected position because the OWCP did not properly discuss the claimant's actual earnings or explain why they should not be used to compute entitlement to compensation.)

b. If not, or if clarification is required in this regard, the CE should refer the case to the RS on a limited basis for preparation of a list of suitable positions from the DOT (or OWCP specified equivalent), as described in FECA PM 2-0813. Thereafter, the CE should consider the contemporaneous medical evidence related to any accepted and pre-existing conditions, and the associated work restrictions, before selecting an appropriate position which reflects the claimant's WEC as provided in paragraphs 4 et seq. above. See Thaddeus J. Spevack, Docket No. 00-1180 (issued April 3, 2002).

c. Once a retroactive WEC determination has been made, the CE should issue a decision in accordance with paragraph 8 and pay compensation for the LWEC for the entire period of partial disability. See Vincent C. DeRico, Docket No. 99-659 (issued March 1, 2001).

d. Retroactive constructed LWEC determinations are not to be made where compensation is being paid for temporary total disability. In such cases, payments must continue until the LWEC decision is made.

Chapter 2-0900, Determining Pay Rates

1. Purpose and Scope. This chapter addresses determination of pay rates for injured workers who meet the criteria as employees within the meaning of 5 U.S.C. 8101(1). It describes the steps for establishing pay rates, including the statutory basis of payment; the effective date of

the pay rate; the elements of pay which are included in the pay rate, and those which are excluded; and how to establish daily, weekly, and monthly pay rates. The chapter also includes a section on special determinations (which are also addressed in various FECA Program Memoranda).

Section 8101(4) defines "monthly pay" as "the monthly pay at the time of injury, or the monthly pay at the time disability begins, or the monthly pay at the time compensable disability recurs, if the recurrence begins more than 6 months after the injured employee resumes regular full-time employment with the United States, whichever is greater, except when otherwise determined under section 8113 of this title with respect to any period." The monthly pay for wage loss compensation is subject to a minimum and maximum level of compensation that is set forth in 5 U.S.C. 8112. Section 8113 sets forth certain criteria for an employee employed in a learner's capacity. Section 8114 sets forth various formulas for how to calculate the rate of pay and sets forth elements of pay such as overtime that must be excluded from pay rate calculations.

2. Establishing a Pay Rate. This paragraph describes in general how to determine a pay rate and where to find relevant information. While Forms CA-1, CA-2, CA-6, CA-7, and CA-2a contain much useful information, the Claims Examiner (CE) must also consider any narrative evidence in file. To establish a pay rate, the CE should take the following steps:

a. Determine the Basis of Payment Under 5 U.S.C. 8114 and whether the claimant is a full-time, part-time, temporary, seasonal, casual, etc. worker. If the claimant worked the whole year prior to injury or would have done so but for the injury (Form CA-7, section 9b), this determination is straightforward. If not, however, the CE must investigate all sources of income to determine the claimant's "average annual earnings" before proceeding further. See paragraphs 3 and 4 below.

b. Determine the Effective Date of Pay Rate. The CE must next decide whether to set the pay rate as of the date of injury (DOI) (or death), the date disability began (DDB), or the date of recurrence (DOR). The pay rates on the date of injury and date disability began should be noted on Form CA-7, section 8. Pay rates for newly reported recurrences should be shown on Form CA-2a, while pay rates for previously accepted recurrences should be noted in the Compensation application of the Integrated Federal Employees' Compensation System (iFECS). See paragraph 5 below.

c. Consider Inclusions and Exclusions from Pay Rate. The nature of the increment must be considered first. Commonly encountered increments are reported on Form CA-7, section 8. The CE should also review Form CA-1, CA-2, or CA-2a for evidence of entitlement to premium pay. If the increment can be included, the CE must determine how long it has been received and the amount of money that has been paid. See paragraphs 6-8 below.

d. Clarify Any Discrepancies. The employing agency (EA) or claimant may challenge, correct, or expand on the evidence in the original reports with respect to terms of employment, amount of pay, or types and amounts of increments.

(1) The CE must clarify any material discrepancies in the record before establishing a pay rate for compensation purposes. This can be done by letter, secure e-mail with the employing agency

to and from a government network, or by telephone call followed by written confirmation. Document the information received via telephone in the case file on a CA-110 pending receipt of written confirmation.

(2) Evidence submitted by an EA that is supported by records will usually prevail over statements from the claimant, unless such statements are supported by documentary evidence.

(3) When a discrepancy in the reported pay rates is identified, compensation should be paid based on the lower figure until the CE resolves the discrepancy. A provisional rate of GS-2, step 1, or the amount reached by multiplying the daily wage by 150 may be used if necessary. The eight hours per day used in the "150-formula" is based on a five-day work week, or 40 hours per week. Any adjustment should be included in a later payment. The CE should note use of a provisional or temporary rate in the compensation screen of iFECS and in the case record.

e. Decide on Daily, Weekly, or Monthly Basis. While disability claims may be paid on a daily basis under limited circumstances, most are paid on a weekly basis. All death claims are paid on a monthly basis. See paragraphs 9-11 below.

3. Kinds of Appointments and Tours of Duty. This paragraph describes the most common kinds of appointments in both regular Federal employment and in the Postal Service, as well as other types of appointments or duty status.

a. Civil Service.

(1) Kinds of Appointments. The Office of Personnel Management (OPM) recognizes four kinds of appointments: career; career-conditional (essentially a probationary period); term (not to exceed four years, and with no career status); and temporary (not to exceed one year, with a one-year extension possible, and with no career status).

(2) Tours of Duty. OPM recognizes five tours of duty:

(a) Full-time (40 hours per week);

(b) Part-time (16-32 hours per week);

(c) Intermittent (no regularly scheduled hours);

(d) Seasonal (less than 12 months per year, with either a full-time, part-time, or intermittent schedule); and

(e) On-call (usually at least six months per year on an as-needed basis, with either a full-time or part-time schedule).

Items 20 and 21 on Form CA-1 and items 21 and 22 on Form CA-2 should show the employee's work schedule.

b. Postal Service.

(1) Kinds of Appointments. The Postal Service recognizes the same kinds of appointments as OPM. The Postal Service may differentiate these duties by use of different job titles such as Part-Time Flexible or Casual, and by the type of schedule the employees work.

(2) Tours of Duty. The Postal Service recognizes several types of tours of duty, depending on the kind of work performed. Review of Form PS-50 should clarify the tour of duty on the date of injury and kind of work performed.

An employee may work more hours than indicated by the tour of duty, but careful consideration of base pay versus overtime pay should be given to clarify the regular work schedule. In such cases, the pattern established by the actual number of hours worked or actual amounts of money earned takes precedence over the stated schedule or tour of duty in deciding which part of 5 U.S.C. 8114 to use in determining the pay rate.

Postal Service tours are distinguished as follows:

(a) Craft employees such as letter carriers and mail clerks, or other full-time employees, are paid under the Postal Service (PS) salary structure. These are full-time regular employees and work 40 hours per week.

(b) Part-time regular employees have a fixed schedule but work less than 40 hours per week.

(c) Full-time rural carriers are assigned to specific routes, each of which is evaluated at 36 to 48 hours per week, depending on the size of the route.

The salaries for full-time rural carriers are based on the evaluation of their routes. The Postal Service uses a formula to determine the evaluated salary, which may be based on an evaluation of between 36 and 48 hours per week. Salaries derived from routes which are evaluated at more than 40 hours per week are not considered to include overtime for rural carriers.

Rural carriers are not in an overtime status unless they actually work more than the number of hours stipulated in their contract for their route evaluation and are paid accordingly for overtime. The evaluated pay, therefore, is the pay rate for compensation purposes.

The salary for full-time rural carriers may vary over the life of the claim due to re-evaluations of the employee's assigned route. These changes will only affect the pay rate for compensation purposes on the date disability begins, or if the employee is performing regular work on a full-time basis at the time of a recurrence that qualifies for a recurrent pay rate. If the pay rate on the date disability begins or at the time of a qualifying recurrence is lower than the DOI pay rate, then the DOI pay rate is used to compute compensation.

If a change occurs during a period of disability, compensation continues to be based on the original pay rate.

(d) Rural carrier associates (RCA) are employed irregularly and paid When Actually Employed (WAE). Leave replacement workers, which include RCA's, relief carriers, and substitutes, can work any schedule. For rural carrier leave replacements, who are hired on a part-time basis to substitute for rural carriers and may work from one to six days in a given week, the pay rate should be established in accordance with 5 U.S.C. 8114(d).

(e) Part-time flexible employees, like RCA's, do not have a fixed schedule and can work any schedule up to 40 hours per week and are also paid WAE. Part-time flexible employees are not paid extra for holidays, as their basic pay rate includes an increment for holidays.

(f) Casual employees only work a guaranteed 89-day period, which may or may not be renewed by the Postal Service. A careful review of the employee's PS-50 should clarify the employee's entry on duty date for reference.

(g) Postal inspectors have scheduled work weeks of six days per week and are not paid overtime for the sixth day. These employees are included in the Executive and Administrative Salary (EAS) pay structure, which also covers executives, professionals, supervisors, postmasters, and technical, administrative and clerical employees.

(h) Postmasters (A-E) may work 40 hours per week over six days. Pay for the sixth day does not constitute overtime.

(i) Postal Career Executive Service (PCES) employees are paid an annual salary and may work any schedule with no overtime payable.

c. Military Sealift Command.

(1) Kinds of Appointments. Members of the Military Sealift Command (MSC) crew are assigned to a ship(s) which is usually based out of Norfolk, Virginia or San Diego, California. The duties the crew members perform, which are dependent on the needs of the boat and the boat's specific mission(s), determine what extra pay they may earn.

(2) Tours of Duty and Types of Extra Pay Earned. The tour of duty for MSC crew members is dependent on the boat and the particular duties assigned. Tours of duty may be more than eight hours per day. All crew members are guaranteed a set base salary but may earn extra pay for items discussed under paragraph 6(b) below. Not every crew member will necessarily earn all of the allowable extra pay elements, and duties can change each day.

d. National Guard.

(1) Kinds of Appointments. National Guard members are required to be members of the Air and/or Army National Guard because this membership is contingent upon their civilian Federal employee status. This is considered an accepted dual status.

Federal employees who are not civilian members of the Air and/or Army National Guard are

ineligible for this dual status because it is not a requirement for any other Federal employee to retain this dual Federal employment.

(2) Tours of Duty. Civilian members of the Air and/or Army National Guard normally work a set 40-hour work week but perform a two-week or 15-day drill duty each year in addition to monthly training assemblies.

An employee may also be recalled to duty for active Federal service under a Presidential "call" for a period not to exceed 270 days. Refer to paragraph 6(b) below for clarification when a civilian National Guard employee is entitled to compensation above his or her base salary.

e. Census Bureau. Census Bureau employees can be either full-time 40 hour per week regular employees, or may be hired every ten years to work in temporary appointments (not to exceed 180 days) as enumerators, crew leaders or clerks. Temporary positions such as enumerators historically average 4.5 hours per day, four days per week, but crew leaders or clerks can work more than this during the 180-day appointment period.

f. Federal Jurors. Grand Jurors can sit for up to 36 months but do not necessarily convene every day. They may hear evidence for many different cases. Petit Jurors participate in criminal and civil trials and normally serve for one trial only. See FECA PM 2-0802-20 for further details.

g. Firefighters.

(1) Kinds of Appointments. There are several categories of firefighters employed with the Federal Government:

- (a) Full-time firefighters, such as those on military installations.
- (b) Seasonal firefighters with the US Forest Service.
- (c) Firefighters hired on an emergency basis to address specific critical incidents.

(2) Tours of Duty. Tours of duty may vary:

- (a) Firefighters who normally work three 24-hour shifts per week. Most firefighters who work a 24-hour shift have a regular bi-weekly tour of 144 hours (six 24-hours shifts), consisting of 106 regular hours and 38 "firefighter overtime" hours.
- (b) Firefighters with an extended regular tour built on top of a 40- hour basic workweek.
- (c) Emergency firefighters who are typically employed with the Forest Service, National Park Service, and Bureau of Land Management. These employees are not "career seasonal" and are hired on an as-needed basis. Schedules often exceed eight hours per day and five days per week.

h. Department of Agriculture Co-op Employees. These employees work with the Department of Agriculture under a cooperative agreement with a non-Federal public or private organization. See paragraph 12 below.

i. Peace Corps. Each volunteer works in an assignment for a period of 27 months and is considered enrolled 24 hours per day during his or her enrollment period. See FECA PM 2-1700-4 for more information. Pay rates for volunteers are set forth in 5 U.S.C. 8142 (c).

j. Job Corps. Training offered by Job Corps for enrollees as young as 16 years can take from eight months to two years to complete. Subject to the statutory guidance and procedures set forth in FECA PM 2-1700-6, the employee is generally considered covered under the FECA 24 hours per day during this time frame. Pay rates for Job Corps students are set forth in 5 U.S.C. 8143.

k. Americorps VISTA. AmeriCorps itself is split into three main divisions, including AmeriCorps State and National, Volunteers in Service to America ([VISTA](#)), and National Civilian Community Corps (NCCC). Each member works for a minimum of one year and is generally covered under the FECA 24 hours per day during this time frame. See FECA PM 2-0802-30.

4. Average Annual Earnings. This paragraph describes how to determine average annual earnings. This determination, which depends on the nature and duration of the employment, must be made before establishing weekly and monthly pay rates.

The four methods provided by the FECA for making these determinations are set forth in 5 U.S.C. 8114(d)(1) through (d)(4) and are outlined briefly as follows:

Section 5 U.S.C. 8114(d)(1) is used if the employee worked substantially the whole year prior to the injury.

Section 5 U.S.C. 8114(d)(2) is used if the employee did not work substantially the whole year prior to the injury, but would have been employed for substantially a whole year had it not been for the injury.

Section 5 U.S.C. 8114(d)(3) is used if the employee was not employed for substantially the whole year and the employment would not have lasted for substantially the whole of the year.

Section 5 U.S.C. 8114(d)(4) is used when an employee works without pay or nominal pay.

When determining a pay rate, the above criteria should be considered in the order listed, so that only if the method prescribed in 5 U.S.C. 8114(d)(1) cannot be reasonably and fairly applied should the CE consider using the method stated in 5 U.S.C. 8114(d)(2), and so forth.

a. Whole-Year Employment - 5 U.S.C. 8114(d)(1).

5 U.S.C. 8114(d)(1) states,

(d) Average annual earnings are determined as follows:

(1) If the employee worked in the employment in which he was employed at the time of his injury during substantially the whole year immediately preceding the injury and the employment was in a position for which an annual rate of pay--

(A) was fixed, the average annual earnings are the annual rate of pay; or

(B) was not fixed, the average annual earnings are the product obtained by multiplying his daily wage for the particular employment, or the average thereof if the daily wage has fluctuated, by 300 if he was employed on the basis of a 6-day workweek, 280 if employed on the basis of a 5 1/2 -day week, and 260 if employed on the basis of a 5-day week.

Therefore, if the employee worked at least 11 months ("substantially the whole year") before the injury in the job held at the time of injury (see section 9(b) on Form CA-7 or item 19 on Form CA-6), the CE may accept the basic pay rate reported without further inquiry.

The following considerations also apply to section 5 U.S.C. 8114(d)(1):

(1) Career seasonal employment. This is an arrangement where the employee regularly works just part of a calendar year, usually for the same general period each year and at the same type of job. Such workers often perform highly specialized duties (e.g., forest firefighters, IRS tax examiners, forestry technicians).

(a) An employee who has worked in such a position during more than one calendar year by prior written agreement with the employer is considered to be a career seasonal employee. Such an employee is entitled to receive compensation on the same basis as an employee with the same grade and step who has worked the whole year.

(b) Information as to the status of the employee may appear on Form CA-7. If not, the CE must contact the EA. The kind of appointment (career, career-conditional, term or temporary) is shown on the SF-50, Notification of Personnel Action, or on Form PS-50 for Postal employees. The form should show clearly that the appointment is seasonal. An employee should not be considered career seasonal without explicit written documentation by the agency of his or her status.

(c) Employment during the year before the injury is not a factor. For example, compensation for a career seasonal firefighter paid at a GS-7 level, who had worked full-time in such a position by mutual agreement during more than one calendar year, would be computed at the full-time year-round GS-7 salary, regardless of how much or how little the employee worked during the year prior to the injury.

(d) An employee who has worked in a position with no prior written agreement is not considered to be a career seasonal employee. For example, a holiday casual Postal clerk may be rehired on new appointments several years in a row, but since the employer and the employee have not

explicitly agreed that the employment will continue from year to year, it is not considered career seasonal work.

(2) Teachers. Teachers are not considered to fall under the provisions of career seasonal employment as set forth above in (1), but they are considered whole-year employment by nature of the position. As noted above, the FECA provides for different methods of computation of average annual earnings, depending on whether the employee worked in the employment in which he or she was injured for substantially a whole year. Substantially the whole year is normally defined as at least 11 months. However, in the teaching profession, substantially the whole year would not necessarily be 11 months. Therefore, in order to determine the average annual earnings for a teacher, consideration must be given to whether the claimant worked substantially the whole actual school year, i.e., 11/12ths of the school year, and whether he or she would have been employed for substantially a whole school year had it not been for the injury.

(3) Concurrent employment. Concurrent employment can be included in determinations made under 5 U.S.C. 8114(d)(1) to the extent that it establishes the ability to work full time. As discussed more fully below, either similar or dissimilar employment can be used to demonstrate this ability.

Program Memorandum No. 147 discusses Irwin Goldman, 23 ECAB 6 (1971), and notes that a pay rate for compensation purposes is not limited to only what an employee earns in part-time employment for a Federal employer when there is concurrent employment that demonstrates the ability to work full time.

(a) When a claimant has been employed for 40 or more hours per week for substantially the year prior to injury, but not all of these hours are with a Federal employer, he or she has demonstrated the ability to work full time. Therefore, the claimant is entitled to compensation at the rate of a regular full-time employee in the same position.

(b) A claimant who can establish that he or she worked for substantially the entire year prior to the injury on a full-time basis is entitled to receive compensation on the same basis as a regular employee working in the same type of job. It does not matter what type of work the claimant performed during that year (though attending school is not considered employment and sporadic employment also would not demonstrate the ability to work full time). The fact that he or she had been employed consistently demonstrates the ability to work full time.

(c) Dissimilar employment. In the Goldman decision, it was determined that a part-time Postal employee who worked four hours per day, five days a week, and had a set salary, could have his pay rate expanded to support that his outside full-time employment in dissimilar private industry demonstrated he could perform work full-time as a Postal employee for compensation calculation purposes.

Therefore, work performed in another job during the year prior to a work-related injury can demonstrate an ability to perform full-time work in the job in which the injury occurred. When a part-time or short-term employee has demonstrated the ability to work full time by performing

dissimilar employment for the year prior to the date of injury, the pay rate of an employee working full time in the actual Federal job held by the injured employee should be used to compute compensation.

However, the Goldman decision notes these same private industry earnings could not represent an employee's wage-earning capacity (which is discussed in further detail in FECA PM 2-0814). The actual pay received for dissimilar employment cannot be used in the calculation of the pay rate, but the hours worked can be used to establish an employee's ability to work full time.

(d) Similar employment. Similar outside employment also demonstrates the ability to work full time; however, as opposed to dissimilar employment, similar employment requires the Office to combine the actual earnings from Federal employment with the actual earnings for the similar employment to obtain the average annual pay the employee earned. This total would be divided by 52 to obtain the weekly pay rate.

For example, if a part-time x-ray technician for the VA also works part-time as an x-ray technician at a private hospital, the total earnings of both would be added together to obtain the average annual earnings.

However, a pay rate based on full-time Federal employment may not generally be expanded to include the pay earned in any other concurrent employment, even if that employment is similar to the Federal duties. See J.G., Docket No. 05-943, issued May 23, 2007, where the injured worked was a full-time employee who worked another full-time job but was only entitled to compensation for wage loss for full-time Federal employment. Likewise, a pay rate based on career seasonal employment may not be expanded to include the pay earned "off season."

It is important to distinguish this situation from that addressed by the ECAB in Daniel Shaw, Docket No. 97-1680, issued April 14, 1999. In Shaw, the Board found that the transcript fees the employee, a court reporter, received constituted consideration for his federal employment and therefore were required to be included in the pay rate for compensation purposes. In this case, the claimant did not have similar, concurrent private-sector employment but, as an official court reporter, he was permitted by law to receive payment for transcripts he produced as part of his duties in addition to his salary. The fees he was allowed to charge for these transcripts were set by the employer. Payment was received from both the federal government and by private individuals for official, certified transcripts required in court proceedings. However, such payment was allowed by law and by the employing establishment, and the amount was set under the regulations of the employing establishment. Even though payment was received from other than the claimant's employer, the payment was made for the product of the duties he performed for his salaried position. He was, therefore, being paid for work performed within the performance of his duties.

(4) Pay for Whole Year Employment. For employees who have worked for at least a full year prior to the injury, but whose pay fluctuated during the year, the weekly pay rate for compensation purposes is determined under 5 U.S.C. 8114(d)(1)(B).

For instance, the pay rate of a rural carrier associate or part-time flexible employee of the Postal

Service who works substantially the entire year prior to injury would be computed under section 8114(d)(1)(B), not section 8114(d)(3), even if the earnings fluctuated considerably from week to week, because an annual rate of pay can be established by obtaining the yearly earnings, without overtime, for the year prior to the injury.

b. Anticipated Whole-Year Employment - 5 U.S.C. 8114(d)(2).

5 U.S.C. 8114(d)(2) states,

(d) Average annual earnings are determined as follows:

(2) If the employee did not work in employment in which he was employed at the time of his injury during substantially the whole year immediately preceding the injury, but the position was one which would have afforded employment for substantially a whole year, the average annual earnings are a sum equal to the average annual earnings of an employee of the same class working substantially the whole immediately preceding year in the same or similar employment by the United States in the same or neighboring place, as determined under paragraph (1) of this subsection.

Therefore, the next issue to be considered in determining average annual earnings is anticipated whole-year employment. An affirmative answer to section 9(b) on Form CA-7 or item 20 on Form CA-6 is sufficient to show that the employee's position would have afforded employment for substantially a whole year had it not been for the injury. A negative, absent, or ambiguous answer to this question should prompt the CE to release Form CA-1030 to the EA. This can also be documented by a CA-110 following a call with the employing agency.

The average annual earnings are determined as described in paragraph 4(a) above. The discussion of concurrent employment in paragraph 4(a)(3) above also applies to these cases.

c. Irregular Employment - 5 U.S.C. 8114(d)(3).

5 U.S.C. 8114(d)(3) states,

(d) Average annual earnings are determined as follows:

(3) If either of the foregoing methods of determining the average annual earnings cannot be applied reasonably and fairly, the average annual earnings are a sum that reasonably represents the annual earning capacity of the injured employee in the employment in which he was working at the time of the injury having regard to the previous earnings of the employee in Federal employment, and of other employees of the United States in the same or most similar class working in the same or most similar employment in the same or neighboring location, other previous employment of the employee, or other relevant factors. However, the average annual earnings may not be less than 150 times the average daily wage the employee earned in the employment during the days employed within 1 year immediately preceding his injury.

Therefore, any situation not involving regular whole-year employment, career seasonal employment, a demonstrated ability to work full time, or anticipated whole-year employment - as discussed in the preceding paragraphs - is considered irregular employment. This category includes intermittent, seasonal, on-call, and discontinuous work, as well as employment where average annual earnings cannot be established under 5 U.S.C. 8114(d)(1) or (2).

The provisions of 5 U.S.C. 8114(d)(3) are not to be used if sections 8114(d)(1) or (2) can be applied. As noted earlier, for example, the pay rate of a part-time flexible employee of the Postal Service who works substantially the entire year prior to injury would be computed under section 8114(d)(1)(B), not section 8114(d)(3), even if the earnings fluctuated considerably from week to week, because an annual rate of pay can be established by obtaining the yearly earnings without overtime for the year prior to the injury.

Among other situations, irregular employment may include:

- Postal Service employees hired for the holiday season;
- Census enumerators (see paragraph 12 for further details);
- Casual firefighters hired by the Forest Service;
- Bin-site workers, county and precinct committee workers, and a variety of other inspection personnel, food technologists, veterinary medical officers, and agriculture commodity workers personnel employed on an occasional basis by the Department of Agriculture.

The Office must first take into consideration the earnings of the employee in Federal employment for the year prior to injury. Then the Office should review the earnings of other employees in the same or most similar class working in the same or most similar employment in the same or neighboring location. Finally, the Office must consider any other employment of the employee, or other relevant factors.

However, the average annual earnings may not be less than 150 times the average daily wage that the employee earned in the employment during the year just before the injury. This "150 Formula" should be used by the Office as a provisional pay rate when the employee is entitled to compensation for wage loss and further investigation is required to determine the claimant's average annual earnings.

(1) Claimant's prior-year Federal employment. This information should be obtained from the EA or other Federal agency where the employee worked. Form CA-1030 may be used to request this information.

(2) Similarly-employed worker. The Office should determine the earnings of another Federal employee working the greatest number of hours during the year prior to the injury in the same or most similar class, in the same or neighboring locality, as obtained from the EA or another Federal agency in the same or neighboring locality. Form CA-1030 requests this information.

(a) "Same or most similar class" refers both to the kind of work performed and the kind of appointment held. A similarly situated employee would most likely hold the same type of

appointment and the same pay grade and step as the claimant. For example, a rural carrier associate or part-time flexible employee should not be compared to a regular rural carrier or letter carrier, as these are different types of appointments. If the employee's job was temporary and seasonal in nature, it should be compared to that of another temporary and seasonal employee.

(b)(b) If the "same or most similar class" contains more than one employee, the EA should be asked to state the earnings of the employee who worked the "greatest number of hours" and therefore had the highest earnings. If the claimant's term of employment is less than a year, the earnings of the similar employee should be pro-rated to match the same term of employment as the claimant's.

(c) The selected employee's grade and step should also be provided for reference so that it will be on file for wage-earning capacity purposes.

(3) Claimant's prior-year non-Federal employment. The CE will usually need to explore the claimant's full employment history for the year before the injury. This may be accomplished by sending Form CA-1029 to the employee, Form CA-1030 to the EA, or by other means, such as requesting pay stubs or tax returns, or holding a telephone conference with the claimant or EA. The CE may also release Form CA-935 with the SSA-581 to the claimant, and then send the claimant's completed SSA-581 to the Social Security Administration.

Form CA-1027 may be sent to private employers to verify the claimant's reported earnings, but if the earnings appear reasonable, they may be used without verification. Only earnings in employment which is the same as, or similar to, the work the employee was doing when injured may be considered. For this reason, the CE must determine the nature of the employment. Any other relevant factors which may pertain to the employee's "average annual earnings" in the employment in which he or she was working at the time of the injury should be considered. These factors are too various to enumerate, so supportive rationale should be included in a pay rate memo.

(4) The "150 Formula." The last part of 5 U.S.C. 8114(d)(3) states that the average annual earnings shall not be less than 150 times the employee's average daily wage earned in the particular employment during the year just before the injury.

To obtain the average daily wage, the CE should divide the employee's gross earnings in the year prior to the injury by the actual number of days the employee worked. This figure is then multiplied by 150 and divided by 52.

However, in order to establish a provisional pay rate while obtaining other necessary information, the CE may calculate the daily wage on the actual date of injury and apply the 150 formula, i.e. hourly wage multiplied by the number of hours scheduled on the date of injury multiplied by 150 and divided by 52.

(5) To determine the employee's "average annual earnings" after development is complete, the CE should take the highest of:

- (a) The earnings of the employee in the year prior to the injury, including any similar non-Federal employment;
- (b) The earnings of a similarly-situated employee (see subparagraph (2) above); or
- (c) The pay rate determined by the "150 formula."
- (6) The CE should prepare a memorandum setting forth this determination and explaining the basis for it. This memorandum, which is subject to the certifier's concurrence, should be made part of the record. Unless conflicting evidence is present or a protest occurs, approval at a level higher than the certifier is not required.
- (7) Absent evidence of varying pay rates, the CE need not investigate whether the pay rate changed during the year just before the injury. However, if such evidence is received, the CE should determine the employee's various pay rates during the year just before the injury and the number of days during such period the employee was paid at each rate. The average daily wage will be determined based on this evidence according to the number of days employed at each rate.

d. Employment without Pay -5 U.S.C. 8114(d)(4).

5 U.S.C. 8114(d)(4) states,

(d) Average annual earnings are determined as follows:

(4) If the employee served without pay or at nominal pay, paragraphs (1), (2), and (3) of this subsection apply as far as practicable, but the average annual earnings of the employee may not exceed the minimum rate of basic pay for GS-15. If the average annual earnings cannot be determined reasonably and fairly in the manner otherwise provided by this section, the average annual earnings shall be determined at the reasonable value of the services performed, but not in excess of \$3,600 a year.

(1) Persons serving under 5 U.S.C. 8101(1)(B) - i.e., without pay or at nominal pay - come within the meaning of 5 U.S.C. 8114(d)(4). These persons usually have work schedules that are irregular as to hours worked per day and days worked per week, or the duration of the assignment is limited in some way.

The CE should consider these factors when determining a pay rate, using narrative letters or form letters CA-1027 or CA-1029 to request needed evidence. The CE should allow a pay rate based upon full-time employment only if the evidence clearly shows that the person had served on a full-time basis for substantially the whole year immediately preceding the injury, or that the assignment would have afforded employment for substantially the whole year.

(2) The EA should be asked to furnish the following evidence:

- (a) A description of the duties performed by the claimant;

(b) Full details about the claimant's work schedule, including the hours worked per day, the days worked per week, the date when the claimant began the assignment, and the date when the assignment was to be completed; and

(c) The title, grade, and pay rate of a full-time position at the EA in which the service performed is the same or most similar to that performed by the injured person.

(3) The claimant should be asked to submit a signed statement showing all of his or her employment during the year immediately preceding the injury, including the names and addresses of employers, the type of work performed for each, and gross earnings exclusive of overtime from each employer.

(4) The CE should prepare a memorandum setting forth the pertinent facts and recommending a determination of the average annual earnings. The pay rate may not exceed the minimum rate of pay of an employee at the GS-15, step 10, level. A Quality Assurance and Mentoring Examiner or higher-level employee must concur with the determination.

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5. Effective Date of Pay Rate. This paragraph describes how to determine the date on which the pay rate should be based.

a. Disability Cases.

(1) In keeping with Section 5 U.S.C. 8101 (4), compensation in disability cases is computed using the pay rates in effect on:

(a) The date of injury (DOI);

(b) The date disability began (DDB); or

(c) The date disability recurred (DOR), if the recurrence began more than six months after the employee resumed regular full-time employment with the U.S.

The dates when compensable "disability began" or "disability recurred" are the dates the employee stopped work due to the injury, not the dates pay stopped. An increase of pay during the continuation of pay (COP) period does not change the pay rate for compensation purposes.

For occupational disease claims where the claimant remains exposed to the work factors claimed, the pay rate is the rate of pay effective the date of the last exposure to causal employment factors (which may be the date of a medical examination). If the claimant no longer remains exposed to the work factors claimed and there has been a change in work duties, e.g., limited duty, then the date of last exposure is used. See Patricia K. Cummings, 53 ECAB 623 (2002).

Peace Corps volunteers and VISTA and Job Corps enrollees are not covered by Section 5 U.S.C. 8101 (4); therefore, they are not entitled to a recurrent pay rate.

(2) The CE must first decide which date to use in establishing the pay rate for disability compensation. To do this, the CE should determine whether:

(a) The employee stopped work due to injury-related disability on or immediately after the date of injury; and

(b) The disability began at that time or is continuous from that time. If so, there is no choice and the DOI will be used.

(3) If the employee did not stop work on the DOI (or immediately afterward, defined as the next day), and the disability began at a later date, the case record should show the pay rate for the DOI and the DDB. The greater of the two will be used in computing compensation. If they are the same, the pay rate should be effective on the DDB. This is true even if the employee is working in private industry at the time the disability begins.

(4) Recurrences of disability are defined in FECA PM 2-1500 and 20 C.F.R. § 10.5(x). A recurrent pay rate applies only if the total or partial disability for work began more than six months after the first return to regular full-time employment (after the original disability) with the U.S. To be eligible for a recurrent pay rate, there need not be a "continuous" six months of full-time employment prior to the recurrence of disability. See Johnny Muro, 19 ECAB 104 (1967).

(a) The ECAB has defined "regular" employment as "established and not fictitious, odd-lot or sheltered," contrasting it with a job created especially for a claimant. The ECAB has also noted that the duties of "regular" employment are covered by a specific job classification, pointing out that the legislative history of the 1960 amendments to the FECA, which added the alternative provisions to section 8101(4), demonstrates that "Congress was concerned with the cases in which the injured employee had 'recovered' or had 'apparently recovered' from the injury." The test is not whether the tasks that appellant performed during his limited duty would have been done by someone else, but instead whether he occupied a regular position that would have been performed by another employee. See also Eltore D. Chinchillo, 18 ECAB 647 (1967)

[Remanding the case for further development, the ECAB noted that if the employee only returned to work in a temporary position designed to keep him on the payroll until his future ability to perform shipfitter duties was ascertained, the employee did not resume "regular" full-time employment within the meaning of the statute.]; and Thomas M. Schuerman, 51 ECAB 336 (2000) [Going to Vocational Rehabilitation isn't returning to regular full-time employment.].

(b) "Full time" means returning to the same number of hours of work per week as prior to the injury. For example, a claimant who worked a standard 40-hour week before the injury and returns to work eight hours per day for only three days per week has not returned to full-time employment. For employees who worked regular part-time schedules when injured, the term "full-time" should be construed as "full-schedule."

(c) Entitlement to a recurrent pay rate based on return to private employment requires that the employee must have returned to Federal employment after the original disability and six months

must have elapsed since that return-to-work date. (See FECA Program Memoranda Nos. 164 and 268.)

(5) If a recurrence of disability is established, the CE should compare the pay rates on DOI, DDB, and DOR. The greatest of these pay rates will be used to compute compensation. Accepting a recurrence does not automatically constitute a recurrent pay rate. The employee still needs to meet the requirements of paragraph 5(a)(4) above.

(6) Once the claimant has met the initial requirements for entitlement to a recurrent pay rate, subsequent recurrences qualify the claimant for a new recurrent pay rate, without regard for another six-month return-to-work requirement. In determining subsequent DOR pay rates, however, the claimant's work schedule at the time of recurrence must be taken into account.

A recurrent pay rate may be lower than the pay rate in effect on the DOI, DDB, or previous DOR. This can happen when the claimant is originally injured in full-time employment, and the recurrence occurs when the claimant is working part-time or has been rated for loss of wage-earning capacity (LWEC). Even if the EA reports a higher hourly pay rate for a DOR, the recurrent pay rate should be considered the actual weekly amount the claimant earned. In such cases, the pay rate on DOI, DDB, or a previous DOR, with the applicable effective date, would be used because it was higher.

(7) Due to application of cost-of-living increases, compensation based on the DOI pay rate may exceed the amount payable using the DOR pay rate. However, if the DOR pay rate is higher than the DOI pay rate, the DOR should be used, even if a lower payment of compensation will result. (See G.H., Docket 07-1738, 01/05/2009.)

(8) Payment of a schedule award does not entitle the claimant to a recurrent pay rate.

b. Non-Disability Cases.

(1) Claimants are entitled to receive compensation for medical appointments attended as a result of the injury. Medical appointments are not considered disability from work. Compensation for medical appointments should be computed on the pay rate in effect as of:

(a) The DOI, for traumatic injury claims;

(b) The date of last exposure (which is, in effect, the DOI), for occupational disease claims.

In an occupational disease claim, if the claimant continues to be exposed to the same work factors accepted as having caused the condition and claims compensation for medical appointments, the date of the first medical appointment is used as the DOI date, since that is the first date of any eligibility to compensation. Since the accepted period of exposure and/or work factors has already been determined, the effective pay rate date will not change unless the employee actually becomes disabled (e.g., surgery, lack of suitable work, etc.) or later files a claim for a schedule award (in which case the actual date of last exposure should be used as the DOI pay rate).

If the claimant did not lose any time from work but began working limited or modified duties due to restrictions imposed as a result of the accepted injury, then the date prior to the date the modified duty began should be used as a new DOI pay rate and pay rate effective date for purposes of paying compensation for ongoing medical appointments, since this is the date of last exposure to the work factors that were accepted by OWCP.

If the claimant then loses time from work due to disability resulting from the work injury, a new pay rate (DDB) would be established.

c. Schedule Award Cases. The pay rate used for the payment of the schedule award is the greatest of the established pay rates (DOI, DDB, or DOR). See Exhibit 1.

For occupational disease claims where the claimant remains exposed to the work factors claimed, the pay rate is the rate of pay effective the date of the medical examination. If the claimant no longer remains exposed to the work factors claimed and there has been a change in work duties, e.g., limited duty, then the date of last exposure is used. See Patricia K. Cummings, 53 ECAB 623 (2002).

Where there was no prior injury-related disability from work, the DOI pay rate should be used. However, the CPI-effective date is the beginning date of the schedule award, since that is the first date of any eligibility to compensation.

d. Death Cases. The pay rate in death cases is determined by the DOI, which is the date of death, unless a different pay rate has been reached in a disability claim due to delayed or recurrent disability leading to the death, or because the decedent was a minor or learner whose pay rate was re-determined according to 5 U.S.C. 8113(a). (See paragraph 12a below.)

6. Elements Included in Pay Rate. This paragraph lists the increments of pay which may be included in the pay rate, either by statute or administrative determination.

a. Statutory Inclusions.

(1) 5 U.S.C. 8114 includes the following elements for determining an employee's pay rate:

- (a) The employee's full salary or full cash wage;
- (b) The value of any subsistence and quarters received for services in addition to the cash wage (not including subsistence and quarters furnished by the employer and paid for directly by the employee or by deduction from the employee's salary); and
- (c) Premium pay for scheduled standby duty as provided by 5 U.S.C. 5545(c)(1).

(2) The employer does not usually provide subsistence and quarters to employees unless the conditions and place of employment render it impossible or impractical for an employee to obtain food and lodging from another source. Therefore, the CE need be concerned with subsistence and quarters only where:

(a) The industry or the employer customarily provides such services (e.g., crew members employed by the Military Sealift Command, employees aboard boats, dredges, barges, and floating plant vessels, or temporary firefighters working for the Forest Service);

(b) A quarters allowance is paid to personnel serving overseas, pursuant to Section 901(1) of the Foreign Service Act of 1946 and Executive Order No. 10011, dated October 22, 1948; or

(c) Item 18 on Form CA-6, section 8 on Form CA-7, or some other written evidence from the claimant or employing agency shows that the employer provided food and lodging.

b. Administrative Inclusions. It has been determined administratively that the following elements will be included in computing an employee's pay rate:

(1) Night differential is paid for regularly scheduled work between the hours of 6:00 p.m. and 6:00 a.m.

(2) Shift differential is paid to wage-grade employees and is typically 7.5% for the entire shift of a swing shift or shift 2. This differs from night differential in that shift differential is typically paid for the entire shift if the majority of that shift falls after or before the hours of 6:00 p.m.

(3) Extra compensation for performing work on Sundays or holidays paid to regular employees of the Postal Service.

(4) Premium pay for work on Sundays and/or Saturdays under 5 U.S.C. 5546(a), which provides for extra pay when an employee's regular work schedule includes an eight-hour period, any part of which falls on a Sunday or described as being within the period commencing at 12:00 a.m. Saturday and ending at 12:00 a.m. Sunday. Saturday pay is usually payable to health professionals working for the Department of Veterans' Affairs.

(5) Premium pay for work on holidays under 5 U.S.C. 5546(b), which provides for extra pay when an employee's regular schedule includes work on a holiday. This increment may not be paid for work which exceeds eight hours or which represents overtime.

(6) Retention pay when the employee is in a field which is difficult to staff or requires specific and/or difficult to hire employment, such as certain medical professionals, Military Sealift Command employees, or air traffic controllers. This will be documented by the agency if this is included and provided by the agency.

(7) Premium pay for administratively uncontrollable overtime (AUO), including holiday pay under 5 U.S.C. 5545(c)(2) (see also FECA Program Memoranda Nos. 106 and 280).

(8) Availability pay for criminal investigators pursuant to 5 U.S.C. 5545a. This increment (25% of basic pay) is paid to ensure the availability of investigators for unscheduled duty, and replaces AUO (see above) for these employees.

(9) Extra pay received by immigration inspectors for work performed between 5:00 p.m. and 8:00 a.m., and for all work performed on Sundays and holidays (see FECA Program Memorandum No. 68).

(10) Extra pay received by customs inspectors for work performed between 5:00 p.m. and 8:00 a.m., and for all work performed on Sundays and holidays, until January 1, 1994 (see FECA Program Memoranda Nos. 278 and 281).

(11) Wages paid for National Guard service when membership in the National Guard is a condition of the employee's civilian employment with the Guard.

Earnings received for active Federal service under a Presidential call are also included. A Presidential call is a statutory method by which reservists can be involuntarily ordered to active duty. Any extra wages earned for this specific service under a Presidential call should be obtained for the year prior to the date of injury, since serving under a Presidential call is not a voluntary action. This should be divided by 52 weeks and added to the basic pay rate. Other supplemental Reserve pay, obtained through voluntary actions of the employee, is not included. (See R.E., ECAB Docket 2008-1728, issued April 10, 2009.) [Any compensation that was paid for other voluntary active duty pay prior to the issuance of this ECAB decision is not considered an overpayment of compensation.]

(12) Extra pay authorized under the Fair Labor Standards Act (FLSA), 29 U.S.C. 207(k), for emergency medical technicians and other employees who earn and use leave on the basis of their entire tour of duty, and who are required to work more than 106 hours per pay period. GS-081 firefighters with pay-rate effective dates prior to October 11, 1998 would also be included in this section.

Such pay may be included retroactive to July 21, 1987, when OPM made changes in its regulations. To be entitled to an adjustment in the pay rate, the claimant must have been in pay status on or after that date. If retroactive payment is authorized in a long-term disability case, the pay rate must be adjusted so that CPIs will be included.

(13) The Federal Firefighters Overtime Pay Reform Act of 1998 (Public Law No. 105-277) amended Title 5 of the U.S. Code to define hours worked by firefighters in excess of 106 bi-weekly, or 53 weekly, as "overtime." Public Law 106-554, which was enacted in December 2000, contained language establishing that those hours in excess of 106 bi-weekly (or 53 weekly) should not be considered "overtime" pay for the purpose of computing pay under Section 5 U.S.C. 5545b. These changes became effective the first day of the first pay period after October 1, 1998. (This date is presumed to be October 11, 1998.) This change applies only to GS-081 firefighters who are covered by Section 5 U.S.C. 5545b.

The Federal Firefighters Overtime Pay Reform Act of 1998 provides "overtime" for hours in the regular tour of duty to both FLSA nonexempt and exempt firefighters. The weekly pay rates are computed in the same manner for both types of firefighters, except there is a cap on the "overtime" hourly rates for FLSA exempt firefighters. The cap is set at 1.5 times the GS-10, step

1 hourly rate (computed using the 2087 divisor and including any applicable locality pay), but the capped rate may not fall below the individual firefighter's hourly rate of basic pay.

(14) Premium, hazard and penalty pay for crew members employed by the Military Sealift Command is granted by the master of the ship they work for and is only paid depending on the needs of this ship and its particular mission. Not all crew members may earn these pay elements, but these are payments for involuntary duties.

The following are considered "leave supplements" that are paid to all unlicensed crew members or watch-standing officers by the Military Sealift Command, to compensate for overtime, penalty or premium pay that is not earned while on authorized leave. The leave supplement is a means of maintaining wage differentials among the crew, and is not among the categories of pay excluded by Section 5 U.S.C. 8114(e).

(a) Hazard pay. This is only earned when the boat is in a combat zone during wartime. When the ship is not in a combat zone, this cannot be earned by any crew member.

(b) Premium pay. This is dependent on the position and duties of the crew member and granted by the master of the ship itself when a crew member is ordered to do specific tasks that will require a minimum of two hours to perform.

(c) Penalty pay. This is paid when a specific task requires a crew member to miss meals or sleep (such as a task which is required at night).

(d) Subsistence pay. This is paid when a crew member lives over 50 miles from his or her regular duty station and is waiting for work and in an official standby waiting status; this will be granted by the master of the boat.

(e) Habitability pay. This is paid when crew members are required to stay on shore while their assigned boat is being serviced in dry dock.

(f) Retention Allowance. This is paid as an incentive to retain personnel such as able seamen or engineers.

(g) "Non-watch" or Non-watch-standing pay. This is paid to able seamen or engine personnel who are performing security duties for a particular boat. These are the only two types of employees who may earn this pay as part of their assigned duties.

The extra pay the claimant earned for these items in the year prior to the effective pay rate date should be requested from Military Sealift Command payroll or injury compensation staff, since the amount earned can vary widely.

(15) FAA Air Traffic Controller (ATC) Pay. Along with night differential, Sunday premium, or holiday pay, an ATC can earn the following extra pay, as it is involuntarily earned based upon the employer's needs: Controller-in-Charge and controller retention or incentive pay.

(16) "Arctic bonus" pay received by personnel working at Foreign Arctic Weather Stations of the National Oceanic and Atmospheric Administration, Department of Commerce.

(17) "Dirty-work pay" extended to employees who work under conditions which soil the body or clothing more than normally expected in performing the duties of the job.

(18) "Hazard pay" when it is included for work which is recurrent in nature and part of the employee's normal duties. This is not to be confused with "danger pay" awarded for hazardous services in time of war, which is excluded as described in the next section.

(19) Locality pay or "COLA" (cost-of-living allowance) paid to certain employees as part of their normal pay and in addition to their salary, because of differences in cost of living within the U.S. and its possessions (e.g., Puerto Rico).

(20) "Remote worksite allowance" under the provisions of 5 U.S.C. 5942 paid to certain employees assigned to regular duty at designated locations so remote from the nearest established communities or suitable places of residence as to require an appreciable degree of expense, hardship, and inconvenience beyond that normally encountered in metropolitan commuting.

(21) "Post differential" paid under 5 U.S.C. 5925. This is regarded as a special recruitment and retention allowance granted because of the overall environmental conditions or rigors of the particular post. It is not a cost-of-living differential or economic equalization factor, which would be excluded from the pay rate for compensation purposes.

(22) Dive pay is authorized for wage system employees for those hours when they are actually performing diving duties. The pay rate is 175 percent of the WG-10, step 2 rate, adjusted for locality.

7. Elements Excluded from Pay Rate. This paragraph list the increments of pay which may not be included in the pay rate, as determined either by statute or administrative decision.

a. Statutory Exclusions. 5 U.S.C. 8114(e) excludes the following elements from an employee's pay rate:

(1) Overtime pay. The extra pay required by the Fair Labor Standards Act (FLSA) for hours worked in excess of the standard prescribed under the FLSA is not to be included in computing pay for the purposes of continuation of pay or compensation. Such extra pay is earned only if the actual hours are worked and is considered to be overtime pay for the purposes of 5 U.S.C. 8114(e).

(2) Additional pay or post-allowance authorized outside the United States and its possessions because of differential in cost of living or other special circumstances. The separate maintenance allowance authorized in 5 U.S.C. 5923(3) is also excluded, since it is a cost-of-living allowance paid to an employee in a foreign area.

(3) Bonus or premium pay for extraordinary service, including "danger pay," which is any amount paid as a bonus for particularly hazardous services in time of war.

b. Administrative Exclusions.

(1) Per diem received by an employee while in a travel status.

(2) Extra allowance paid for an employee's use of his or her private motor vehicle (such as rural carriers for the US Postal Service).

(3) Unemployment compensation.

(4) Earnings from dissimilar concurrent employment. For example, if the claimant works for the Federal Government as a part-time secretary and also works as a cashier part time for a private employer, the earnings from the cashier position would not be included in the pay rate. However, such earnings may help in determining the claimant's ability to work full time. (See section 4(a)(3) above.)

(5) Earnings as an activated reservist or National Guard member when the activation is not as a result of a presidential call under §12301(a), §12302, or §12304 of Title 10, United States Code (See R.E. Docket 08-1728, 04/10/2009.)

(6) Earnings as a reservist or National Guard member when the membership is not a condition of the employee's civilian employment with the Guard or Reserve.

8. Applying Increments of Pay. This paragraph discusses when the CE may accept the amounts of differential pay increments as reported and when to seek clarification. The CE should normally not delay a payment to obtain such clarification, which can be obtained in writing or by a phone call to the EA and then documented by placing a CA-110 in file.

a. Receipt on Regular Basis. If an additional amount or percentage was paid for premium, night differential, Sunday, holiday, shift pay, FLSA extra pay, or firefighters extra pay (see paragraph 6 in this chapter), and the file contains no evidence showing that this amount varies or is paid irregularly, the CE may add the indicated amount or percentage to the base pay reported without further inquiry. The CE should verify with the employing agency whether shift differential is included with the base pay provided for wage-grade employees.

b. Varying Amounts. If the evidence shows that the amount or percentage paid for premium, night differential, Sunday, shift pay, FLSA extra pay, or firefighters extra pay varies or is paid irregularly, the CE should determine the amount of additional pay received during that year and add it to the reported base pay. (See subparagraph 8(c) below concerning FLSA pay and subparagraph 8(d) below concerning firefighters' pay.)

c. FLSA Pay for Firefighters. The pay rates of individuals entitled to this increment of pay are based on annual pay rate and percentage of premium pay. Their pay is based on 144 hours of work each 14-day pay period, of which 106 are regular hours and 38 are FLSA overtime hours.

The number of biweekly hours should be verified with the employing agency if not readily determined in the case documentation. The formula is as follows:

- (1) $\text{Yearly pay} / 26 = \text{basic biweekly pay}$.
- (2) $\text{Basic biweekly pay} \times \text{premium pay percentage} = \text{standby premium pay}$.
- (3) $\text{Basic biweekly pay} + \text{standby premium pay} = \text{total pay without FLSA Overtime}$.
- (4) $\text{Total pay without FLSA OT} / 144 = \text{hourly regular rate}$.
- (5) $\text{Hourly regular rate} \times .5 \times 38 = \text{FLSA overtime}$.
- (6) $\text{Total pay without FLSA OT} + \text{FLSA overtime} = \text{total pay}$.

d. GS-081 Firefighters Pay. Under the Federal Firefighters Overtime Pay Reform Act of 1998, there are two categories of firefighters based on the type of work schedule. Different pay computation rules apply to each category.

(1) Firefighters with regular tours of duty generally consisting of 24-hour shifts (which is the most common situation).

- (a) $\text{Annual salary} / 2756 \text{ (53 hours of regular pay per week} \times 52 \text{ weeks)} = \text{firefighter hourly rate}$.
- (b) $\text{Firefighter hourly rate} \times 106 \text{ hours} = \text{biweekly base pay}$.
- (c) $\text{Firefighter hourly rate} \times 1.5 = \text{"firefighter overtime" rate}$ (subject to GS-10, step 1 cap as described in PM 2-0900.6.b(13)).
- (d) $\text{"Firefighter overtime" rate} \times \text{number of hours in regular tour in excess of 106 hours} = \text{biweekly "firefighter overtime"}$.
- (e) $(\text{Biweekly base pay} + \text{biweekly "firefighter overtime"}) / 2 = \text{weekly pay rate}$.

(Note: most 24-hour shift firefighters have a regular biweekly tour of 144 hours (six 24-hours shifts), consisting of 106 regular hours and 38 "firefighter overtime" hours; thus, 38 hours (144-106) would be used in step (d) above.)

(2) Firefighters with an extended regular tour built on top of a 40-hour basic workweek.

- (a) $(\text{Annual salary} / 2087) \times 80 \text{ hours} = \text{biweekly base pay}$.
- (b) $\text{Annual salary} / 2756 = \text{firefighter hourly rate}$.
- (c) $\text{Firefighter hourly rate} \times 26 \text{ hours} = \text{additional biweekly base pay}$.

(d) Firefighter hourly rate X 1.5 = "firefighter overtime" rate (subject to GS-10, step 1 cap as described in PM 2-0900.6.b(13)).

(e) "Firefighter overtime" rate X hours in regular tour in excess of 106 hours = biweekly "firefighter overtime".

(f) (Biweekly base pay + additional biweekly base pay + biweekly "firefighter overtime") / 2 = weekly pay rate.

(Note: a common schedule would be a 40+16 weekly tour, which translates into a biweekly tour of 112 hours, including 6 "firefighter overtime" hours to be used in step (e) above.)

9. Computing Daily Pay Rate. This paragraph provides guidance on how to compute daily pay rates, which may be used under the circumstances noted below. However, in practice, payments in disability claims are almost always based on the weekly rate.

a. Criteria. A daily pay rate may be used only when all of the following four tests are met:

(1) The injury caused only temporary total disability.

(2) The period of compensable disability (the period for which compensation is paid) does not, or is not expected to, exceed 90 calendar days.

(3) No additional increments of pay (e.g. Sunday premium, shift differential, etc.) are involved.

(4) The "average annual earnings" of the employee are not readily determinable.

b. Length and Permanency of Disability. In deciding whether the injury will likely cause permanent disability or a period of temporary total disability exceeding 90 calendar days, the CE must consider the nature and severity of the injury; the medical prognosis; the age of the employee; and the nature of the employment. When it is unclear whether permanent effects will result from the injury, or whether the temporary total disability will exceed 90 calendar days, and the "average annual earnings" cannot be readily determined, the CE should set up payment based on the daily pay rate and make appropriate inquiries to develop the weekly pay rate.

If the disability extends beyond 90 calendar days, the CE will need to reassess the pay rate.

c. Fixed Schedule. Where the evidence on Form CA-1 or CA-2 shows that the employee works the same hours on a daily basis and the same days each week, the CE will determine the actual daily wage according to how it is reported:

(1) If the wage reported is on a daily basis, the amount shown will be used as the actual daily wage;

(2) If the wage reported is on an hourly basis, the actual daily wage will be computed by multiplying the hourly pay by the hours worked per day shown in item 20 on Form CA-1 or item 21 on Form CA-2; or

d. Intermittent Schedule. Where Form CA-1 or CA-2 shows that the employee did not work the same hours per day or the same days per week, the CE should obtain the actual dates worked during the month immediately preceding the injury to determine whether the employee worked a reasonably regular schedule of 5, 5 ½, or 6 days per week, for example. This is necessary to determine the actual days of compensation entitlement.

If the claimant worked a reasonably regular schedule, the actual daily wage will be computed by dividing the employee's gross earnings during the month just before the injury by the actual number of days the employee worked during such period.

e. If paying compensation on a daily rate, the employee is paid for the days he or she would have worked but for the injury (work days). For example, a married worker sustains an ankle fracture on her third day of employment and stops work. She is disabled for 17 days before returning to her full, regular duties. The employee was hired on a temporary basis and makes \$10.00 per hour. The EA reports that the claimant worked 15 total hours during her 3 days of employment. The daily pay rate would be calculated as follows:

15 hours divided by 3 days = 5 hours per day
\$10.00 per hr X 5 hrs per day = \$50.00
\$50.00 X ¾ = \$37.50 per day compensation rate
\$37.50 x 17 days lost = \$637.50

10. Computing Weekly Pay Pate. This paragraph provides guidance on how to compute a basic weekly pay rate, depending on the form in which pay is reported:

a. Annual Basis. An annual salary, which may be reached either by report from the employing agency or determination of average annual earnings, is divided by 52.

b. Daily Basis. The amount shown is multiplied by 5 for a five-day workweek, 5½ for a five-and-a-half day workweek, and so on.

c. Hourly Basis.

(1) For Postal Service employees, the amount shown is multiplied by 2080, and then divided by 52.

For USPS employees who work less than a full schedule, the figure of 2080 hours should be prorated (e.g. 1040 hours when the employee works four hours per day), then multiplied by the amount shown; or

(2) For regular Federal employees, the amount shown is multiplied by 2087 (by administrative determination, the number of hours in a full work year based on a 40-hour work week). This figure is then divided by 52.

For employees who work less than a full schedule, the figure of 2087 hours should be prorated (e.g., to 1043.5 hours when the employee works four hours per day), then multiplied by the amount shown.

The figure of 2087 hours equals 52 weeks plus .875 of one workday. To calculate increments of pay (night, Sunday, etc.), first multiply the hourly increment by 2087, then divide the sum by 52 to obtain the amount of the weekly increment.

11. Computing Monthly Pay Rate. This paragraph describes how to compute a monthly pay rate, which is used in death cases. To do so, the CE must first determine the employee's "average annual earnings" in the manner provided by Section 5 U.S.C. 8114(d) and the instructions appearing in paragraph 4 above. This figure is then divided by 12. For example, if the average annual earnings are determined to be \$65,000, the claimant's monthly pay rate would be established as \$5,416.67 (\$65,000/12).

12. Special Determinations. This paragraph defines the rules for determining pay rates based on unusual terms of employment, pay scales, or increments of pay.

a. Census Enumerators and Census Field Supervisors - 2020 Census. (Census Field Supervisors were formally known as Crew Leaders in the 2010 Census) Information about calculating compensation for these employees may be found in FECA PM 2-0901-10.

(1) For the 2020 Census, the Bureau of the Census hired individuals in Area Census Offices (ACOs, formally known as Local Census Offices (LCOs) in the 2010 Census) throughout the U.S., including Alaska, Hawaii and Puerto Rico. Most employees in ACOs were either enumerators or census field supervisors on temporary (not-to-exceed 56 days) appointments.

(2) All temporary-hire positions, including enumerators and census field supervisors, were paid on an hourly basis. Wages in the ACOs varied by geographical area, and pay types were assigned accordingly. In addition, the 2020 Census assigned different pay rates to enumerators and census field supervisors in training than to those who actually performed enumerator and census field supervisor duties. Any questions regarding pay rates can be referred to the Bureau of the Census, Decennial Administrative Branch, at (301) 763-4899. Following are the hourly wage rates for enumerators, crew leaders and clerks:

Enumerator: \$13.50 to \$30.00

Enumerator Trainee: \$12.00 to \$27.50

Census Field Supervisor (formerly Crew Leader): \$15.00 to \$33.00

Census Field Supervisor Trainee: \$13.50 to \$29.50

Clerk: \$12.00 to \$24.00

(3) Based on an analysis of the 2010 Census data, the Bureau of the Census determined that, on average, enumerators worked 5.25 hours per day, 4 days per week. The work patterns for the 2020 Census were anticipated to be similar to the 2010 Census. However, individuals may have worked more or less depending on the ACO's operational requirements, and the factual evidence should be evaluated carefully. Because of their irregular Federal employment, these employees are usually paid under the provisions of 5 U.S.C. 8114(d)(3), as outlined in 4(c) of this chapter.

(4) Temporary hire workers may have worked more than one "operation" or assignment during the course of their employment for the census. The CE should evaluate the particular duty requirements for each position when determining whether any collateral or consecutive jobs constitute "same or similar employment" under §8114 of the Act when calculating compensation.

b. Census Enumerators and Crew Leaders - 2010 Census. (For injuries occurring during previous censuses, consult the National Office.) Information about calculating compensation for these employees may be found in FECA PM 2-0901.

(1) For the 2010 census, the Bureau of the Census hired individuals in Local Census Offices (LCOs) throughout the U.S., including Alaska, Hawaii and Puerto Rico. Most employees in LCOs were either enumerators or crew leaders on temporary (not-to-exceed 180 days) appointments.

(2) All temporary-hire positions, including enumerators and crew leaders, were paid on an hourly basis. Wages in the LCOs varied by geographical area, and pay types were assigned accordingly. Any questions regarding pay rates can be referred to the Bureau of the Census, Demographic and Decennial Staff, at (301) 763-9620. Following are the hourly wage rates for enumerators, crew leaders and clerks:

Enumerator: \$10.93 to \$22.10
Crew Leader: \$12.43 to \$23.60
Clerk: \$8.20 to \$15.82

(3) Based on an analysis of the 2000 Census data, the Bureau of the Census determined that, on average, enumerators worked 4.5 hours per day, 4 days per week. The work patterns for the 2010 Census were anticipated to be similar to the 2000 Census. However, individuals may have worked more or less depending on the LCO's operational requirements, and the factual evidence should be evaluated carefully. Because of their irregular Federal employment, these employees are usually paid under the provisions of 5 U.S.C. 8114(d)(3), as outlined in 4(c) of this chapter.

(4) Temporary hire workers may have worked more than one "operation" or assignment during the course of their employment for the census. The CE should evaluate the particular duty requirements for each position when determining whether any collateral or consecutive jobs constitute "same or similar employment" under §8114 of the Act when calculating compensation.

c. Special Census Employees. The Census Bureau sometimes enters into contracts with state, county and city governments to conduct various types of surveys. Most of the workers are hired for very short periods of time, and they are paid directly by the local entity conducting the study. As they are covered under separate legislation, it has been determined that they are not eligible for COP (Reference 20 CFR §10.200). The CE should follow the guidance given above in paragraph 4 to establish their average annual earnings.

Exhibit 1 - DETERMINING EFFECTIVE PAY RATE DATE FOR SCHEDULE AWARDS

Traumatic Injury Claims -

With prior disability:

Pay Rate Date = DOI, DDB, or DOR (whichever is greatest)
SA Start Date = DMI (date of maximum medical improvement)
CPI Start Date = DOI, DDB, or DOR (pay rate effective date)

Without prior disability:

Pay Rate Date = DOI
SA Start Date = DMI
CPI Start Date = DMI

Occupational Disease Claims -

With prior disability, working full duty (still exposed to injurious work factors) at time of rating exam:

Pay Rate Date = DOI, DDB, or DOR (whichever is greatest)
(DOI = Date of Last Exposure (DLE) = Date of Impairment rating exam)
SA Start Date = DMI
CPI Start Date = DOI, DDB or DOR (pay rate effective date)

With prior disability, not working or working limited duty at time of rating exam:

Pay Rate Date = DOI, DDB, or DOR (whichever is greatest)
SA Start Date = DMI
CPI Start Date = DOI, DDB or DOR (pay rate effective date)

Without prior disability:

Pay Rate Date = DOI
(DOI = DLE = Last date exposed to causal employment factors in full-duty capacity or date of medical exam if still exposed)
SA Start Date = DMI
CPI Start Date = DMI

Occupational Hearing Loss and Asbestosis Claims -

When claimant is disabled due to occupational hearing loss or asbestosis:

Pay Rate Date = DOI, DDB, or DOR (whichever is greatest)

SA Start Date = DMI

CPI Start Date = DOI, DDB or DOR (pay rate effective date)

When there is no disability, claimant has continuing exposure:

Pay Rate Date = DOI

(DOI = DLE = date of last exposure before diagnostic exam - audiogram/chest x-ray)

SA Start Date = DMI

CPI Start Date = DMI = date of audiogram or chest x-ray

When there is no disability, retired:

Pay Rate Date = DOI

(DOI = date of retirement or last documented date of exposure to hazardous noise or asbestos)

SA Start Date = DMI

CPI Start Date = DMI = date of last audiogram or chest x-ray

* The SA start date can be moved forward in time if documented in the case file. However, it cannot be moved back in time. See PM 2-808-7.

Chapter 2-0901, Compensation Claims

1. Purpose and Scope. This chapter discusses the development of compensation claims, explains how to calculate compensation, and provides formulas for calculating basic entitlements. This chapter also covers payment certification, waiting days, work days/calendar days, compensation rates, minimum and maximum compensation limits, deductions for insurance, Consumer Price Index (CPI) increases, payees other than the claimant, leave buy-back (LBB), and wage loss for medical appointments.

Information related to compensation payments may also be found in other chapters of the FECA PM.

- a. Pay rates are discussed in FECA PM 2-0900, Calculating Pay Rates.
- b. Continuing payments on the periodic roll (PR) are addressed in FECA PM 2-0812.
- c. Schedule awards are addressed in FECA PM 2-0808.

- d. Compensation in death cases is addressed in FECA PM 2-0700.
- e. Dual benefits and elections between various entitlements are discussed in FECA PM 2-1000.
- f. Lump-sum payments are discussed in FECA PM 2-1300.

2. Responsibilities.

a. Adjudication. Claims Examiners (CEs) are responsible for adjudicating each claim for compensation. Claims that are not payable upon receipt should be developed and then adjudicated after the allotted time for a response (generally 30 days) has passed. If the claim is not payable, a formal decision is required. If the claim is payable, the CE is responsible for calculating and paying compensation.

The adjudication and case status codes should be updated in the case management system when a claim is adjudicated. These codes are discussed in FECA PM 2-0401.

b. Calculation. The CE is responsible for determining all factors involved in calculating payments, to include the pay rate, compensation rate, number of days, insurance deductions, etc. The CE may also be responsible for the manual calculations in some cases where the automated system cannot perform the calculations.

Fiscal personnel may also be involved in various parts of this process, including the manual calculation of payments. Any manual calculation should be documented in the file.

c. Data Entry. Once the CE has determined each element of the payment and documented all elements of the payment appropriately, the CE is responsible for entering payment data directly into the case management system in order to initiate the payment.

The CE should verify the claimant's current payment address, which may be different from the mailing address, prior to initiating a payment. If the address is incorrect, the address must be updated and certified prior to making the payment. The CE should also verify whether the claimant has electronic funds deposit (EFT), and ensure that the claimant's account information is recorded in the compensation management system.

3. Certification. Payments will not be issued without being properly certified. By certifying a payment, the certifier is verifying that the adjudication and calculation of the payment (including all pay elements) are correct, that all payment data is entered correctly in the case management system, and that all pay elements entered correspond with the documentation in the file.

a. Certification levels are as follows, though an individual may be specifically delegated to certify payments at a higher level for a period of time by his or her supervisor:

- (1) General GS-12 CEs may certify payments up to \$20,000.

(2) A Quality Assurance and Mentoring Examiner may certify payments up to \$50,000.

(3) Payments over \$50,000 must be certified by a Supervisory CE, GS-13 or above.

(4) Payments over \$99,999 must be certified by the District Director (or Assistant District Director).

b. Types of Payments.

(1) Lump-sum schedule award payments must be certified by a Supervisory CE or higher-level authority. See PM 2-1300.

(2) The following payment types must be certified by a Quality Assurance and Mentoring Examiner or higher. No delegation is authorized.

(a) Initial Payments

(b) Placement on the Periodic Roll for Loss of Wage-Earning Capacity (LWEC)

(c) Survivor compensation

(3) The following payment types must be certified by a GS-12 CE or higher-level authority. A Supervisory CE may individually grant certification authority to a GS-11 Claims Examiner for the following payment types.

(a) Placement on the Periodic Roll (excluding LWEC)

(b) Payment adjustments (e.g. changes to compensation rate, pay rate, etc.)

(c) Leave buy back

(d) Continuing payments for temporary total disability (TTD)), LWEC or intermittent wage loss

(e) Schedule Awards

(f) Death expenses (burial and administrative)

(4) Self-Certification. A GS-12 CE or higher-level authority may be authorized to self-certify ongoing payments for temporary total disability or intermittent wage loss (excluding LWEC payments) unless there is a change in the official pay rate. In addition, a Supervisory CE or higher-level authority may also individually grant self-certification permission to a GS-11 CE.

4. Receipt of Claims.

a. Initial Claim for Compensation after Continuation of Pay (COP). In traumatic injury cases, as outlined in FECA PM 2-0807, if medical evidence demonstrates that disability is expected to

continue beyond 45 days, the Employing Agency (EA) should give Form CA-7 to the employee by the 30th day of the COP period and submit the completed form to the OWCP by the 40th day of the COP period, if a completed form is returned by the employee. See 20 C.F.R. §10.111(b).

(1) If an initial Form CA-7 is received immediately following the COP period, the CE may use the authority provided by the FECA to approve a payment for a period not to exceed 15 days into the future (15 days post termination of COP) if disability for the period is medically supported, and the EA verifies that the claimant has not returned to work at the time the payment is processed. (This authority does not extend to occupational disease claims and applies only to the initial 15-day period following COP in cases of traumatic injury.)

(2) Payment may be approved even if the Form CA-7 received was signed prior to the dates claimed. If the claim was submitted in advance, however, the CE should verify that the employee has not returned to work at the time of processing the payment. If a payment is processed with future dates, the CE should advise the claimant in writing of his/her obligation to advise the OWCP immediately if he/she returns to work, since an overpayment could be created. Payment should not be authorized if the attending physician states that the employee can return to duty but the employee does not return, makes an unauthorized change in physicians, and subsequently submits medical evidence of disability from the second physician.

See FECA PM 2-0807-15 for a complete discussion of the initial claim for compensation after COP.

b. All other Initial and Subsequent Claims for Compensation. 20 C.F.R. §10.102(b)(1) provides that it is the employee's responsibility to submit Form CA-7 for any period of disability. Without receipt of such claim, the OWCP has no knowledge of continuing wage loss. Therefore, while disability continues, it is expected that the employee should submit a claim on Form CA-7 each two weeks until otherwise instructed by the OWCP.

(1) The discretion to process a payment for dates into the future applies only to initial claims for compensation following COP in traumatic injury cases, as outlined above. For all other claims, the EA must verify work/leave status when submitting the form, and this can only be done once the period has passed.

(2) The CE can key a payment through the date the EA signed the form only if the medical evidence supports the claimed disability. See paragraph 5a below. The EA must verify Leave Without Pay (LWOP) status when submitting this form, and this can only be done once the period has passed; LWOP status cannot be verified into the future.

(3) If the entire period claimed cannot be paid, the CE should "split" the claim prior to keying the payment so that the initial period can be paid and the remaining period for dates into the future can be coded as Not Payable. The claimant should then be advised via letter to submit a new claim for the additional dates once the period has passed.

(4) If a claim is received and all dates claimed are in the future, the Form CA-7 can be coded as Not Payable. The claimant should be advised via letter to submit a new claim once the period has

5. Development of Compensation Claims. Development may be required to adjudicate the claim, make the payment, or both. Therefore, it will be necessary for the CE to request additional information when a claim for compensation is received, but there is insufficient evidence of record to pay the claim.

a. Initial Review. Prior to adjudicating a claim for compensation, the CE must determine if the medical and factual evidence of record supports the claim that has been submitted.

(1) The factual evidence must establish that the claimant actually lost time from work on the dates claimed. Clear verification of dates and hours lost should be provided by the EA on the Form CA-7, Form CA-7a, and/or any supporting documentation. If the EA did not verify the claimed dates, or if the verification is ambiguous, clarification is necessary. If not clear, the CE should also verify the dates of Continuation of Pay (COP) and any leave used following the injury.

The factual evidence may also require development if the Form CA-7 or other documentation in the case file indicates the claimant has (1) other employment, or (2) is in receipt of a prohibited dual benefit (such as a retirement annuity from the Office of Personnel Management) during the period claimed.

(2) The medical evidence must establish that the lost time claimed was the result of the accepted work injury.

(a) To be eligible for compensation, the medical evidence should support that the claimant is disabled as a result of the accepted work injury. The evidence should either establish that the claimant is precluded from performing any type of work, or that the claimant has work restrictions due to the injury that the employing agency is not able to accommodate.

(b) To be eligible for compensation for lost time from work due to a medical examination or treatment, the medical evidence should establish that the claimant attended an examination or treatment for the accepted work injury on the date(s) claimed. These cases are further discussed in paragraph 19 of this chapter.

(3) If the evidence submitted supports the claim for compensation, the CE can proceed with calculating the compensation due and initiating the payment. Clarification may be needed, however, to obtain the information necessary to make the payment.

(4) If the evidence submitted does not support the claim for compensation, the CE must develop the claim before payment can be considered. Development may also be needed to obtain the information necessary to make a payment, and this should be requested simultaneously with the evidence needed to support the claim so that payment can be made quickly if the compensation claim is ultimately approved.

b. Development Actions. If it is determined that additional evidence is necessary before a claim for compensation can be adjudicated or a payment can be processed, the CE should decide from whom to request this information, and the most appropriate and efficient method for obtaining it

so that the payment can be processed as soon as possible. CEs should avoid requesting evidence which is already contained in the file or for which no need is anticipated.

(1) Obtaining Evidence from the Claimant. If the evidence of file is insufficient to support the period claimed, the CE should provide the claimant (and authorized representative, if any) with notice and an opportunity to respond and furnish the required evidence. The request should be tailored to the specifics of the case and clearly explain that failure to submit the necessary information within 30 days may result in the denial of the specific claim for compensation.

At times the CE may contact the claimant via telephone if only basic information is needed, but usually the type of evidence needed from the claimant to support a compensation claim is best obtained in writing, e.g. medical evidence to support disability, factual evidence concerning any employment during the period claimed, etc.

(2) Obtaining Information from the Employing Agency (EA). If the CE needs pay or benefits information from the EA prior to making a payment, calling the EA to obtain the information and then documenting the file with a CA-110 (pending receipt of written confirmation) is preferred (as opposed to requests made via mail) so that payments can be made as quickly as possible. This communication can also be accomplished via secure email with the EA to and from a government network.

If the EA does not respond timely to these requests, the CE should request the required information via letter, and a copy of this letter should be forwarded to the claimant. Note - While it may be necessary to send a letter to the EA for pay information, this typically should not delay an initial payment to the claimant, since in most instances payment can be made using a temporary (base or minimum) pay rate while awaiting more precise pay information.

Evidence submitted by an EA that is supported by records will usually prevail over statements from the claimant, unless such statements are supported by probative evidence.

(3) For a claim to be placed into development status, a specific development action should coincide with the date of the status, e.g. a letter to the claimant requesting medical evidence to substantiate disability for the period claimed. A telephone call to the claimant or EA may be used to obtain necessary information quickly, but may not be used as the basis for placement in development status.

(4) If a claim for compensation is received with the initial claim for injury (or any time prior to acceptance of the case), the compensation claim should be placed into a development status, but a determination should be delayed until the case is adjudicated. The claimant should be notified that any claims received prior to adjudication of the claim will be reviewed if the case is accepted. If the case is later accepted, the claim for compensation should be considered at that time. If the case is later denied, the claim status should be updated to reflect the denial and no further action is needed.

These same basic procedures should also be followed if claims for compensation are received with (or after) a Form CA-2a, Claim for Recurrence.

c. If a portion of the claim can be paid, the CE should pay the period that can be paid while simultaneously developing the period that cannot be paid. The CE should not delay in making a payment for any period that can be paid while awaiting information to substantiate the entire period.

Additionally, if pay rate or other payment information is partially missing, the CE should process a payment based on the evidence of record while simultaneously developing for the deficiencies, as long as such a payment would not be expected to create an overpayment.

For example, if the EA provides base pay information and not night differential (ND) information for a claimant that works evenings, the CE should process the payment using the base pay rate while simultaneously requesting ND information from the EA. Alternatively, if a child between the age of 18 and 23 is the sole claimed dependent but student status is not yet established, the CE should process payment at the lower 66 2/3 compensation rate while simultaneously developing to determine if the claimant is entitled to augmented compensation.

d. Follow up actions. Every reasonable effort should be made to expedite the receipt of the evidence needed in order to process claims and issue payments promptly.

If after the 30 days has passed, the evidence of file:

(1) Substantiates the claimed period – the CE should proceed with calculating and initiating the payment.

(2) Does not support payment of the claim - the CE should issue a formal denial outlining the deficiencies and provide the claimant with appeal rights. For more information on formal denials, see FECA PM 2-1400.

(3) Substantiates a portion of the period claimed - the CE should proceed with payment of that period and issue a formal denial for the period not supported. Note that a claim for medical appointments may be paid if supported by the evidence of record, even if a period of disability is denied.

A formal denial should only be issued when the deficiency is the result of the claimant's failure to establish the claim. A formal denial should not be issued when the deficiency is the sole result of the EA's failure to provide necessary information in response to a request from the OWCP.

e. Disability Management. If a claim for wage loss is paid and the claimant has not returned to work in a full-duty capacity, Disability Management actions should commence. See FECA PM 2-0600.

6. Factors in Calculating Compensation. Several factors are involved in the calculation of a payment as established by the FECA. The CE must ensure the case file contains information regarding these elements prior to issuing a compensation payment. These factors include:

- a. The pay rate on which to base compensation. See FECA PM 2-0900.
- b. The period of entitlement. See paragraph 7.
- c. Whether payment will be made on the basis of work days or calendar days. See paragraph 8.
- d. Whether the three-day waiting period is applicable and the dates covered. See paragraph 11.
- e. The compensation rate (percentage of pay), including minimum and maximum payments. See paragraphs 12-14.
- f. Whether the claimant is enrolled in a health benefits insurance (HBI) and/or life insurance (LI) plan and, if so, the period for which premiums should be deducted. See paragraph 15.
- g. The payee, if not the claimant, and whether additional miscellaneous deductions are necessary for child support, overpayments, etc., and, if so, the applicable amount payable. See paragraph

7. Period of Entitlement. The length of time for which compensation may be paid can be a period of time in the past, or it can extend indefinitely into the future. The CE is responsible for specifying the dates of payment, as follows:

a. Periodic Roll – When the medical evidence indicates that disability is expected to continue for more than 60-90 days, compensation should usually be paid on the periodic roll (PR). When a claimant is placed on the PR, an initial payment is made for any period due in the past, and then the claimant receives ongoing payments every 28 days according to the compensation schedule. Compensation continues until action is taken by the CE to terminate such payments.

b. Daily Roll - When the initial anticipated period of disability is unclear, or disability is expected to continue for fewer than 60-90 days, compensation should usually be paid on the daily roll. Any payments processed on the daily roll are released once per week. These are one-time payments.

(1) The CE will provide a beginning date and an ending date for the period.

(2) The CE must also decide whether to pay the claim based on work days or calendar days. See paragraph 8.

c. Intermittent hours – Payment should be made on the daily roll for intermittent hours lost when a claim is made for intermittent hours only, i.e. partial days or partial hours lost during a period. Payment for straight total disability should not be made on hours lost. See Paragraph 9.

(1) The total number of hours missed should be calculated, and portions of an hour should be keyed as a decimal. For example, when entering a payment for 4¼ hours, it should be keyed as 4.25 hours.

(2) If a claimant with an intermittent or irregular work schedule submits a claim for intermittent hours lost, the CE should compute entitlement for that period using the Shadrick formula. For example, an RCA whose pay rate is based upon year-prior earnings works a varied schedule from week to week, or a firefighter who often works greater than 40 hours per week. Payment for intermittent hours lost cannot be made on a weekly schedule of more than 40 hours.

8. Work Days/Calendar Days. A "work week" includes only the regularly scheduled work days, while a "calendar week" includes all seven days, including off-duty days.

The employee's regular schedule can be determined from Form CA-7, Section 9; Form CA-2a, items 28 and 29; or narrative evidence. The schedule can also be obtained from the Form CA-1 or Form CA-2, but the CE should take care to use the most contemporaneous evidence of file, since schedules may change over time. Any discrepancies should be resolved by the CE, usually by contacting the EA, and the case record must be documented with this evidence.

a. Work Days. If compensation is paid in a disability case, and the claimant has a regular work schedule, the claimant should be paid for each actual work day lost. A "regular work schedule" is one in which the claimant works the same fixed days each week. If the claimant's normal work week is five days, the OWCP pays one-fifth of the weekly compensation for each lost work day. This is the "work day" basis of payment.

Computation is as follows: $\text{Weekly pay rate} \times \text{compensation rate} = \text{amount (rounded to the nearest \$0.01)} \times \text{no. work days lost} \div \text{no. work days in work week}$.

b. Calendar Days. If the employee has an irregular work schedule, or if the claimant is placed on the PR for temporary total disability, payment is made on a "calendar day" basis. An "irregular work schedule" is one in which the claimant works different days each week, has a rotating day off, or is otherwise variable. The claimant receives pay for every day of the week during the period of disability, at the rate of one-seventh of the weekly compensation rate for each day.

Computation is as follows: $\text{Weekly pay rate} \times \text{compensation rate} = \text{amount (rounded to the nearest \$0.01)} \times \text{no. days of entitlement} \div 7 \text{ days per week}$.

c. The CE must specifically choose either work days or calendar days as the method of calculation when initiating the payment. When choosing the work days method of payment, the CE must be sure to accurately enter the claimant's schedule (days per week and hours per day) when initiating the payment.

d. Flexible Work Schedules. Some employees work their usual number of hours per week or per pay period on a flexible work schedule (flextime). This arrangement may be informal, allowing the employee to work less or more than eight hours each day, within certain limitations, as long as a biweekly total of 80 hours (for a full-time employee) is met.

When entering a work schedule, the CE should use the number of days/hours which would correspond with the usual number of hours worked per week, with the number of hours worked per week evenly distributed throughout the week. For instance, an employee who works 40 hours

per week (even with a flextime option) is considered to have a work week of five days, eight hours per day. That schedule can be entered and payment can be made based on work days.

9. Basic Calculations. Compensation is calculated using different methods depending on the claimant's work schedule and time lost from work. Compensation for disability is usually calculated on a weekly basis, though payments are sometimes made on a daily basis. Compensation in death cases is computed on a monthly basis. See FECA PM 2-0700 for more detail on calculating benefits in death cases.

a. Daily Basis. Using the daily pay rate, compensation is paid for the regularly scheduled work days on which the employee was disabled due to the injury. The CE determines the employee's basic work week and regular days off as outlined in FECA PM 2-0900 to pay compensation on this basis. FECA PM 2-0900 addresses when it is appropriate to use the daily basis to pay compensation.

b. Weekly Basis. Most temporary total disability cases, and all cases where the injury causes permanent total or partial disability and temporary partial disability, are paid on a weekly basis. Compensation for a full work week is calculated according to either work days or calendar days, as discussed in paragraph 8 of this chapter.

c. Compensation for less than a full work week is paid for the regularly scheduled work days on which the employee was disabled due to the injury, rather than the calendar week. (See Cecil W. Wood, 22 ECAB 257 (1971).) The CE will need to determine the claimant's regularly scheduled work week prior to initiating a payment. Compensation should be paid only for the regularly scheduled work days that the claimant missed.

For any period less than a full work week, or for any individual whose work days do not comprise a full work week, the formula for calculating compensation is:

Weekly pay rate x compensation rate = amount (rounded to the nearest \$.01) x no. work days lost ÷ no. work days in work week.

d. Compensation payable for less than a full work day is calculated as follows:

Weekly pay rate x compensation rate = amount (rounded to the nearest \$.01) x no. hours lost ÷ no. hours in work week

For example, compensation for three hours of pay loss, with a weekly pay rate of \$400.00 for 40 hours of work, at the basic rate of compensation, is calculated as follows:

$\$400.00/\text{week} \times 2/3 = \$266.67$; $\$266.67 \times 3 \text{ hours lost} \div 40 \text{ hours/week} = \$20.00$.

10. Special Determinations. This paragraph describes the rules for calculating compensation to certain groups of employees.

a. Decennial Census Workers. Pay rates for these employees are addressed in FECA PM 2-0900-12.

(1) Temporary Workers.

(a) Where disability does not exceed 90 calendar days, compensation can be paid on a daily basis according to 5 U.S.C. 8114(c).

(b) For the 2000 Census, enumerators and crew leaders ordinarily worked 6.5 hours per day, six days per week.

(c) For the 2010 Census, enumerators and crew leaders ordinarily worked an average of 4.5 hours per day, four days per week.

(d) For the 2020 Census, enumerators and census field supervisors ordinarily worked an average of 5.25 hours per day, four days per week.

(e) Where disability extends beyond 90 days, and the claimant had similar employment during the year prior to the injury, compensation should be paid according to section 5 U.S.C. 8114(d)(1) and (2).

If there was no provision to pay under §8114(d)(1) and (2), or disability extended beyond 90 days, compensation for wage loss should be paid on a weekly basis using the following formula: 150 x the actual daily wage divided by 52 (the actual daily wage should be determined by multiplying the hourly pay rate by the number of hours scheduled per day).

(2) Compensation should be determined using 5 U.S.C. 8114(d)(1) and (2) for clerks, lead clerks, data entry clerks, and lead data entry clerks who are disabled longer than 90 days and who have had similar employment which demonstrated that they worked full time during the previous year.

(3) Regular full-time Census employees eligible for HBI, LI, and retirement should have pay calculated according to the provisions of 5 U.S.C. 8114 (d)(1) or (2).

b. Firefighters.

(1) Regular Firefighters. These employees normally work three 24-hour shifts per week. Compensation entitlement should be calculated using the number of hours lost divided by 24 hours to arrive at the number of "work days" lost. The result of this calculation should be divided by three, which represents the number of work weeks lost. The result should be multiplied by 3/4 or 2/3 of the pay rate to arrive at the amount of compensation to be paid.

This formula is:

Hours lost ÷ 24 hours = Work days lost

Work days lost ÷ 3 (shifts per week) = Work weeks lost

Weekly pay rate X compensation rate = amount (rounded to the nearest \$.01) x work weeks lost
= compensation due

(2) Emergency Firefighters. The work day and work week for firefighters recruited on an emergency basis by the Forest Service, National Park Service, and Bureau of Land Management (other than those who are "career seasonal" as outlined in FECA PM 2-0900) may exceed eight hours per day and five days per week.

On an actual daily basis, the daily pay rate is the number of hours actually worked times the hourly pay rate reported, and compensation will be computed on the work week reported. In other cases, the minimum weekly pay rate is determined by the following formula:

Hourly wage X no. of hours per day X 150 days ÷ 52 weeks per year

Where more than eight hours are worked per day, actual hours worked shall be used in the calculation.

If the EA reports an additional allowance for subsistence or quarters, or if premium pay is received because of standby status, the amount(s) should be included in the pay rate.

11. Waiting Days. Under §8117 of the FECA, waiting days are the first three days of injury-related disability. Waiting days are counted differently for employees of the US Postal Service (USPS) and employees of other agencies. See 20 C.F.R. §10.401(a).

a. Non-Postal Employees.

(1) Section 8117(a) of the FECA provides that an employee is not entitled to compensation for the first 3 days of temporary disability, except:

- (a) when the disability exceeds 14 days;
- (b) when the disability is followed by permanent disability; or
- (c) when seeking medical treatment, supplies or related medical services.

(2) Determining Waiting Days in non-Postal cases.

- (a) This provision applies regardless of whether the three days are regularly scheduled non-work days (e.g., Saturday and Sunday) or holidays.
- (b) Non-work days occurring prior to or during any period of COP or leave use should not be considered as waiting days.
- (c) Non-work days and holidays that fall within a period of disability from work count toward the 14-day total.

(d) Disability days do not need to be consecutive to count toward the 3 waiting days or 14-day minimum.

(e) Waiting days should not be applied where time lost was solely due to the employee's absence for medical treatment, as time lost for medical appointments is not considered disability.

(f) If a claim, or portion of a claim, is not payable because of the three waiting days, the claimant should be notified of this provision and reason for non-payment.

(g) If the claimant later sustains 14 days of disability, the three waiting days are restored and should be paid at that time.

b. Postal Employees. The Postal Accountability and Enhancement Act of 2006 (Title IX) altered the three-day waiting period for USPS employees. It provides that for USPS claimants, the three-day waiting period applies at the beginning of the disability period, regardless of the type of injury sustained.

The claimant will not receive COP until the fourth day of disability. If disability extends beyond fourteen days, the Postal Service will offer the claimant the choice to change the three waiting days to COP. If the claimant is not entitled to COP, or the three-day waiting period was not met during the COP eligibility period, the three-day waiting period will be applied by the OWCP upon receipt of a claim for wage loss due to disability. Just as with non-Postal employees, waiting days should not be applied where time lost was solely due to the employee's absence for medical treatment, as time lost for medical appointments is not considered disability.

(1) In traumatic injury cases, the waiting period applies to the beginning of the COP period. The claimant must elect annual leave (AL), sick leave (SL), or Leave Without Pay (LWOP).

(2) In occupational disease cases, the choice at the beginning of disability will remain as AL, SL, or LWOP.

12. Compensation Rate. The compensation rate is the percentage of pay to which a claimant is entitled for periods of disability and medical treatment. There are two compensation rates when calculating claims for time loss. The basic compensation rate is 66 2/3 percent of the claimant's wages. The augmented rate is 75 percent of the claimant's wages and is based on whether the claimant has one or more eligible dependents as defined in section 8110 of the FECA. See 20 C.F.R. §10.401(b).

a. No Dependents. Section 8105 of the FECA establishes the basic compensation rate of 66 2/3 percent for payment of compensation. The claimant is entitled to the basic rate if he/she does not have an eligible dependent as defined in 5 U.S.C. 8110.

b. Spouse. If the claimant is legally married, including to a spouse of the same sex, he or she is eligible for augmented compensation (at the 75% rate) as long as one of the three criteria outlined in §8110 of the FECA is met:

- (1) He/She is a member of the same household as the claimant, or
- (2) He/She is receiving regular contributions from the employee for his/her support, or
- (3) The claimant has been ordered by a court to contribute to his/her support.

NOTE: On June 26, 2013, in United States v. Windsor, the Supreme Court ruled that Section 3 of the Defense of Marriage Act (DOMA) is unconstitutional; that section limited the definition of spouse to a person of the opposite sex and prohibited the federal government from recognizing, and providing benefits on the basis of, lawful same-sex marriages. Where a claimant previously precluded from seeking benefits based on Section 3 of DOMA establishes a same sex marriage, augmented compensation (if not previously granted due to the existence of another eligible dependent such as a child) will be granted retroactively back to the date of the valid same sex marriage or the triggering event for payment, whichever is later. See FECA Bulletin No. 14-01.

Domestic partnerships (whether same-sex or opposite-sex), are still not eligible for augmented compensation under FECA. Augmented compensation also continues to be unavailable to all ex-spouses, whether same-sex or opposite-sex even if support payments are being made. See Raymond Kaufman, Docket No. 04-104 (issued March 2, 2004) (ECAB held that as appellant was no longer married, his former spouse did not qualify as a "dependent," and his support payments to her did not entitle him to augmented compensation).

An indication on a claim form, such as a Form CA-1 (Notice of Injury and Claim for Compensation) or Form CA-7 (Claim for Compensation), is usually sufficient to verify marital status, since both forms require certification of the information provided via the claimant's signature and have warnings pertaining to false statements. If evidence to the contrary is present, however, the CE should develop the issue further and may request documentary evidence such as a marriage certificate. If necessary, the employing agency may assist in verifying marital status in the initial stages of the claim.

c. Children. Section 8110 of the FECA provides that a claimant is entitled to the 75% augmented compensation rate for one or more child (see 20 C.F.R. §10.405) who is:

- (1) Not married; and
- (2) Living with the employee or receiving regular contributions from the employee toward his/her support, as long as the child is under 18 years of age or over 18 years of age but incapable of self-support due to a physical or mental disability.

The claimant's eligibility for augmented compensation for a dependent child terminates on the date of the child's marriage.

Where only one dependent is claimed and that person is a child over the age of 18, the CE must ensure that entitlement exists. See sections d and e, below.

d. Student Status. Augmented compensation being paid based on the claimant's unmarried child, which would otherwise be terminated when the child turns 18, may continue if the child is a student pursuing a full-time (as verified by the institution) course of study or training at an accredited institution. Such benefits may be paid for four years of education beyond the high school level, or until the child reaches age 23, whichever comes first.

(1) A "year of education beyond the high school level" is defined at 20 C.F.R. §10.5(aa)(2) to include:

(a) The 12-month period beginning the month after the child graduates from high school, if the child has indicated an intention to continue schooling during the next regular session, and each successive 12-month period, provided that school attendance continues; or

(b) The 12-month period beginning the month the child actually enters school, if the child had originally indicated that he or she would not continue schooling within four months of graduating high school, and each successive 12-month period, provided that attendance continues.

(2) Each year during all or part of which compensation is paid based on school attendance constitutes a year of entitlement to student status. If a child should decide for any reason not to attend school for part of a year during which augmented compensation was paid on account of student status, the claimant would be charged with having used an entire year of eligibility out of the allotted four years, even though compensation terminates when the child leaves school. If a child has already completed one or more years of college before turning 18 years old, those years would be deducted from the four years of entitlement.

(3) Augmented compensation may continue during any interval between school terms which does not exceed four months if the child demonstrates a bona fide intent to continue in school the following year. In the absence of specific contrary evidence, the CE may consider the student's decision to begin or continue full-time studies a bona fide statement of intent.

(4) Where a student is prevented by reasons beyond his or her control (such as brief but incapacitating illness) from continuing in school, augmented compensation may be continued for a period of reasonable duration. However, any such period would be counted toward the four years of entitlement. The CE will determine what constitutes "reasons beyond the control" of the student and decide what may be considered a period of reasonable duration during which augmented compensation may continue. The CE should document the file outlining the circumstances of the case and the reasons for the decision.

(5) An institution for study or training consists of:

(a) A school, college or university operated or directly supported by the United States, a state or local government, or political subdivision thereof;

(b) A school, college or university accredited by a state or by a state or nationally-recognized accrediting agency or body;

(c) An unaccredited school, college or university whose credits are accepted, on transfer, by at least three accredited institutions on the same basis as if transferred from another accredited institution; or

(d) A technical, trade, vocational, business or professional school accredited or licensed by the United States Government, a state government, or other related government entity that provides courses at least three months long, and prepares an individual for work in a trade, industry, vocation or profession. See 20 C.F.R. §10.5(aa)(1).

(6) The CE should request proof of student status shortly before a child reaches the age of 18 if augmented compensation is being paid solely on the basis of a dependent whose dependency status rests on the "student" requirement. The CE should request verification of the student status as long as compensation is being paid at the augmented rate based on this "student" criteria. A request should be released for completion on a yearly basis; the claimant is required to report any changes to student status in the interim.

See PM 2-0812 for further information on the requirements for monitoring dependent status.

(7) If the child is still a student upon turning 23 years old, augmented compensation should terminate at the end of that semester or enrollment period.

e. Children Over 18 Incapable of Self-Support. When augmented compensation is claimed based on a child who is over 18 years old but physically or mentally incapable of self-support, the CE must investigate the extent and expected duration of the illness involved.

(1) To be entitled to benefits, the child over 18 years old must be incapable of self-support by reason of a mental or physical disability. Augmented compensation is not payable for a child over 18 years old who is unable to obtain employment due to economic conditions, lack of job skills, etc.

(2) A child is incapable of self-support if his or her physical or mental condition renders him or her unable to obtain and/or retain a job, or engage in self-employment that would provide a sustained living wage. This determination must be based on medical evidence. When medical evidence demonstrates incapacity for self-support, this determination will stand unless refuted by sustained work performance.

A medical report covering the child's past and present condition must be submitted for review to determine whether it establishes incapacity for self-support. A physician's opinion must be based on sufficient findings and rationale to establish lack of employability. If the CE needs assistance with review of the medical condition or report, the case may be referred to the District Medical Advisor (DMA).

(3) A request should be released on a yearly basis asking the claimant to submit a medical report verifying that the dependent's medical condition persists, and that it continues to preclude self-support. As outlined in PM 2-0812, such a request should be sent each year for the duration of

entitlement to augmented compensation on the basis of a dependent over the age of 18 being incapable of self-support.

As outlined in 20 C.F.R. §10.417(d), if the status of such a dependent is unlikely to change, the claimant may establish the permanency of the condition by submitting a well-rationalized medical report which describes that condition and the ongoing prognosis of that condition. Once the permanency of the condition is established, the CE does not need to seek further information regarding that condition; however, if there is a change in that condition, the claimant is required to immediately report that change to the OWCP. If the permanency of such a condition is established, the CE should prepare a memorandum to the file for concurrence by the Supervisory Claims Examiner.

f. Wholly-Dependent Parent. When augmented compensation is claimed based on a parent, the CE must investigate whether and determine that the parent is wholly dependent upon and supported by the claimant.

(1) Proof of parentage is established by a birth certificate for the employee or, in the case of adoption, copies of the legal documents. In the case of a step-parent, the file must contain proof of the step-parent's marriage to the natural or adoptive parent of the claimant, along with the birth certificate indicated above.

(2) Parents in receipt of other monetary benefits, such as Social Security or a retirement pension, are not considered wholly dependent on the claimant. Augmented compensation cannot be granted in these circumstances.

13. Minimum Compensation (MIN). The minimum rate of compensation for disability, death or medical treatment is 75 percent of the lowest pay for a GS-02 Federal employee. See 20 C.F.R. §10.406. This figure changes with the Federal pay scale.

The MIN is compared to the compensation rate in a disability case, and to the pay rate in a death case. [Exhibit 1](#) provides a detailed listing of yearly MIN rates.

a. Statutory Provisions. The MIN was established by the 1966 amendments to the FECA. Section 8112 of the FECA states that in cases of total disability and death, except in cases of non-citizen employees, the monthly rate of compensation for disability, including augmented compensation for eligible dependents, but not including additional compensation for attendant allowance, may not be less than the lesser of:

(1) 75 percent of the monthly pay of the minimum rate of basic pay for GS-2, or

(2) The amount of the monthly pay of the employee.

b. In a disability case, the MIN in effect during the period of entitlement is compared to the claimant's weekly compensation.

(1) If the weekly pay is more than the MIN, but the weekly pay multiplied by the applicable compensation rate (66 2/3 or 75 percent) would be less than the MIN, the claimant receives the MIN instead of the calculated compensation.

(2) If the weekly pay is less than the MIN, the claimant receives 100 percent of the pay rate, instead of the 66 2/3% (basic) or 75% (augmented) rate.

c. In disability (and death) cases, the "100 Percent Rule" applies, which caps the compensation rate at 100 percent of the pay rate.

d. The MIN is always compared to the amount of compensation, including Consumer Price Index adjustments (CPIs). Because CPIs are applied to compensation, compensation for disability usually exceeds the MIN after the first year.

e. The MIN does not include locality pay adjustments. 20 C.F.R. §10.406.

f. The MIN does not apply to Job Corps or foreign national claims. When making payments for these cases, the CE should enter an activity code in the case management system to prevent overpayments. See [Exhibit 4](#).

g. The MIN does not apply to schedule awards.

h. The compensation management application automatically calculates the MIN rate when payments are entered and makes the appropriate comparisons.

14. Maximum Compensation (MAX). The maximum rate of compensation for disability, death or medical treatment, is 75 percent of the monthly salary of a GS-15, step 10. This figure changes with the Federal pay scale. [Exhibit 2](#) provides a detailed listing of yearly MAX rates.

a. Statutory Provisions. The MAX was established by the 1966 amendments to the FECA. Section 8112 of the FECA states that, except in cases of non-citizen employees, the monthly rate of compensation for disability, including augmented compensation for eligible dependents, but not including additional compensation for attendant allowance, may not be more than 75 percent of the monthly pay of the maximum rate of basic pay for GS-15.

Section 8112 provides only one exception to this rule in that any employee whose disability is a result of an assault which occurs during an assassination or attempted assassination of a Federal official described under section 351(a) or 1751(a) of title 18, shall not be subject to the MAX.

b. Allowable Compensation Rate. In a disability case, the MAX in effect during the period of entitlement is compared to the claimant's weekly compensation, while in a death case the monthly compensation is used to determine MAX.

(1) If a claimant's weekly compensation rate is greater than the MAX, compensation is limited to the maximum amount.

(2) When a new MAX is established, it is compared to the amount of compensation in each case at MAX. If the compensation is greater than the old MAX but less than the new, compensation may be paid at the regular rate. Adjustments are made retroactive to the effective date of the new MAX, which is generally the date of an increase in the Federal pay scale.

(3) Consumer Price Index (CPI) increases do not affect the allowable MAX, though a claimant may be subject to MAX after the application of CPIs.

c. The MAX does not include locality pay. 20 C.F.R. §10.406.

d. Schedule awards are limited to the MAX.

e. The compensation management application automatically calculates the MAX rate when payments are entered and makes the appropriate comparisons.

15. Insurance Deductions. If the claimant was enrolled in a Federal Employees Health Benefit Plan (FEHBP) and/or Life Insurance plan at the time he or she became eligible to receive compensation for wage loss, deductions for health benefits insurance (HBI) and/or life insurance (LI) premiums will be taken from the compensation entitlement.

a. Determining Effective Date for Deductions. Generally, the EA will make deductions through the last date in which the claimant received pay. In this case, OWCP deductions for HBI and LI become effective the next calendar day. If another date for the last deductions is clearly present (e.g. the end of the pay period), the CE should use that date and begin deductions the day after.

Unless specified on the Form CA-7 (or in some other documentation in the file), the CE can assume that premium deductions were made only through the last day that the employee received pay, and accordingly begin deductions the following day.

If there is any discrepancy in the file with regard to the date of the last deduction, the CE should contact the EA to determine the date of last deductions and document the date for the case record.

(1) If disability is not supported when pay has stopped, deductions would begin on the first day compensation is payable.

(2) HBI and LI deductions are not made or intermittent hours or days within a pay period.

b. Health Benefits Enrollment. Claimants who are disabled for more than 60-90 days should be placed on the periodic roll, and their health benefits enrollment should be transferred in to the office in a timely manner (unless the evidence indicates a return to work in the near future). See FECA PM 5-0400 for a more detailed discussion regarding the deductions for HBI.

(1) The OWCP should confer with the EA and Office of Personnel Management (OPM) to reconcile any outstanding issues concerning claimants' continued entitlement. Properly

maintaining the enrollment and making the correct deductions is part of this process and the responsibility of the OWCP.

(2) It is critical that a claimant's health benefits enrollment be promptly and properly transferred in, or the EA may subsequently terminate the claimant's enrollment in the health benefits plan, causing unnecessary complications for the claimant.

(3) When the health benefits transfer-in process is complete, the date should be entered in the case management system. Form CA-73 (or equivalent) can be used to initiate the transfer-in process.

c. Life Insurance. Unlike HBI, there is no enrollment to transfer-in for LI. Claimants enroll in LI through their EA, and any inquiry concerning LI coverage should be referred to the claimant's employer or to the OPM. There are several types of LI deductions. See FECA PM 5-0401 for details regarding LI deductions.

(1) Basic Life Insurance (BLI). Federal employees are automatically enrolled in BLI on the date employment begins, unless coverage is waived by the employee. Deductions for BLI, though, are not automatic. Deductions should only be made if the OWCP receives verification that the claimant has the coverage. BLI stops at age 65.

There is no charge for BLI in cases with a date of injury (DOI) prior to 01/01/1990.

(2) Optional Life Insurance (OLI). In order to be eligible for OLI, the claimant must also be enrolled in BLI, unless the claimant's DOI is prior to January 1, 1990, then this coverage is free, so no additional deductions are needed. Premiums are withheld until the claimant reaches age 65. Deductions from compensation payments cease during the first full PR payment after the claimant's 65th birthday (unless he or she opts to freeze Option B and C). This change happens automatically.

(3) Post Retirement Basic Life Insurance (PRBLI). PRBLI prevents a life insurance benefit reduction at age 65. The default reduction is a reduction of 75%, but the claimant can elect either "No Reduction" or "50% Reduction." Claimants must elect this coverage when separated or retired from Federal employment. The coverage is effective immediately, and the premiums continue until death. Prior to age 65, the claimant must pay for both BLI and PRBLI if it has been elected.

CEs are notified of the claimant's election of PRBLI via Form RI 76-13 from the OPM. Upon notification, the next PR payment should be adjusted to indicate PRBLI. The "75% reduction" option is free. The "50% Reduction" and "No Reduction" options are calculated automatically in the case management system when issuing a payment.

(4) Option B and C Freeze. At age 65, the claimant can elect to continue Option B and Option C LI. This is a "Post 65 Reduction Election," and it is open to all claimants who currently have Option B or C LI coverage. A notification letter is sent to the claimant, and, if elected, he or she must send the response to the OPM. The OPM then notifies the National Office of the election. If

the claimant makes this choice, the CE will be notified by letter from the OPM regarding the deductions for any Option B or Option C Freeze.

Upon notification, the CE should adjust the PR payment to include the deduction and calculate any adjustment, making sure to convert any monthly amount from the OPM into a 28-day amount for the PR cycle.

d. Dental and Vision Insurance. Dental and vision insurance are options for FECA recipients, but unlike HBI and LI deductions, these deductions must be added to the existing PR payment by the National Office. If the PR payment is deleted and later re-entered for some reason, the dental and/or vision insurance deductions will have to be entered again by the National Office. For any periods that the claimant is on the daily roll or has missed PR deductions, FedVIP will either directly bill the claimant or adjust the withholding made in the compensation management system.

16. Consumer Price Index Adjustments. The 1966 Amendments to the FECA provide for increases in compensation benefits based upon the Consumer Price Index (CPI). CPI adjustments are automatically included in compensation payments processed in the compensation management system. (See [Exhibit 3](#) for a list of CPI increases.)

a. Entitlement. Under 5 U.S.C. 8146a, CPI increases are granted where the disability (i.e., compensable disability or the date when an injured employee stopped work on account of the injury) occurred more than one year, i.e. at least a year and a day, before the effective date of the CPI increase. See 20 C.F.R. §10.420.

(1) The disability need not have been continuous for the whole year before the increase. The use of a higher (recurrent) pay rate precludes addition of a CPI increase within one year following the application of such a pay rate.

(2) The increase is applicable to death cases where the compensable disability occurred more than one year prior to the effective date, although the death may have occurred less than a year before the effective date.

(3) CPI adjustments are rounded in disability cases to the nearest dollar on a 28-day basis, and in death cases to the nearest dollar on a monthly basis.

(4) When the compensation rate changes (e.g., from 3/4 to 2/3), the CPI adjustments are automatically recalculated.

(5) Where a schedule award is being paid and the claimant had no disability for work prior to the date of maximum medical improvement, the one-year waiting period begins on the starting date of the award. This date represents the claimant's first entitlement to compensation, even though the effective date of the pay rate (DOI) is earlier.

(6) If a lump-sum schedule award is paid per 5 U.S.C. 8135, there is no provision for inclusion of possible future CPIs at the time the award is calculated and paid, as CPI determinations are made

on a yearly basis, and there is no provision in the FECA that allows an estimate of future cost of living increases.

b. Inclusions and Exclusions.

(1) Entitlement to CPI increases extends to: emergency relief workers (CCC, WPA, CWA, FH and ERA); Reserve Officers Training Corps cadets; Civil Air Patrol volunteers; maritime workers; civilian war benefits workers; Peace Corps volunteers and volunteer leaders; VISTA volunteers; Neighborhood Youth Corps enrollees; and Job Corps enrollees.

(2) Entitlement to CPI increases does not include military reservists or their survivors and members of the Women's Army Auxiliary Corps (WAAC) and the Coast Guard Auxiliary.

(3) Periodic increases under the Longshore and Harbor Workers' Act are applied to Enemy Action (EA) and War Hazard (WH) cases on October 1.

c. Calculation of the CPI. CPIs are granted 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. The first cost-of-living increase using this standard was effective March 1, 1981.

17. Other Payees. Parties other than the claimant may receive payments from the OWCP due to various circumstances.

a. Employing Agency. When leave buy back is authorized, the agency may be designated to receive the compensation due. The agency then becomes a case payee. See paragraph 18 of this chapter for more information on the leave buy back process.

b. Office of Personnel Management. If funds are offset to repay the OPM for a period of dual benefits (see FECA PM 2-1000), the OPM becomes a case payee, though a payment is not keyed directly to the OPM. Instead, repayment should be made by selecting "OPM/CSRF" in the Miscellaneous Deductions tab of the Compensation application.

c. State/Municipal Court or Agency or Income Withholding Order. In cases where the claimant is failing to comply with, or is in arrears for, alimony and/or child support payments, the OWCP may allow for garnishment of compensation benefits. Such garnishment may be requested by providing a copy of the state agency or court order to the office. The OWCP has also entered into a Memorandum of Understanding with the U.S. Department of Health and Human Services' Office of Child Support Enforcement in order to identify parents who owe child support. In such cases, state agencies may issue Income Withholding Orders for back child support. There are maximum deductions that apply to these deductions. If the order is clear, the office may begin such deductions. Otherwise, such orders should be referred to the Office of the Solicitor for review before garnishing compensation benefits. There is no requirement that a claimant be in

receipt of augmented compensation benefits before the OWCP can withhold payments to comply with a valid child support enforcement order. References: 20 C.F.R. §10.423; 42 U.S.C. 659; 5 C.F.R. §§581.203 and 581.402.

When entering a child support deduction, the CE should use the Child Support Enforcement (CSE) Organization as a payee and enter the "Remittance Number" and the "Order Received Date" from the Child Support order. The Remittance Number is the case file number provided by the state child support agency. Once the CSE has been certified as a payee, the CE then enters the amount of the child support obligation as a "Fixed Allocation."

d. Secondary Beneficiaries. In a death case, a student or other adult beneficiary may receive payments in his or her own name. See FECA PM 2-0700.

e. Representative Payee. When the OWCP determines that a claimant is incapable of managing his or her benefits because of a mental or physical disability, legal incompetence, or because he or she is under 18 years of age, the OWCP in its sole discretion may approve a person to serve as the representative payee for funds due the claimant. Where a guardian or other party has been appointed by a court or administrative body authorized to do so, to manage the financial affairs of the claimant, the OWCP will recognize that individual as the representative payee, pursuant to 20 C.F.R. §10.424. The representative payee is not equivalent to an authorized representative who may be designated by a claimant to represent him/her before proceedings before the OWCP, pursuant to 5 U.S.C. 8127.

(1) Where the claimant is 18 years old or older, is incapable of self-support, and no guardian has been appointed, the OWCP shall approve the person or institution in the following order of preference:

- (a) An individual or institution having legal custody of the claimant;
- (b) A spouse, other relative, or friend, in that order, who demonstrates strong concern for the personal welfare of the claimant;
- (c) Someone qualified and willing to serve as a payee for a claimant.

(2) Where the claimant is under age 18 and there is no parent or legal guardian, the following order of preference should be followed:

- (a) An individual who has custody of the claimant;
- (b) A social agency or custodial institution chartered, authorized or licensed by a government entity;
- (c) An individual who is contributing toward the claimant's support;
- (d) An individual demonstrating concern for the claimant's well-being.

(3) Power of attorney is a legal process where one individual grants a third party the authority to transact certain business for that individual. Even if an adult beneficiary has granted an individual a "power of attorney" that includes the authority to handle the funds of the beneficiary, the CE is still responsible for making an individualized determination as to whether the person holding the power of attorney should be designated as a representative payee under the FECA. As the laws regarding what should be included in a power of attorney are not uniform across the states, any questions regarding the legal sufficiency of a power of attorney document should be referred to the FEEWC Division of the Solicitor's Office.

(4) Upon consideration of approval of a representative payee, the CE will advise the payee that the payee has the responsibility to spend or invest payments received only for the benefit of the claimant, in the order outlined in (5) below; that the payee must notify the OWCP of any event that would affect the amount of benefits, such as status of dependents; that the payee must advise the OWCP of any change in the payee's circumstances that would affect performance of the payee's responsibilities; and that the payee must maintain on an annual basis and submit to the OWCP, upon request, a written report accounting for the benefits received. With the exception of parents of minor children, to protect the beneficiary's funds, a checking or savings accounts title should reflect the beneficiary's ownership of the funds and the representative payee's relationship as a fiduciary (financial agent).

The representative payee should also be advised of his or her responsibility to notify the OWCP if the beneficiary moves; if the beneficiary starts receiving another government benefit or the amount of the benefit changes; if the beneficiary is imprisoned for a felony conviction; or if the beneficiary dies. The representative payee must complete the Form CA-1032 on behalf of the beneficiary. The representative payee must inform the OWCP in writing of any change in residence of the representative payee. The representative payee must inform the OWCP in writing in the event he or she no longer wishes to serve as a representative payee, or in the event he or she becomes incapable of being responsible for the beneficiary.

(5) The CE should ask the payee to submit a statement accounting for the benefits if there is any question about the manner in which the payee is using the benefits. For example, questions may arise when the representative payee does not advise the OWCP of changes as outlined above; when the OWCP is contacted by the claimant's creditors; or when the institution where a claimant resides reports problems with billing. The CE should examine the statement to ensure that the benefits are used in the following order:

- (a) The claimant's maintenance, including food, shelter, clothing, medical care, and personal comfort items;
- (b) Institutional care, including expenses that will aid in recovery or release, and for personal needs;
- (c) Support of claimant's legal dependents;
- (d) Claims from creditors - only if the claimant's needs are met for the present and the foreseeable future;

(e) Funds not needed for (4)(a) through (4)(d) above, conserved or invested on behalf of the claimant in non-speculative accounts, in accordance with rules followed by trustees. Any profit from an investment is the property of the claimant and not the payee.

(6) The services of the payee may be terminated when the payee has not used the funds according to (5)(a) through (5)(e) above, or has not timely discharged other responsibilities. Issues concerning misuse or questionable use of funds by a representative payee should be referred to the National Office. By an administrative determination from the Office, a representative payee may be held responsible for repaying an overpayment.

18. Leave Buy Back (LBB). When an employee elects to use accrued or advanced annual leave (AL) or sick leave (SL) during a period of disability, he or she may later, with the concurrence of the EA, claim compensation for the period of disability and "buy back" the AL or SL used (20 C.F.R. §10.425) and have it restored. Leave donated to an employee by an EA leave bank is not restorable leave.

Where a claim for LBB is approved, the OWCP will issue payment to the employer covering the period of approved time loss. Upon receipt of the payment from the OWCP, the employer is responsible for reinstating the claimant's leave once the employee pays his/her portion, if any.

a. Participation in this process is at the discretion of the employer. The OWCP does not govern whether a claimant may repurchase leave from an EA, and any decision by the EA to disallow a LBB is not a formal decision over which the ECAB may exercise jurisdiction. (See K.J., Docket No. 11-571 (issued January 25, 2012); Aberline Smith, Docket No 96-1699 (issued June 4, 1988).

b. LBB Forms. The CE should review the submitted forms carefully to be sure they are complete. If one or more of the necessary forms are not received or are incomplete, the CE should send a written request to the EA for the completed form(s). The claimant should receive a copy of this letter as well. Forms used in a LBB claim include:

(1) Form CA-7, Claim for Compensation, showing a claimant has elected LBB is required.

(2) Form CA-7b, Leave Buy Back (LBB) Worksheet/Certification and Election, is required.

(3) Form CA-7a, Time Analysis Form, is optional. If the Form CA-7a is not submitted though, a clear breakdown of leave used is required.

c. Review of Medical Evidence. The CE should review the medical evidence to verify the lost time claimed for disability or medical appointments. In processing claims for LBB, it is still necessary to determine the dates for which the claimant would have been eligible for wage-loss compensation if he or she had gone into LWOP status rather than taking AL or SL. The same basic rules apply for wage-loss compensation as identified in other sections of this chapter.

d. The CE must also calculate the gross amount of compensation due for the compensable time period, and document the calculations in the case record. HBI and OLI deductions are not made

when a claimant wants to buy back AL or SL used for a period of disability, since the EA made those deductions while the employee was in leave status.

e. The CE then compares the amount of the calculated compensation entitlement with the EA's estimate of FECA entitlement.

(1) Where the medical evidence supports all hours claimed and the EA's estimate of FECA compensation is within 10% of the amount determined by the OWCP to be payable, the CE should document the calculations in the case record and process the payment. The CE should add the EA as a payee in the case management system and direct the payment to the agency address provided on the Form CA-7b, which may be different than the agency correspondence address. The new payee address will also need to be certified in order for the payment to be processed.

The CE should then complete and send Form CA-1208 (or equivalent) to the claimant and EA, advising that the claim was approved in full with the inclusive dates and amount of the payment made. Since compensation is paid at 2/3 or 3/4 of gross wages, the amount of compensation is usually less than the amount paid to the claimant while on AL or SL. The claimant will have to pay the difference to the EA.

In rare situations, the total FECA entitlement will exceed the amount owed by the claimant to the EA. In these instances, the CE should pay the EA the balance due to repurchase the leave. The CE should then pay the claimant the remaining balance of FECA entitlement.

(2) Where the medical evidence supports all hours claimed, but the EA's estimate of entitlement is not within 10% of the amount determined by the OWCP, the CE will issue Form CA-1207 (or equivalent) showing the correct entitlement amount. If the claimant still wishes to pursue LBB, he or she will then complete his or her portion of the enclosure EN-1207 and provide it to the EA. If the parties reach an agreement on reinstatement of leave, the EA will complete its portion of the EN-1207 and forward the completed form to the OWCP. The CE will then issue a compensation payment to the agency and release Form CA-1208 to the claimant, with a copy to the EA.

(3) Where medical evidence supports some, but not all, of the hours claimed, the CE should develop the claim by advising the claimant of the deficiencies in writing, and allow 30 days for the claimant to provide supporting evidence. The CE should also advise the claimant regarding what hours claimed have been determined to be payable. In this instance, if exigent circumstances do not exist, the CE may delay the payment of the hours that have been determined to be payable so that the comparison of the amount calculated by the agency can be more accurately evaluated, as outlined above, prior to processing a payment

(a) If no medical evidence is received in response to the development letter, or if the evidence is not sufficient to establish entitlement for any part of the remaining hours, the CE should process a payment for the supported hours and issue Form CA-1208 showing the number of hours approved and the corresponding dates. The CE should then issue a formal decision denying the hours not supported by the evidence of record.

(b) If medical evidence is received in response to the development letter, the CE will evaluate the evidence to determine whether it supports the remaining hours of lost time. If so, the CE should issue payment to the employer covering all supported hours. The CE should then issue Form CA-1208 showing the total number of hours approved and the corresponding dates. If any claimed hours are still not supported by the evidence of record, the CE should issue a formal decision denying the hours not supported by the evidence of record.

(4) Where there is no medical evidence to support any of the lost time claimed, the CE must develop the claim by advising the claimant of the deficiency in writing, and allow 30 days for the claimant to provide supporting evidence.

(a) If no medical evidence is received in response to the development letter, or if the evidence is not sufficient to establish entitlement for the lost time, the CE will issue a formal decision denying the LBB claim in its entirety.

(b) If medical evidence is received in response to the development letter, the CE will evaluate it to determine whether it supports any of the time lost. If so, the CE should issue a payment to the EA covering the verified hours. The CE will then issue Form CA-1208 showing the total number of hours approved and the corresponding dates. If only a portion of the claim was substantiated, the CE should issue a formal decision denying the specific hours that are not supported.

19. Wages Lost for Medical Examination or Treatment.

a. Entitlement. A claimant who has returned to work following an accepted injury or illness may need to undergo examination, testing, or treatment. Such a claimant may be paid compensation for wage loss under 5 U.S.C. 8103 while obtaining the medical services or treatment.

(1) Reimbursement of lost wages for attending medical appointments includes a reasonable time spent traveling to and from the provider's location.

(2) Wage loss is payable only if the examination, testing, or treatment is provided on a day which is a scheduled work day and during a scheduled tour of duty. Wage-loss compensation for medical treatment received during off-duty hours is not reimbursable.

(3) The evidence should establish that the claimant attended an examination or treatment for the accepted work injury on the date(s) claimed in order for compensation to be payable. If the evidence is not present on initial review, the case should be developed and subsequently reviewed after 30 days for either payment or issuance of a formal denial of any claimed hours still not supported by medical evidence.

b. Absence from work for the purpose of medical evaluation or treatment does not constitute a recurrence of disability. The ECAB has interpreted the word "disability" at 5 U.S.C. 8101(4) to mean incapacity because of injury to earn the wages which the employee was receiving at the time of such injury, or disability for work. An absence to obtain medical services while otherwise capable of working does not reflect an incapacity for work and therefore does not establish "disability" for purposes of changing the pay rate.

Since absence from work for the purpose of medical evaluation does not constitute a recurrence of disability, the claimant is not entitled to a higher pay rate under section 8101(4) of the FECA (Amelia S. Jefferson, 57 ECAB 183 (2005)).

c. For a routine medical appointment, a maximum of four hours of compensation may be allowed. However, longer periods of time may be allowed when required by the nature of the medical procedure and/or the need to travel a substantial distance to obtain the medical care. These claims for wage loss should be considered on a case-by-case basis and any exception should be documented in the file. Some agencies do not allow employees in particular job classifications (e.g. USPS rural carriers) to take less than a full day off from work. Such employees should be compensated for the full shift of lost time from work.

d. When a formal LWEC is in place, the LWEC should not be modified to pay claims for wage loss due to medical appointments. However, in certain circumstances, the compensation previously paid for loss of wage-earning capacity must be deducted from the compensation payable for the time lost due to medical appointments.

(1) Where there is no LWEC, or the LWEC being paid is based on part-time work, and the claimant has lost additional hours to obtain medical treatment, the CE should pay those hours without regard to any prior LWEC compensation paid. However, the CE should ensure that the total number of hours worked and/or compensated for per week does not exceed the number of weekly scheduled hours when injured.

(2) Where the LWEC being paid is based on other wage loss, e.g. lost premium pay, and the claimant has incurred additional wage loss due to attending medical appointments, the previously paid LWEC must be deducted from the compensation payable for the intermittent hours lost.

e. OWCP-Directed Examination. If the OWCP directs a claimant who is working to undergo a second opinion or referee medical examination, reimbursement for wage loss should be paid under the authority of 5 U.S.C. 8123 at 100% of gross wages lost. Therefore, the CE should request the EA to provide the actual amount of gross wages the claimant lost on the date of the examination, and compensate the claimant accordingly. Careful attention is needed in cases in which the claimant is already receiving partial wage-loss compensation (due to loss of premium pay, for example). In such cases, the gross amount of daily compensation previously paid for partial wage loss should be deducted from the gross wages lost, as reported by the EA.

Payment in these instances should be calculated manually and processed as a direct payment. Payment should not be made at the "100% compensation rate" in the case management system, as this amount may not be equal to the actual wages lost.

Exhibit 1: Minimum Compensation Rates

EFFECTIVE DATE	DISABILITY MIN COMP RATES PER		DEATH MIN PAY RATES PER MONTH
	DAY	WEEK (4 WEEK)	

10/01/1949	5.19	25.96-(103.84)	150.00
10/01/1960	8.31	41.54-(166.16)	240.00
08/01/1966‡	11.32	56.61-(266.44)	327.08
10/08/1967†	11.85	59.25-(237.00)	342.33
07/14/1968†	12.21	61.03-(244.12)	352.58
07/13/1969†	12.58	62.88-(251.52)	363.33
12/28/1969†	13.33	66.65-(266.60)	385.08
01/10/1971	14.13	70.63-(282.52)	408.08
01/09/1972	14.90	74.51-(298.04)	430.50
10/01/1972	15.67	78.35-(313.40)	452.60
10/14/1973	16.39	81.95-(327.80)	473.50
10/13/1974	17.30	86.48-(345.92)	499.67
10/12/1975	18.16	90.81-(363.24)	524.67
10/10/1976	18.96	94.79-(379.16)	547.67
02/27/1977*	18.96	94.79-(379.16)	547.67
10/09/1977	20.29	101.47-(405.88)	586.25
10/08/1978	21.41	107.05-(428.20)	618.50
10/01/1979*	21.41	107.05-(428.20)	618.50
10/07/1979	23.45	117.23-(468.92)	677.33
10/05/1980	25.82	129.10-(516.40)	745.92
10/04/1981	27.06	135.30-(541.20)	781.75
01/01/1982*	27.06	130.30-(541.20)	781.75
10/03/1982	28.14	140.71-(562.84)	813.00
12/18/1982*	28.14	140.71-(562.84)	813.00
01/08/1984	29.27	146.34-(585.36)	845.50
01/06/1985	30.29	151.46-(605.84)	875.08
01/04/1987	31.20	156.00-(624.00)	901.33
01/03/1988	31.82	159.12-(636.48)	919.33
01/01/1989	33.13	165.63-(662.52)	957.00
01/14/1990	34.32	171.59-(686.36)	991.42
01/13/1991	35.73	178.63-(714.52)	1,032.00
01/12/1992	37.23	186.13-(744.52)	1,075.42
01/10/1993	38.60	193.01-(772.04)	1,115.17

(‡)The amendments of 07/04/1966 established the minimum compensation rate in disability cases as 75% of the first step of GS-2 or the pay rate, whichever is less, and the minimum pay rate in death cases as the pay rate for the first step of GS-2.

(†)1 day earlier for Postal Service

(*)Maximum adjustment only. The minimum rate was not affected.

Exhibit 1: Minimum Compensation Rates (continued)

EFFECTIVE DATE	DISABILITY MIN COMP RATES PER		DEATH MIN PAY RATES PER MONTH
	DAY	WEEK (4 WEEK)	
01/08/1995	39.38	196.88-(787.52)	1,137.50
01/07/1996	40.16	200.81-(803.24)	1,160.25
01/05/1997	41.09	205.43-(821.72)	1,186.92
01/04/1998	42.03	210.16-(840.64)	1,214.25
01/03/1999	43.34	216.68-(866.72)	1,251.92
01/02/2000	44.98	224.91-(899.64)	1,299.50
01/01/2001	46.20	230.99-(923.96)	1,334.58
01/02/2002	47.86	239.31-(959.24)	1037.00
01/02/2003	49.34	246.72-(986.88)	1425.50
01/12/2004	50.68	253.38-(1013.52)	1464.00
01/09/2005	51.94	259.72-(1038.88)	1501.00
01/08/2006	53.03	265.17-(1060.68)	1532.08
01/07/2007	53.94	269.69-(1078.72)	1558.16
01/06/2008	55.28	276.42-(1105.67)	1597.08
01/09/2009	56.89	284.44-(1137.75)	1643.42
01/03/2010	57.74	288.71-(1154.83)	1668.08
01/01/2011	57.74	288.71-(1154.83)	1668.08
01/01/2012	57.74	288.71-(1154.83)	1668.08
01/01/2013	57.74	288.71-(1154.83)	1668.08
01/05/2014	58.12	291.59-(1166.37)	1684.75
01/04/2015	58.90	294.50-(1178.00)	1701.58
01/10/2016	59.49	297.45-(1189.76)	1718.58
01/08/2017	60.08	300.42-(1201.67)	1735.75
01/07/2018	60.93	304.63-(1218.52)	1760.08

Exhibit 2: Maximum Compensation Rates

EFFECTIVE DATE	DISABILITY MAX COMP RATES PER		DEATH MAX PAY RATES PER MONTH
	DAY	WEEK (4 WEEK)	
11/01/1949	24.23	121.15 (484.60)	525.00
10/01/1960*	24.23	121.15 (484.60)	525.00
08/01/1966‡	66.38	331.92 (1,327.68)	1,438.31
10/08/1967†	69.00	345.01 (1,380.04)	1,495.06
07/14/1968†	74.17	370.83 (1,483.32)	1,606.94
07/13/1969†	80.97	404.84 (1,619.36)	1,754.31

12/28/1969†	85.82	429.12 (1,716.48)	1,859.50
01/10/1971	90.93	454.66 (1,818.64)	1,970.19
01/09/1972	95.94	479.71 (1,918.84)	2,078.75
10/01/1972	100.88	504.39 - (2,017.56)	2,185.69
10/14/1973	103.85	519.23 - (2,076.92)	2,250.00
10/13/1974*	103.85	519.23 - (2,076.92)	2,250.00
10/12/1975	109.04	545.19 - (2,180.76)	2,362.50
10/10/1976	114.23	571.15 - (2,284.60)	2,475.00
02/27/1977	126.70	633.5 - (2,534.00)	2,745.19
10/09/1977	135.65	678.25 - (2,713.00)	2,939.06
10/08/1978	137.02	685.10 - (2,740.40)	2,968.75
10/01/1979	143.10	715.50 - (2,862.00)	3,100.50
10/07/1979	144.56	722.78 - (2,891.12)	3,132.03
10/04/1981*	144.56	722.78 - (2,891.12)	3,132.03
01/01/1982	165.87	829.33 - (3,317.32)	3,593.75
10/03/1982*	165.87	829.33 - (3,317.32)	3,593.75
12/18/1982	182.06	910.31 - (3,641.24)	3,944.69

(*) Minimum adjustment only. The maximum rate was not affected.

(‡) The amendments of 07/04/66 established the maximum compensation rate as 75% of the highest step of GS-15.

(†) 1 day earlier for Postal Service

Prior to 09/07/74, total monthly compensation could not exceed the monthly pay or the minimum compensation rate. Effective 09/07/74, total monthly compensation could not exceed the monthly pay except for CPI increases (5 USC 8146a), or the maximum monthly compensation rate.

In cases where maximum compensation is paid, proportionate shares are as follows:

Prior to 09/07/74:
Widow/er only--All

Effective 09/07/74:
Widow/er only--All

Widow/er--8/11, 1 child--3/11

Widow/er--3/4, 1 child--1/4

Widow/er--4/7, 2 children--3/7

Widow/er--3/5, 2/more children--2/5

Widow/er--8/15, 3/more children--7/15

Exhibit 2: Maximum Compensation Rates (continued)

EFFECTIVE DATE	DISABILITY MAX COMP RATES PER		DEATH MAX PAY RATES PER MONTH
	DAY	WEEK (4 WEEK)	
10/05/1980*	144.56	722.78 - (2,891.12)	3,132.03
10/04/1981*	144.56	722.78 - (2,891.12)	3,132.03
01/01/1982	165.87	829.33 - (3,317.32)	3,593.75
10/03/1982*	165.87	829.33 - (3,317.32)	3,593.75
12/18/1982	182.06	910.31 - (3,641.24)	3,944.69
01/08/1984	189.35	946.76 - (3,787.04)	4,102.63
01/06/1985	195.98	979.90 - (3,919.60)	4,246.25
01/04/1987	201.85	1,009.27 - (4,037.08)	4,373.50
01/03/1988	205.90	1,029.48 - (4,117.92)	4,461.06
01/01/1989	214.34	1,071.68 - (4,286.72)	4,643.94
01/14/1990	222.06	1,110.32 - (4,441.28)	4,811.38
01/13/1991	231.17	1,155.84 (4,623.36)	5,008.62
01/12/1992	240.87	1,204.36 - (4,817.44)	5,218.88
01/10/1993	249.78	1,248.88 - (4,995.52)	5,411.81
01/08/1995	254.79	1,273.93 - (5,095.72)	5,520.38
01/07/1996	259.88	1,299.38 - (5,197.52)	5,630.63

01/05/1997	265.85	1,329.25 - (5,317.00)	5,760.06
01/04/1998	271.98	1,359.91 - (5,439.64)	5,892.94
01/05/1998	265.85	1,329.25 - (5,317.00)	5,760.06
01/03/1999	280.39	1,401.94 - (5,607.76)	6,075.06
01/02/2000	283.59	1,427.93 - (5,671.72)	6,144.38
01/01/2001	298.91	1,494.56 - (5,978.24)	6,476.44
01/02/2002	309.68	1,548.42 - (6,193.68)	6,709.81
01/01/2003	319.28	1,596.38 - (6,385.52)	6,917.63
01/12/2004	327.91	1,639.53 - (6,558.12)	7,104.63
01/09/2005	336.11	1,680.53 - (6,722.12)	7,282.00
01/08/2006	343.14	1,715.72 - (6,862.88)	7,434.81
01/07/2007	348.98	1,744.92 - (6,979.68)	7,561.31
01/06/2008	357.72	1,788.61 - (7,154.42)	7,750.62
01/10/2009	360.09	1,840.44 - (7,361.77)	7,975.25
01/03/2010	373.61	1,868.03 - (7,472.13)	8,094.81
01/01/2011	373.61	1,868.03 - (7,472.13)	8,094.81
01/01/2012	373.61	1,868.03 - (7,472.13)	8,094.81
01/01/2013	373.61	1,868.03 - (7,472.13)	8,094.81
01/05/2014	377.34	1,886.68 - (7,546.73)	8,175.63
01/04/2015	381.12	1,905.61 - (7,622.44)	8,257.63
01/10/2016	384.93	1,924.67 - (7,698.69)	8,340.25
01/08/2017	388.78	1,943.89 - (7,775.54)	8,423.50

01/07/2018	394.21	1,971.04 - (7,884.16)	8,541.19

(*) Minimum adjustment only. The maximum rate was not affected.

Exhibit 3: Cost-Of-Living Adjustments under 5 U.S.C. 8146a

Effective Date	CPI Rate Change (%)
10/01/1966	12.5
01/01/1968	3.7
12/01/1968	4.0
09/01/1969	4.4
06/01/1970	4.4
03/01/1971	4.0
05/01/1972	3.9
06/01/1973	4.8
01/01/1974	5.2
07/01/1974	5.3
11/01/1974*	6.3
06/01/1975	4.1
01/01/1976	4.4
11/01/1976	4.2
07/01/1977	4.9
05/01/1978	5.3
11/01/1978	4.9
05/01/1979	5.5
10/01/1979	5.6
04/01/1980	7.2
09/01/1980	4.0
03/01/1981	3.6
03/01/1982	8.7
03/01/1983	3.9
03/01/1984	3.3
03/01/1985	3.5
03/01/1986	None
03/01/1987	0.7
03/01/1988	4.5
03/01/1989	4.4
03/01/1990	4.5
03/01/1991	6.1

- (*) Before 09/07/74, 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 09/07/74, the new compensation after adding the CPI is rounded to the nearest \$1.00 on a monthly basis or the nearest multiple of \$.25 on a weekly basis (\$.25, \$.50, \$.75, or \$1.00).

Prior to 11/01/74

.08-.34= .23

.35-.57= .46

.58-.80= .69

.81-.07= .92

Effective 11/01/74

.13-.37= .25

.38-.62= .50

.63-.87= .75

.88-.12= 1.00

Exhibit 3: Cost-Of-Living Adjustments under 5 U.S.C. 8146a (continued)

Effective Date	CPI Rate Change (%)
03/01/1992	2.8
03/01/1993	2.9
03/01/1994	2.5
03/01/1995	2.7
03/01/1996	2.5
03/01/1997	3.3
03/01/1998	1.5
03/01/1999	1.6
03/01/2000	2.8
03/01/2001	3.3
03/01/2002	1.3
03/01/2003	2.4
03/01/2004	1.6
03/01/2005	3.4
03/01/2006	3.5
03/01/2007	2.4
03/01/2008	4.3
03/01/2009*	(0.5) = No change
03/01/2010	3.4
03/01/2011	1.7
03/01/2012	3.2
03/01/2013	1.7
03/01/2014	1.5
03/01/2015	.3
03/01/2016	.4
03/01/2017	2.0

03/01/2018	2.2

(*)December 2007 had a CPI-W level of 205.777 per BLS. The CPI-W level for December 2008 was reported as 204.813 by BLS, which is in fact a decrease of 0.5% from the December 2007 level. As a result of this decline in the CPI-W level, there was not a cost of living increase for FECA recipients in 2009.

Exhibit 4: Activity Codes

In the iFECS case management system, it is necessary to assign an Activity Code to certain groups of cases so that iFECS performs certain calculations. For instance, Military Reservists cases are not entitled to the minimum pay rate calculations or CPI's; thus, an Activity Code of "002" must be placed in iFECS. The default code is "001," so the keyer must change the code to "002."

ACTIVITY CODE	TYPE OF CASE	CASE PREFIX
001	Federal Civilian Employee	X, no prefix, or any office prefix
002	Military Reservists (no minimum; no cost-of-living increases)	X, or any office prefix
003	Civil Air Patrol	CP
004	Reserve Officer Training (ROTC)	TC
005	Maritime War Risk	RA
006	Federal Relief Projects	WP, NY, CC, FE, CA, FH
007	War-connected Benefits for Employees of Government Contractors	WH
008	Civilian War Benefits	CB
009	Total Benefits, War Claims	WC
010	Social Welfare Programs	X, VISTA, A50 prefix
011	Law Enforcement Officers (LEO)	LE
012	Coast Guard Auxiliary (no minimum; no cost-of-living increases)	Any prefix
013	Job Corps (no minimum)	Any prefix
014	Neighborhood Youth Enrollees	Any prefix
015	Military Reservists Survivor	Any prefix
016	Members of Woman's Army Auxiliary	Any prefix
017	Peace Corps Volunteer Leader	Any prefix
099	Other	Any prefix

Chapter 2-1000, Dual Benefits

1. Purpose and Scope. This chapter explains dual benefits allowed and prohibited under the FECA and establishes procedures for obtaining required elections and for requesting refunds

2. Statutory Provisions. 5 U.S.C. 8116 outlines the limitations on the right to receive compensation and the necessity for an election between certain prohibited dual benefits (see Exhibit 1).

3. Responsibility. It is the responsibility of the Claims Examiner (CE) to determine if the claimant either qualifies for or is receiving benefits from another Federal agency. When a claimant is entitled to or is receiving a benefit from another agency, the CE must determine if that benefit constitutes a prohibited dual benefit and requires an election, or if it is an exception which will not affect the claimant's compensation entitlement.

Where receipt of dual benefits is prohibited, the CE must advise the claimant of the entitlement as well as the need for and terms of the election appropriate to that case. The CE should make every effort to obtain a timely election where necessary to ensure that the claimant does not suffer undue hardship while awaiting compensation payments.

4. Annuity Benefits Paid by Office of Personnel Management. References: FECA Program Memoranda (ProM) Nos. 12, 27, 72, 90, 138 242, 249, 262, 263 and 267. (For non-Federal retirement systems standing in lieu of the Civil Service Retirement System, see ProM Nos. 242 and 262.)

a. Disability Compensation. When a claimant is entitled to disability benefits under the Federal Employees' Compensation Act (FECA), and annuity benefits from the Office of Personnel Management (OPM) under the Civil Service Retirement System Act (CSRS) or the Federal Employees' Retirement System Act (FERS), the employee must make an election between OWCP benefits and OPM benefits. The employee has the right to elect the monetary benefit which is the more advantageous. This policy also applies to reemployed annuitants (see Harold Weisman, Docket No. 93-1335, issued March 30, 1994). (The claimant may receive concurrent benefits from the Office of Workers' Compensation Programs (OWCP) and the Thrift Savings Fund.)

Section 5 U.S.C. 8337(f) provides that the prohibition against the payment of dual benefits does not bar the right of a claimant to the greater benefit conferred by either Act for any part of the same period of time. Thus, an election of disability compensation under the FECA or an election of an annuity benefit provided by OPM is not irrevocable.

b. Death Benefits. When compensation for death is payable under the FECA and fatal benefits are payable under CSRS or FERS, the eligible survivor(s) must make an election between OWCP benefits and OPM benefits. This includes the lump sum death benefit paid under the FERS, though any beneficiary may concurrently receive benefits from OWCP and the Thrift Savings Fund.

The Employees' Compensation Appeals Board held in the case of Adeline Etzel, 21 ECAB 151, that the statutory language concerning irrevocability of election was intended to apply only to those cases where:

the disability or death of an employee has resulted from an injury sustained in civilian employment by the United States and the Veterans Administration has held that the same disability or death was caused by military service.

Therefore, except for those few cases where an election of veterans' benefits and FECA benefits is required for the reason stated in Etzel, the OWCP considers any election of death benefits provided by OWCP and OPM to be revocable. However, OPM considers an informed election of OWCP benefits in lieu of OPM benefits to be irrevocable.

Where a survivor is entitled to both an annuity from OPM in his or her own right because of his or her own Federal service, and an entitlement to death benefits under the FECA, no election is required between these two benefits. Similarly, if the money paid by the OPM is paid to the (former) employee and/or his or her estate, death benefits paid to the survivor would not constitute a dual benefit (unless the OPM benefit were paid directly to the survivor in his or her own right).

c. Communications with OPM's Office of Retirement Programs. All correspondence with OPM, whether by form or narrative letter, shall contain the claimant's full name, OPM claim number, date of birth and Social Security number. Where closed benefit periods are involved, they should be shown clearly in terms of inclusive dates (e.g., "Compensation was paid from (date) through (date), inclusive."). The type of FECA benefit (i.e., disability, schedule award, or death) must be identified also. Where OPM so requests, the CE should provide a copy of any later formal decisions or letters describing benefits to OPM.

d. Effect of Lump Sum Payment by OPM. 5 U.S.C. 8343a(b) provides that OPM shall offer alternative forms of annuities for employees retiring under the Civil Service Retirement Act. These forms include payment of a lump-sum credit plus payment of an actuarially reduced annuity. Since the lump-sum credit is clearly part of the retirement benefit (and not simply a refund to the employee of the contributions the employee made to CSRS), it is considered a dual benefit which is prohibited under 5 U.S.C. 8116(a). Similarly, the lump-sum death benefit under FERS authorized in 5 U.S.C. 8442 is also considered a prohibited dual benefit.

e. Social Security Act Benefits. Social Security benefits are payable concurrently with FECA benefits, but the following restrictions apply:

(1) Social Security Act benefits paid for disability shall be reduced by the compensation payable;

(2) In disability cases, FECA benefits will be reduced by the Social Security Act benefits paid on the basis of age and attributable to the employee's Federal service;

(3) In death cases, FECA benefits will be reduced by the survivor's benefits paid under the Social Security Act attributable to the employee's Federal service.

5. Obtaining Elections Between OWCP and OPM Benefits.

a. In all death cases, and in disability cases where the record indicates that a claim has been made for benefits under CSRS or FERS, the CE should release Form CA-1101 to OPM during initial development of the claim. This request should help to ensure that the necessary information about the status of the claim for annuity is in file when entitlement to FECA benefits is determined. If the initial response from OPM is negative, but some time elapses before entitlement to FECA benefits is determined, the CE should make further inquiry to OPM before FECA benefits are paid if there is any reason to believe that a claim for OPM benefits was later made.

b. When an election is required in a disability case, the CE will release Form CA-1102 to the employee, with copies to all parties in interest. This letter provides information about the rate of compensation payable and the employee's right to elect the more advantageous benefit. Two copies of Form CA-1105, Election of Benefits, should accompany Form CA-1102.

(1) Pay Rates. The monthly rate of the compensation entitlement should be shown on Form CA-1102, so that the employee may compare the two benefits easily. The four-weekly rate should also be indicated.

(2) Retroactive Payment. When the claimant is entitled to retroactive compensation and CPIs are applicable, the form should show the amount payable for each period from the beginning of entitlement to the present.

(3) Certification. The CE should have both the finding of entitlement and the determination of the compensation rate certified before releasing Form CA-1102.

(4) Lump Sum. Form CA-1102 also advises the employee that any lump sum paid by OPM under CSRS as part of an alternative annuity (equal to the employee's contribution) is considered a dual benefit which would have to be repaid to OPM either directly or out of any retroactive and continuing FECA benefits. No benefits under FECA can be paid to a claimant until the entire amount of benefits paid by OPM (including both regular annuity payments and the lump sum) has been recouped. Under no circumstance should OWCP pay any retroactive benefits to a claimant until the possibility of an outstanding debt to OPM is resolved.

c. When an election is required in a death case, the CE will release Form CA-1103 to the person claiming the death benefit, with copies to all parties in interest. This letter provides information about the rate of compensation payable and the right of election. Two copies of Form CA-1105, Election of Benefits, should accompany Form CA-1103.

(1) Terms of Entitlement. To permit an informed election, the CE should ensure that complete information is provided. The information should include the terms of and the termination dates of compensation for each beneficiary involved in the award.

(2) Retroactive Payment. When the beneficiary is entitled to retroactive compensation and CPIs are applicable, the election form should show the amount payable for each period from the beginning of entitlement to the present.

(3) Certification. The CE should have the findings of entitlement, the determinations of compensation rates, and periods of entitlement certified before releasing Form CA-1103.

(4) Lump Sum. Form CA-1103 also advises the claimant that any lump sum paid by OPM as part of the death benefit available under FERS is considered a dual benefit which would have to be repaid to OPM before any FECA benefits could be paid to the claimant. Such repayment would be made either directly by the claimant or through payment of all retroactive FECA benefits and a portion of the continuing benefits.

The FERS lump sum is paid to the surviving spouse only; FECA benefits paid to children would not be a dual benefit. In some cases, therefore, a spouse may find it more advantageous to elect FECA benefits for the children but not for herself or himself and thus avoid repaying the FERS lump sum.

d. On return of Form CA-1105 electing FECA benefits, the CE should take the following actions:

(1) Contact the appropriate person at OPM using the list of telephone numbers provided in [Exhibit 2](#). Inform the contact person in OPM of the claimant's election to receive benefits under the FECA, and request that the OPM annuity be suspended immediately. It will be necessary to provide OPM with the claimant's name, current address and OPM claim number.

(If this information is not on the election form, contact the claimant by telephone to obtain it. If the claimant does not know his or her OPM claim number, be prepared to provide OPM with the claimant's date of birth and Social Security number).

The CE should also furnish his or her telephone number to the OPM representative so that he or she can confirm that the annuity has been suspended. This confirmation should come within 72 hours. If it does not, follow up with OPM.

(2) When OPM confirms that the annuity has been suspended, the CE will take action to commence payment of compensation on the periodic roll. The effective date should be the date OPM benefits were suspended, except when repayment of a lump-sum benefit to OPM is necessary. (In this situation, the CE will follow the procedures outlined in subparagraph (5) below.)

(3) The CE will then release Form CA-1104, with copies to all parties of interest, advising OPM of the date FECA compensation began, and requesting that OPM transfer the health benefits

enrollment and advise OWCP of the total amount of benefits paid by OPM from the effective date of the claimant's election until the annuity was suspended. A copy of the claimant's election form will be enclosed with the original letter to OPM.

If there is no retroactive compensation from which to reimburse OPM for benefits paid on and after the effective date of election, the CE should so advise OPM on Form CA-1104 and indicate the net amount of the FECA periodic payment. OPM will then afford the claimant appropriate due process and request offset from continuing FECA payments (see paragraph 6f below).

(4) Upon receipt of a reply to Form CA-1104, the CE should take action to pay the claimant retroactively to the effective date of the election, less reimbursement owed to OPM for annuity benefits, and to transfer the claimant's health benefits enrollment to OWCP. The CE will show the claimant's OPM claim number when authorizing payment to OPM on Form CA-24, CA-25 or CA-25a. Under no circumstances should any retroactive compensation be paid until OPM has been reimbursed in full for the benefits it has paid.

(5) Where a lump-sum payment has been made to the claimant as part of an alternative annuity under CSRS or as part of the death benefit under FERS, FECA benefits should not be paid until OPM benefits can be fully reimbursed by the claimant or unless the retroactive benefits under the FECA fully cover the lump-sum annuity and OPM benefits. If the claimant has already been placed on the periodic roll and the retroactive compensation is insufficient to reimburse OPM, the case should be referred to National Office for further action.

e. On return of Form CA-1105 electing OPM benefits, the CE should take the following actions:

(1) If the claimant is not receiving compensation, close the case on Form CA-800, Nonfatal Summary, or Form 105, Fatal Summary, indicating that OPM benefits have been elected, refer the case to the inactive files; and enter the change of case status in the CMF.

(2) If the claimant is receiving compensation, take action to terminate compensation and compute any reimbursement that may be owed by OPM. Release Form CA-1107 to OPM, with a copy of Form CA-1105. This will notify OPM of the election of OPM benefits; advise that compensation benefits have ended and that OPM benefits should begin; inform OPM of the amount of the reimbursement (if any) due OWCP; and provide OPM with the information which will allow them to transfer the claimant's health benefits enrollment (and life insurance enrollment, if applicable) to their rolls.

6. Entitlement to Other Benefits Under the FECA.

a. Medical Treatment. Regardless of which monetary benefits the claimant elects, any medical treatment required for the effects of the compensable injury will continue to be provided under FECA.

b. Schedule Awards. These awards, payable under 5 U.S.C. 8107 for the permanent loss or loss of use of specified members, organs, or functions of the body, are the only FECA monetary compensation benefits payable concurrently within an OPM annuity. These dual benefits are

allowable for injuries sustained on or after September 13, 1957. For injuries which occurred prior to that date, an election between these two benefits is required.

c. Vocational Rehabilitation. An employee in receipt of OPM retirement benefits is prohibited from receiving vocational rehabilitation assistance under FECA. See FECA ProM No. 27.

d. Attendant's Allowance.

(1) An employee entitled to total or partial disability benefits under 5 U.S.C. 8105 or 5 U.S.C. 8106 who has elected to receive the benefits of the CSRS or the FERS Act may not receive an attendant's allowance under 5 U.S.C. 8111(a) during the time that benefits are being received under one of the retirement acts.

(2) When an employee is entitled to a schedule award under 5 U.S.C. 8107, the attendant's allowance is considered incidental to the award and may be paid concurrently with OPM retirement benefits during the period of the award. See FECA ProM No. 72.

e. Third-Party Credits. Where a claimant has made a third-party recovery resulting in a credit against the compensation entitlement, and it appears that additional compensation may be paid and medical expenses claimed, compensation payments are calculated and charged against the recovery credit to the case, as are injury-related medical expenses paid by the claimant. This procedure continues until the third-party credit is absorbed.

(1) OPM Annuity During Offset. There is no prohibition against receipt of an OPM annuity during the period that the third-party credit is being absorbed by OWCP. The claimant is not actually receiving compensation from OWCP during this period, so the payment of an annuity does not constitute a prohibited dual payment.

(2) Election After Offset. Receipt of an annuity during the third-party credit period does not prejudice the claimant's rights. Thus, when the credit has been exhausted, the claimant should be given an opportunity to elect between FECA benefits and continuation of the OPM annuity.

(3) As noted above, the OPM considers an informed election of OWCP death benefits (in lieu of OPM benefits) to be irrevocable. Thus, it is imperative that the claimant be informed fully of the available benefits, especially in cases involving possible third-party settlements.

(a) To make an informed election, the claimant must be made aware of the opportunity to receive OPM survivor benefits while the third-party credit is being absorbed. If an election is made without this knowledge, the election will be considered null and void.

(b) Inasmuch as the claimant is not required to make an election until after the third-party credit has been absorbed, the one-year time limitation of 5 U.S.C. 8116(b) will not begin to run until the third-party credit has been exhausted.

(4) Nonparticipants. Beneficiaries who do not participate in the third-party settlement are not affected by third-party credit offsets. (See FECA ProM No. 125.)

f. Refunds When Dual Benefits Have Been Paid.

(1) Refund Action When Repayment is Due OPM. A refund due OPM may be paid from accrued and/or continuing compensation, provided that the amount of the debt is at least \$25.

(a) If there is an accrued amount of compensation payable by OWCP, OPM is not required to provide certification of due process before recovering the debt from the accrued OWCP benefits. Upon receipt of notification from OPM of the fact and amount of the debt, the office will deduct the total amount of indebtedness from the accrued compensation and forward that amount to OPM.

(b) If there is accrued compensation but it is not sufficient to cover the total amount owed OPM, the office will forward the entire accrued amount to OPM. When certification of due process is received from OPM as described below in subparagraph (c), the office will make deductions from any continuing compensation payments until the debt has been repaid.

Where the claimant received a lump sum payment from OPM as part of an alternative annuity under CSRS or as part of the death benefit under FERS, OPM is not required to provide certification of due process. The office may withhold continuing net compensation until OPM is fully repaid.

(c) Except where the claimant received a lump-sum payment from OPM as described above in subparagraph (b), OPM will certify in writing that the debt exists and that appropriate due process has been afforded the debtor to request offset from continuing compensation payments. OPM will advise the office of either the dollar amount of the periodic deduction or the percentage of net compensation to offset each payment period.

In general, OPM will request a deduction of ten percent (10%) of the periodic payment, but not less than \$50. A greater or lesser amount may be requested based on an agreement reached between OPM and the debtor. Whenever possible, OPM will try to recover the debt within 36 months.

(2) Method of Setting Up Payments.

(a) The CE will authorize repayment to OPM as a case payee on Form CA-25A, CA-25, or CA-24. The CE must indicate the total amount owed OPM and the amount to be deducted from each compensation payment.

(b) Payment to OPM will be transferred via Treasury's OPAC transfer of funds. A case payee (CP) will be entered in ACPS for this transaction.

(3) OPM Contract. OPM's Debt Collection Branch (DCB) handles debts owed to OPM. Once the DCB contacts the office, all future correspondence concerning the debt should be sent to the DCB. Office staff are encouraged to call the DCB at (202) 254-3094 to expedite resolution of cases.

(4) Refund action when repayment is due OWCP is described in FECA PM 5-505.11.

7. Foreign Service Retirement and Disability System. References: FECA ProM Nos. 14 and 18.

a. Gratuities. Amounts equal to one year's salary at the time of death are paid to surviving dependents of Foreign Service employees who die as the result of injury sustained in the performance of duty outside the United States, excluding diseases proximately caused by the employment. These payments are considered gifts and are payable in addition to compensation or benefits from any other source.

b. Other Benefits. An election is required between FECA benefits and other benefits of the Foreign Service Retirement System. The injured employee is permitted, however, to receive for any period of time the greater of the two benefits. The provisions of this retirement system are substantially the same as those of the Civil Service Retirement System regarding the receipt of these dual benefits. The procedures as outlined in paragraph 4 above should be followed in regard to providing benefits and obtaining elections where benefits of the FECA and the Foreign Service Retirement System are involved.

8. Veterans' Benefits. References: FECA ProM Nos. 80, 108, 123, 166, 169, 175, 180 and 200.

a. Contacting the DVA. Information from DVA files is often helpful in adjudicating claims and preventing dual payments. In particular, when the record shows that an applicant for FECA benefits is receiving veterans' benefits, the CE must determine the nature of those benefits. Such information should be obtained as follows:

(1) Form CA-1019 or Form CA-1077 will be used to request information from DVA whenever possible. Otherwise, a narrative letter should be sent. This letter must contain all identifying information indicated on the form. Requests for information from DVA files must be accompanied by a completed Form CA-57, Authorization for Release of Information.

(2) Preparing the Form. All available identifying information must be entered in the upper right corner of Form CA-1019 or CA-1077. Additional information, such as a Social Security number, can be added if available.

(3) Identification. Requests to the DVA must, if possible, include the veteran's DVA claim number. If the DVA claim number is not available, the request must include at least the veteran's date of birth and military service number. Other helpful identifying information would include the Social Security number, the approximate date the veteran's benefits were last received, the location where the veteran's claim was filed, and the location and approximate date DVA medical services were last received.

(4) Addresses. DVA benefit records are maintained in the DVA Regional Offices (DVARO). In some places the regional offices are combined with an insurance center, hospital, or domiciliary

and are known as DVA Centers. In the District of Columbia, the equivalent of a regional office is known as the Veterans Benefits Office. The U.S. Government Organization Manual contains the addresses of DVA Regional Offices, DVA Centers, and DVA Hospitals.

If the location of the DVA claims folder is unknown, send the request to the DVARO or DVA Center which likely has jurisdiction over the claimant's address. Where regional boundaries are unknown, the Assistant District Director should obtain this information from the DVA. Any DVA office can locate a file on the computer system.

Requests for medical reports of examinations or treatment provided by a DVA Hospital should be sent to the hospital which provided the service.

(5) Information Received. If the reply shows that the veteran's award is other than "pension for service in the Army, Navy or Air Force," the CE must determine whether the award is based on a finding that the same disability or death for which FECA benefits are payable was caused by the military service, or whether the DVA increased an award or found an award was payable for service-connected disability, because of the civilian employment injury for which FECA benefits are claimed (see examples in paragraph b below).

(a) If so, an election between these benefits is required by 5 U.S.C. 8116(a)(3).

(b) If not, except for educational benefits as explained in paragraphs 8c and 8d below, no election is necessary.

b. Definitions. If the veteran's benefit was for a non-service-related condition, no election is required. The following discussion addresses claims involving service-related conditions.

(1) The prohibition against dual payment of FECA and veterans' benefits applies to those cases where the disability or death of an employee has resulted from an injury sustained in civilian employment by the United States and the Department of Veterans Affairs (DVA), formerly the Veterans Administration, has held that the same disability or death was caused by the military service. See Adeline N. Etzel, claiming as widow of Bernard E. Etzel (21 ECAB 151).

Example: Federal employee, a veteran, is disabled by or dies from pulmonary tuberculosis. DVA finds that the disease became manifest within the medical presumptive period after military service and grants benefits on the basis of military service connection. OWCP finds that the disability or death resulting from this disease is related to veteran's Federal civilian employment and grants FECA benefits. Employee or his survivors are eligible for both FEC and veterans' benefits for the same disability or death, namely, that resulting from pulmonary tuberculosis. An election is required.

(2) The prohibition also extends to an increase in a veteran's service-connected disability award, where the increase is brought about by an injury sustained while in civilian employment. See Louis Teplitsky (22 ECAB 142) and France Marie Kral (24 ECAB 157).

Example 1: A Federal employee is receiving benefits from the DVA for 50 percent disability due to a service-connected emotional condition, and has a civilian employment injury which causes a disabling aggravation of the pre-existing emotional condition. OWCP determines that the employee has a total loss of wage-earning capacity due to the emotional condition. Subsequent to the employment injury, DVA increases its award to 100 percent as a result of the aggravation by the civilian employment injury.

An election between benefits is required in this case. The election will be between the amount of entitlement under FECA plus the amount received from the DVA for 50 percent prior to his civilian employment injury, on the one hand, and the total amount of entitlement from the DVA for 100 percent, on the other hand.

In other words, no election is required between the veteran's benefit the claimant was receiving at the time of the civilian employment injury and the FECA benefits to which the claimant is entitled for the civilian employment injury because these benefits are not payable for the same injury. When the DVA increased its benefits an election was required because the increased benefits were payable because of the same employment injury which formed the basis of entitlement to FECA benefits.

Example 2: A Federal employee is receiving benefits from the DVA for 20 percent disability based on a service-connected injury to the right knee. A subsequent injury to the same knee while in civilian employment results in 25 percent disability of the leg, for which FECA benefits are payable. The DVA increases its award to 30 percent because of the civilian employment injury.

The election required in this case is the same as that required in Example No. 1 above--i.e., between a schedule award, for the full extent of the permanent loss of the use of the leg under the FECA plus the amount received from the DVA prior to the employment injury, on the one hand, and the total benefits provided by the DVA subsequent to its increase, on the other hand.

(a) No reduction in a schedule award is required under 5 U.S.C. 8108 where the DVA has made an award for an earlier injury to the same member (see Example 2 above). It has been determined that the word "injury" as used in 5 U.S.C. 8108 means an earlier injury received while in Federal civilian employment.

(b) The claimant may be entitled to compensation for loss of wage-earning capacity (LWEC) at the expiration of the schedule award (see Example 2 above). If so, an informed election cannot be made until the claimant's LWEC is determined.

Thus, two elections are possible and permitted in such cases--the first between the schedule award under the FECA and the veteran's benefit, and the second between compensation for LWEC under the FECA and the veteran's benefit. The conditions of both elections would be as outlined in Example 2 above.

(3) The prohibition does not extend to pensions, since Section 5 U.S.C. 8116(a)(2) expressly provides that there is no limitation on the right to receive FECA compensation because of the

receipt of a pension for service in the Army, Navy or Air Force. The receipt of a pension from the DVA for a non-service-connected disability or death and the payment of compensation under the FECA is therefore not a prohibited dual benefit, and no election is required.

(4) The DVA pays other benefits to veterans and their survivors, which are variously termed compensation, dependency and indemnity compensation, and educational assistance, etc., other than for educational awards. The payment of compensation under the FECA concurrently with such veterans' benefits would constitute a prohibited dual payment only where the veteran's award is based on the finding that the same disability or death for which FECA benefits are payable was caused by the military service. See paragraph 8b above.

(5) When several kinds of disability are present, the DVA combines the percentages allowed for each disability (using a method of computation similar to the combined values chart in the AMA Guides to the Evaluation of Permanent Impairment). The resulting percentage is often less than the sum of all impairments. For instance, the veteran may have 40% disability due to one condition, 30% due to a second condition, and 10% due to a third condition, for a total award of 60%.

(a) When determining percentages for election, the CE should use the amount of the percentage for the work-related condition only.

(b) The amount of the percentage should not be pro-rated to account for use of the combination method. In the example given above, if the work-related condition is the one for which the DVA has granted 40% disability, the entire 40% should be used in determining the amount of the election.

(c) For privacy reasons, the DVA may not provide information about percentages of disability for conditions other than the work-related one. The CE may need to contact the claimant directly to obtain a copy of the notice of benefits showing the percentages paid for each disability.

c. Educational Benefits.

(1) Educational benefits provided under the GI Bill are based on the veteran's own military service. Educational benefits (i.e., benefits for students) under the FECA are based on the employment and the related disability or death of the recipient's relative. The prohibition against concurrent payments contained in 5 U.S.C. 8116 applies only to payments based on the same disability or death. No election is required for educational benefits under the GI bill.

(2) Unless the veteran's educational award is designated a pension or is paid as outlined in the preceding paragraph, the following procedures apply:

(a) Where a widow(er) or child is eligible for benefits based on school attendance under both the FECA and laws administered by the DVA, an election is required, regardless of whether the eligibility for veterans' benefits is based on a finding that the disability or death was service-connected.

(b) Under certain circumstances, veterans' benefits for a widow(er) and the eligible children are divisible. Stated another way, the child or children have a "separate and independent right of election" to veterans' benefits.

(c) If a child does not have a separate and independent right of entitlement under the DVA law, the election by the veteran or the widow(er) is binding on the child in that the benefits for the child are payable only by the same agency paying benefits for the veteran or the widow(er).

(d) An election is binding only for the period of concurrent eligibility.

(e) The election of veterans' benefits by one or more beneficiaries in a family will not serve to increase the rate of compensation payable by OWCP to or on behalf of the other beneficiaries who continue to receive FECA benefits.

d. Obtaining Elections--Educational Benefits.

(1) In a disability case, if the payment of augmented compensation is contingent solely upon the eligibility of a child over 18 who is a student, the CE must determine whether the claimant is a veteran. If so, the CE must determine whether application has been made to the DVA for benefits (on behalf of the child) based on school attendance. This can be accomplished by use of Form CA-1615 or an equivalent narrative letter. Upon receipt of this information, the election procedure as described below in connection with death cases will be followed.

(2) In an accepted death case, the CE must determine whether the decedent was a veteran. If so, and if the decedent is survived by children 18 years of age or older who are eligible for educational benefits under the FECA, send Form CA-1615 or an equivalent letter to determine whether application has been made to the DVA for benefits based on school attendance.

If such application has been made, or benefits are being received, and Form CA-1077 has not previously been released, the CE should send Form CA-1078 to the DVA to determine whether the claimant is eligible for or is receiving veterans' benefits based on school attendance.

(3) Upon receipt of this letter, the DVA will reply in duplicate concerning the type and amount of such benefits and the period during which they have been paid or may be payable. In addition, they will advise whether the child has a separate and independent right of entitlement and can thereby make a separate and independent election of benefits.

(4) The CE should then release an informational letter to the claimant, attaching the copy of the DVA letter and three copies of a narrative election letter for each claimant who is required to make an election. The letter will clearly state the amount payable, the period during which they may be paid, and the basis for their termination.

The letter should also note the copy of the attached DVA letter which outlines the benefits payable by that agency and ask the claimant to make an election in narrative form and return two copies of the election to OWCP.

There may be circumstances when it is not appropriate for the CE to attach the copy of the DVA letter. If this occurs, it will be necessary for the CE to provide a sufficient explanation of the DVA benefits to allow the claimant to make an informed election.

(5) If OWCP benefits are elected and the facts show that prior to the election both agencies made payments concurrently, the CE will ascertain the amount paid by the DVA for periods on or after July 4, 1966, and will deduct such an amount from future payments. The deduction should be made from each monthly payment using a method which will result in minimum financial hardship for the claimant, yet will recover the amount within a reasonable period.

If only the DVA was making payments prior to the election, the CE will ascertain the amount paid by the DVA for periods on or after July 4, 1966, deduct that amount from accrued OWCP payments, and pay the balance to the claimant.

(6) If veterans' benefits are elected, the CE should advise the DVA office of the amount of any OWCP payment to be deducted from future DVA payments. The letter transmitting the election form to the DVA will reflect the amount of the OWCP payments, and the periods for which payments were made, on or after July 4, 1966.

(7) A copy of the election form must always be sent to the DVA. The letter transmitting the election will also request information regarding the amount paid by the DVA on or after July 4, 1966. A narrative letter must also be written to the claimant, with a copy to the DVA, explaining in full the payments, deductions, or method of recovery of dual payments.

(8) When OWCP educational benefits are terminated, a copy of the termination letter should be sent to the DVA office.

(9) The OWCP and the DVA have agreed that there will be no transfer of funds between agencies.

f. Obtaining Elections--Other Benefits. Cases requiring such an election will include those involving increases in service-connected awards made by the DVA because of civilian employment injuries, and those involving military reservists (see paragraph 9 below).

(1) When dual entitlement exists because of a disability which became manifest within the medical presumptive period after military service, as outlined in the example in paragraph 8b above, the CE should advise the DVA of OWCP's determination regarding the employment-relatedness of the condition. If DVA does not then change its determination as to service connection, an election between benefits is required.

(2) Where the DVA increases a service-connected award because of a civilian employment injury for which FECA benefits are payable, as outlined in the examples under paragraph 8b above, an election between benefits is required.

(3) The CE must advise the claimant of the full amount and terms of FECA entitlement and obtain an election in narrative form, between the two benefits.

(4) If FECA benefits are elected and OWCP and DVA made concurrent payments before the election, the CE will determine the amount paid by the DVA and deduct this amount from future payments. The deduction should be made from each monthly payment using a method which will result in minimum financial hardship for the claimant, yet will recover the amount within a reasonable period.

(5) If FECA benefits are elected and only the DVA made payments before the election, the CE will determine the amount paid by the DVA, deduct that amount from accrued OWCP payments, and pay the balance to the claimant.

(6) If DVA benefits are elected, the CE should advise the DVA of the amount of any OWCP payment to be deducted from future DVA payments. The letter transmitting the election form to the DVA will reflect the amount of the OWCP payments, and the periods for which payments were made.

(7) A copy of the election form must always be sent to the DVA. A narrative letter must also be written to the claimant, with a copy to the DVA, explaining the payments, deductions, or method of recovery of dual payments.

(8) When OWCP benefits are terminated, a copy of the termination letter should be sent to the DVA.

(9) OWCP and DVA have agreed that no funds will be transferred between agencies.

9. Military Reservists.

a. Statutory Provisions. Before January 1, 1957, the benefits of the FECA were extended under certain circumstances to reservists of the armed forces and their beneficiaries where the injury or death of the reservist occurred in line of duty while on active duty. Public Law 81-881, approved August 1, 1956, terminated the FECA entitlement to these persons effective January 1, 1957.

Public Law 81-881 provided that the termination of coverage did not deprive any person of benefits to which there was eligibility by reason of disability or death occurring prior to January 1, 1957. It further provided that beneficiaries eligible for compensation for death occurring before January 1, 1957, could continue to receive benefits under the FECA or they could elect benefits from the DVA under PL 81-881.

b. Election Requirements. Since the eligibility for benefits provided by both the FECA and the DVA is based on the same period of service and the same death, an election is required.

c. Irrevocability of Election. The irrevocability of election provided by 5 U.S.C. 8116(b) applies to FECA benefits based on the injury or death of an "employee." Military reservists and their beneficiaries do not fall within the definition of employee as contained in 5 U.S.C. 8101(1). Thus, the beneficiaries in military reservist cases have the right, without time limitation, to elect veterans' benefits. However, under the provision of 38 U.S.C. 416, once an election is made to receive veterans' benefits, the beneficiary cannot later elect FECA benefits.

10. Armed Forces and Other Uniformed Services. References: FECA ProM Nos. 116 and 131.

a. Dual Payment Not Prohibited. Effective September 7, 1974, 5 U.S.C. 8116(a) was amended to provide that retainer pay, retirement pay, or equivalent pay for service in the armed forces or other uniformed services may be continued while an employee is receiving FECA benefits subject to the limitations on receipt of dual compensation by retired officers contained in 5 U.S.C. 5532.

b. Injuries Before September 7, 1974.

(1) Before September 7, 1974, compensation due under the FECA was considered by OWCP to be the employee's basic benefit. Where the employee was receiving retirement or retainer pay, the employee and the military finance office making such payment were advised of the FECA entitlement. If the finance office found that the FECA payment would constitute a dual payment prohibited under 5 U.S.C. 8116, and if the employee agreed, OWCP would deduct the amount representing the dual payment and reimburse it to the finance center, paying the balance to the employee. If the employee did not agree to this arrangement, OWCP would pay the full amount of compensation due to the employee and notify the appropriate finance center of such payment. See Charles W. Akers, 24 ECAB 316.

(2) If compensation is claimed for an injury occurring before September 7, 1974, and the employee is receiving retirement or retainer pay, the full amount of the compensation entitlement will be paid to the employee. The CE, however, will write to the employee, with a copy to the military finance office, advising of the amendment and informing the employee that, effective September 7, 1974 and continuing, the employee may receive compensation and retirement or retainer pay concurrently.

c. Injuries On and After September 7, 1974. If the file reflects that the claimant is receiving retirement or retainer pay, compensation will be paid for appropriate periods. It will not be necessary to notify the military finance offices that compensation payments are being made. There is no need for OWCP to be concerned with reductions applicable to 5 U.S.C. 5532 since these reductions apply to the wages the recipient is receiving and will always have occurred before any injury compensable under the FECA.

11. Social Security Benefits. References: FECA ProM Nos. 10, 20 and 81.

a. OASD Benefits. Old age, survivors, and disability under Title II of the Social Security Act, as amended, are insurance benefits paid from the Social Security insurance fund. These payments are financed by the contributions of employees and employers through the Social Security tax, and are not financed by the United States. Social Security benefits are payable only to persons insured under the system by their respective payments to the system's insurance fund.

b. Dual Payment Not Prohibited. OWCP does not require an election between FECA benefits and Social Security benefits, except when they are attributable to the employee's Federal service (see paragraph 4e above). The Social Security Act was amended on July 30, 1965, providing for

a reduction in Social Security benefits to certain individuals receiving workers' compensation. Inquiries concerning this situation should be referred to the Social Security Administration. That agency will inform the beneficiary concerning the possible reduction of Social Security benefits.

12. Tennessee Valley Authority. References: FECA ProM No. 177.

a. Pension Plan. The Tennessee Valley Authority Retirement System is a private pension plan. The limitations in 5 U.S.C. 8116 apply solely to situations where there is concurrent entitlement to compensation and to some other Federal benefit(s).

b. Dual Payment Not Prohibited. An election between FECA benefits and benefits under the TVA Retirement System is not required by OWCP. Under certain circumstances, the TVA may find that all or part of its retirement benefits are not payable concurrently with FECA benefits. Requests for offset of FECA compensation payments to repay overpayments made under the TVA Retirement System will be honored only upon written authority of the affected beneficiary.

13. Black Lung Benefits. Reference: FECA ProM No. 172.

a. Dual Entitlement Not Prohibited. An election between FECA benefits and benefits under the Black Lung Benefits Act (Title IV of the Federal Mine Safety and Health Act of 1977) is not required under the provisions of 5 U.S.C. 8116.

However, claims under the Black Lung Benefits Act (BLBA) filed on and after January 1, 1974 come under Part C of that Act, and section 422(g) of Part C provides for reduction of Black Lung benefits by the amount of "... any compensation received under or pursuant to any Federal or State workmen's compensation law because of death or disability due to pneumoconiosis."

Claims under Part C are under the jurisdiction of the Office of Workers' Compensation Programs, Division of Coal Mine Workers' Compensation (DCMWC), and the responsibility for making appropriate reduction of Black Lung benefits under section 422(g) rests with DCMWC.

b. Potential Dual Benefit Cases Under the FECA. For all practical purposes, the FECA cases in which there is a potential FECA/BLBA dual benefit situation are those involving cardiopulmonary conditions due to exposure to coal dust filed by employees of the Mine Safety and Health Administration (MSHA) of the U.S. Department of Labor. (MSHA's predecessor agency was MESA, the Mine Enforcement and Safety Administration, U.S. Department of the Interior. Its functions were transferred to MSHA on March 9, 1978.)

c. Exchange of Information Between FECA and DCMWC.

(1) To identify those cases in which dual entitlement exists and to permit DCMWC to make appropriate deductions in BLBA benefits, the timely exchange of case file information between FECA and DCMWC is necessary. Therefore, in all cases involving a cardio-pulmonary condition where exposure to coal dust is alleged to have contributed to the development of the claimed condition, the National Operations Office will complete Form OWCP-33 and forward it to

OWCP, DCMWC, District Office Operations Staff, Frances Perkins Building, Room C-3522, Washington, D.C. 20210.

If necessary, the CE should at this time also request the coal mine employment record and any medical evidence pertaining to the injured employee which may be in the possession of DCMWC. If a claim for the identified individual has also been filed under the BLBA, DCMWC will so advise and, if needed, will request compensation payment information from the FECA Program.

Based on information contained in their records, DCMWC will also use Form OWCP-33 to query the FECA Program regarding the existence of a claim under the FECA for a specific individual and, where appropriate, request information about the claim. Any such request should be handled expeditiously.

(2) In any case where a dual benefit situation has been identified and the provisions of section 422(g) are applicable, the FECA Program is responsible for advising DCMWC of any changes in case or payment status, including commencement, increase, decrease and termination of compensation, as soon as possible after the change occurs. Further, such cases should be placed under periodic six-month call-up to ensure that DCMWC has been advised of all case/payment changes.

(3) Most cases under Part B of the BLBA (which also contains an offset provision) are handled by the Social Security Administration (SSA). Where a potential dual benefit situation of this type exists, DCMWC will request needed information from the FECA Program in the same manner as described above and will forward the information to SSA for appropriate action. The actions and responsibilities of the FECA Program in this situation are the same as described in paragraphs d(1) and (2) above.

d. Exchange of Information Between the FECA Program and DCMWC.

(1) To identify those cases in which dual entitlement exists and to permit DCMWC to make appropriate deductions in BLBA benefits, the timely exchange of case file information between the FECA Program and DCMWC is necessary. Therefore, in all cases involving a cardio-pulmonary condition where exposure to coal dust is alleged to have contributed to the development of the claimed condition, the National Operations Office will complete Form OWCP-33 and forward it to OWCP, DCMWC, District Office Operations Staff, Frances Perkins Building, Room C-3522, Washington, D.C. 20210.

If necessary, the CE should at this time also request the coal mine employment record and any medical evidence pertaining to the injured employee which may be in the possession of DCMWC. If a claim for the identified individual has also been filed under the BLBA, DCMWC will so advise and, if needed, will request compensation payment information from the FECA Program.

Based on information contained in their records, DCMWC will also use Form OWCP-33 to query the FECA Program regarding the existence of a claim under the FECA for a specific

individual and, where appropriate, request information about the claim. Any such request should be handled expeditiously.;

(2) In any case where a dual benefit situation has been identified and the provisions of section 422(g) are applicable, the FECA Program is responsible for advising DCMWC of any changes in case or payment status, including commencement, increase, decrease and termination of compensation, as soon as possible after the change occurs. Further, such cases should be placed under periodic six-month call-up to ensure that DCMWC has been advised of all case/payment changes.

(3) Most cases under Part B of the BLBA (which also contains an offset provision) are handled by the Social Security Administration (SSA). Where a potential dual benefit situation of this type exists, DCMWC will request needed information from the FECA Program in the same manner as described above and will forward the information to SSA for appropriate action. The actions and responsibilities of the FECA Program in this situation are the same as described in paragraphs d(1) and (2) above.

14. Railroad Retirement Act Benefits. Although payments under the Railroad Retirement Act (RRA) are funded by direct appropriations from Congress, these funds are derived from taxes levied upon the railroads and their employees. A study of the legislative history shows that it was the intent of Congress that payments under the RRA be funded entirely by these taxes, which are channeled through the general fund of the Treasury only to avoid Constitutional problems which might be caused by their being earmarked for a specific purpose.

These benefits are therefore not received "from the United States." Furthermore, since RRA benefits are not payable because of the service of the employee as a civil employee of the United States, they are not "salary, pay, or remuneration." Thus, RRA benefits do not qualify as prohibited dual benefits for two independently sufficient reasons, and no election is required.

15. Department of Justice Benefits Paid for Survivors of Federal Law Enforcement Officers. Public Law 98-473 amended the Omnibus Crime Control and Safe Streets Act of 1968 to authorize benefits to officers who die as the direct and proximate result of a personal injury sustained in the line of duty. This benefit, which is paid under the Department of Justice, is to be paid in addition to any other benefit that may be due from any other source. Thus, payment of this benefit does not constitute a dual benefit and is not subject to any offset or reduction.

16. Benefits for Judicial Officials Assassinated in Performance of Duty. Public Law 101-650, approved December 1, 1990, provides that the surviving spouse of an assassinated judicial official may be paid both an annuity and compensation under the FECA. Judicial officials covered under this provision include a justice or judge of the U.S.; a judge of the District Court of Guam, the District Court of the Northern Mariana Islands, or the District Court of the Virgin Islands; or a full-time bankruptcy judge or a full-time U.S. magistrate. The annuity may be reduced if the total amount payable exceeds the current salary of the officer of the judicial official. Any such adjustment would be made by the employing agency, not OWCP.

17. Severance and Separation Pay. Employing agencies may grant severance pay to employees who are involuntarily separated as part of a reduction in force (RIF). Agencies may also offer separation pay ("buyouts") to encourage employees to leave Federal employment voluntarily. Certain severance and separation payments constitute dual benefits under the FECA.

a. Definitions.

(1) Severance pay was first authorized by the Federal Employees' Salary Act of 1965 (Pub. Law 89-301, since codified at 5 U.S.C. 5595). Under this statute, severance pay could not be paid "concurrently with salary or on account of the death of another person."

FECA Program Memorandum 55, dated January 24, 1968, interpreted the phrase "concurrently with salary" to allow payment of severance pay to claimants receiving benefits for LWEC, since the severance pay is calculated on the basis of the salary only, and does not take claimants' LWEC payments into consideration. Also, a schedule award may be paid concurrently.

Severance pay represents a certain number of weeks worth of salary or wages, and it is usually computed as a lump sum. Health benefits and optional life insurance coverage may continue during the period of severance pay as long as the OWCP eventually makes payments for the time period covered by the severance pay to the Office of Personnel Management (OPM).

(2) Separation pay is offered in different forms by different agencies. Sometimes it is defined as a number of weeks of pay, and other times as a specific amount of money, according to the law governing the agency in question.

For example, the Postal Service (in 1992) calculated its payments as six months of the employee's base pay, while the Department of Defense (starting in 1993) used the amount of severance pay to which the employee would have been entitled, or \$25,000, whichever was less.

b. Information Needed. The CE should ask the employing agency to submit:

(1) A statement as to which benefit (severance or separation pay) the employee is to receive. If any doubt exists, a copy of the pertinent law (or a citation to it) should be sent.

(2) A statement as to the period and/or total amount of payments, and the date of retirement or separation.

(3) A copy of the claimant's acceptance of the offer of separation or severance pay (if applicable), and a copy of the retirement or separation papers.

c. Entitlement. The kinds of benefits allowed and prohibited are identical for separation and severance pay.

(1) Compensation for temporary total disability (TTD) may not be paid for the period covered by severance or separation pay. For example, if a claimant receives 13 weeks worth of severance pay, compensation is not payable until the fourteenth week.

(2) Compensation for LWEC may be paid concurrently with severance or separation pay, since the pay is based on the employee's salary, not the payments for LWEC. If an employee who is receiving compensation for LWEC receives severance or separation pay and then retires, an election of benefits will be required at the time of retirement.

(3) Compensation for a schedule award may be paid concurrently with severance or separation pay.

(4) Medical benefits are payable concurrently with severance and separation pay.

d. Methods of Offset. All severance payments are based on a specified number of weeks of pay. Some separation payments are based on a specific number of weeks of pay, while others are capped at a specified amount of money. However, in order to be equitable to all claimants, offsets for both types of payments should be computed in the same manner regardless of the way the employing agency has offered separation pay. (Lynne M. Schaack, Docket No. 05-695, issued November 9, 2005.)

(1) Where the severance or separation payment is based on weeks of pay, the CE should suspend compensation payments for the period in question, effective the date of separation or retirement, by 100% offset for the number of weeks (not the amount of money) which the severance or separation pay represents. (See paragraph e. below concerning health benefits and optional life insurance.)

(2) Where the separation payment is based on an amount of money, the CE should:

(a) Calculate the number of weeks worth of salary that the separation pay represents by dividing the total amount of separation pay by the salary used to compute it.

(b) Suspend compensation payments for the number of weeks calculated, effective the date of separation or retirement, by 100% offset for the number of weeks (not the amount of money) which the separation pay represents. (See paragraph e. below concerning health benefits and optional life insurance.

(3) The claimant should be advised that benefits for TTD will cease immediately because he or she has elected to receive severance or separation pay. The claimant should also be advised of the date on which the offset will end.

(4) Where the OWCP later discovers that a severance or separation payment was made for a period when compensation was paid, an overpayment must be declared and the usual due process rights given.

e. Health Benefits (HB) and Optional Life Insurance(OLI).

(1) For claimants with HB and/or OLI coverage, it may continue during the period of severance or separation pay as long as the claimant remains eligible for compensation benefits but for the

severance or separation pay and OWCP eventually makes the premium deductions for the time period covered by the severance or separation pay.

(2) The agency will transfer the HB enrollment to OWCP effective the date that employment ceases. The claimant is responsible only for his or her own share of the premiums.

(3) The Temporary Continuation of Coverage (TCC) program allows involuntarily separated employees to continue HB coverage for a short period. The TCC program will not allow a person who is entitled to compensation to enroll, and it will terminate the enrollment of a person entitled to these benefits.

f. Claims for Additional Compensation.

(1) If a schedule award ends during the period covered by the separation or severance payment, the employee may claim additional compensation for disability (see subparagraph (2) below). If the claimant was not receiving compensation for disability before the schedule award, he or she would not be entitled to receive compensation afterwards unless the medical condition had worsened such that it disabled him or her from the regular or limited duty job performed before separation. Should entitlement to further compensation be established, the employee would need to elect between OWCP and OPM retirement benefits (if eligible).

(2) A separated employee who was not receiving compensation at the time of separation because of placement in a modified job with no loss of pay will not be entitled to further compensation at the end of the period covered by separation or severance pay solely because the modified job is no longer available. A claimant who has returned to duty, whether regular or light, has the burden of proof to show that injury-related disability had worsened to the point that he or she is now disabled for the limited duty position (see Terry L. Hedman, 38 ECAB 222).

(3) Benefits will not necessarily be reinstated in cases where the employee shows that the condition has worsened, since he or she might have been able to continue performing the modified job even if the condition worsened. Therefore, where a formal LWEC decision has not been issued, the employing agency should be asked to submit a description of the employee's job duties, including the physical requirements, at the time of separation. With this evidence, it will be possible to determine if the employee has any further entitlement to compensation.

(4) An employee who establishes that his or her accepted condition worsened to the point that he or she is unable to perform a modified job will be required to make an election of benefits, if eligible for retirement, since he or she has been formally separated. An employee who elects OWCP benefits should receive compensation for TTD and be considered for referral for vocational rehabilitation services to explore reemployment in another job.

(5) Employees working part time, or working full time but at lower rates of pay, will be entitled to continue receiving compensation at the end of the period covered by separation or severance pay at the LWEC rate, if injury-related disability continues and they elect OWCP benefits in favor of retirement benefits. Should a recurrence be claimed, it will be the employee's burden to show that injury-related disability has worsened (see subparagraph (2) above). If a formal LWEC

decision has been issued, the claimant must establish one of the acceptable criteria for modifying a formal LWEC decision. (See PM 2-0814.11.)

(6) An employee who was performing regular duty at the time of separation would be entitled to receive compensation only if a true recurrence of disability were established (see subparagraph (2) above).

(7) An employee who accepts separation or severance pay and then changes his or her mind may not receive compensation for the duration of entitlement to separation pay or severance pay.

Exhibit 1: Restrictions on Payment of Benefits Under the FECA

RESTRICTIONS ON PAYMENT OF BENEFITS UNDER THE FECA CONCURRENTLY
WITH BENEFITS UNDER
OTHER FEDERAL PROGRAMS

I. Claimants must elect between Federal Employees' Compensation Act (FECA) benefits and the following benefits payable by other Federal agencies:

A. Civil Service Retirement System Act (CSRS) annuity benefits provided by the Office of Personnel Management (OPM), either regular or disability. The election is not irrevocable, but if a lump-sum payment has been made by OPM as part of an alternative annuity, this must be repaid in full either directly by the employee, or by OWCP from FECA benefits due, before the employee may begin receiving FECA benefits. If OPM benefits are elected, the employee is still entitled to payment of medical expenses for treatment of the accepted condition(s). If FECA benefits are elected, the employee may receive concurrently any benefits payable from the Thrift Savings Fund.

B. Federal Employees' Retirement System Act (FERS) annuity benefits provide by OPM, either regular or disability. The election is not irrevocable. If benefits provided by FERS are elected, the employee is still entitled to payment of medical expenses for treatment of the accepted conditions(s). If FECA benefits are elected, the employee may receive concurrently any benefits payable from the Thrift Savings Fund.

C. CSRS Act survivor benefits provided by OPM. When FECA benefits are elected, the beneficiaries may be paid by OPM the amount of the employee's contribution to the retirement fund in one lump sum. OWCP does not consider the election irrevocable. However, OPM considers an informed election of death benefits provided by OWCP to be irrevocable. If FECA benefits are elected, the beneficiary may receive concurrently any benefits payable from the Thrift Savings Fund.

D. FERS Act survivor benefits provided by OPM. OWCP does not consider the election irrevocable. However, OPM considers an informed election of death benefits provided by OWCP to be irrevocable. If OPM benefits have been paid, the lump sum payment provided as part of the FERS Act death benefit must be repaid in full either directly by the beneficiary, or by OWCP from FECA benefits due, before the beneficiary may begin receiving FECA benefits. If FECA

benefits are elected, the beneficiary may receive concurrently any benefits payable from the Thrift Savings Fund.

E. Any retirement or survivor annuity which stands in lieu of either the CSRS or FERS Act, such as Foreign Service or Central Intelligence Agency disability and retirement programs. The election is not irrevocable.

F. Veterans' Disability or Death Benefits. The election is irrevocable only in those case where the disability or death of the employee has resulted from an injury sustained in civilian employment by the United States, and the Department of Veterans Affairs has held that the same disability or death was caused by military service.

II. Claimants need not elect between FECA benefits and the following, and may receive both concurrently:

A. Veterans' Pension (except as noted above in item F).

B. Fleet Reservist Pay.

C. Military Retirement or Retainer Pay.

D. Social Security Act Benefits. The following restrictions apply:

(1) Social Security Act benefits paid for disability shall be reduced by the compensation payable.

(2) FECA disability benefits will be reduced by the Social Security Act benefits paid on the basis of age and attributable to the employee's Federal service.

(3) FECA death benefits will be reduced by the survivor's benefits paid under the Social Security Act attributable to the employee's Federal service.

E. CSRS or FERS Annuity, if the FECA benefit is in the form of a schedule award for a specified number of weeks on the basis of a permanent loss or loss of use of a member or function of the body.

F. Department of Justice Law Enforcement Officers' Survivor Benefits. The \$50,000 benefit paid to survivors of Federal Law Enforcement Officers who die as a direct result of an injury sustained in the line of duty under the Department of Justice does not constitute a dual benefit.

Exhibit 2: [OPM Contact List \(Link to Image\)](#)

Chapter 2-1100, Feca Third Party Subrogation Guidelines

1. Purpose and Scope. This subchapter outlines the procedures for administering the government's rights under §§ 8131 and 8132 of the FECA to require FECA claimants to seek damages from third parties potentially liable for damages as a result of the FECA-covered injuries, and to refund a portion of any money or other property recovered. This is referred to as "FECA subrogation." This subchapter addresses the responsibilities of the Office of the Solicitor (SOL) and Office (personnel in identifying and administering cases involving potential third party actions; the interrelationship between office personnel and SOL personnel in the Division of Federal Employees' and Energy Workers' Compensation (FEEWC) (formerly the Division of Employee Benefits) at the National Office concerning these actions; and the handling of cases involving litigation in federal court. The necessity for careful evaluation of the appropriate course of action regarding a third party case occurs regularly in the claims adjudication process. Except to the extent specifically provided herein, these procedures apply to actions taken by the United States Postal Service (USPS) in pursuing third party claims. (See FECA PM 2-700.13 and 2-800.3.)

When a third party is or may be legally liable for a FECA-covered injury and any damages are recovered from the liable third party or the third party's insurance company, the OWCP has a right to a refund of a portion of any recovery. This is true even if the damages recovered from the third party are not similar or identical to the benefits paid by the OWCP, such as where OWCP has paid for medical treatment and lost time and the recovery from the third party or the third party's insurance carrier is for pain and suffering only. See *Lorenzetti v. United States*, 467 U.S. 167 (1984).

2. Authority.

a. Section 8131 of the FECA (5 U.S.C. § 8131) provides that, to the extent that an injury or death for which compensation is payable under this subchapter is caused under circumstances creating a legal liability on a person or persons other than the United States (a "third party") to pay damages, OWCP may require the FECA beneficiary to assign a right of action to enforce that liability to the United States, or to prosecute the action in his or her own name.

b. Section 8132 of the FECA (5 U.S.C. § 8132) sets forth the formula for computing the refund due to the United States after a FECA beneficiary receives money or other property from a third party in satisfaction of the third party's liability to the beneficiary.

c. 20 C.F.R. §§ 10.705-10.719, as revised effective January 4, 1999, contain further guidance concerning cases involving liability of a third party

3. Responsibilities of OWCP and SOL. All offices (owning offices, FEEWC, are responsible for ensuring that attorneys and claimants are actively pursuing recoveries from third parties, filing any required Statement of Recovery, and paying the required refund.

a. OWCP.

(1) The District Director. With the exception of certain USPS cases (see paragraph 2-1100.12 below), District Directors (DDs) are responsible for identifying and processing third party cases under 5 U.S.C. §§ 8131 and 8132. This responsibility has been delegated to a limited number of claims examiners, or in certain instances, to fiscal officers or workers' compensation assistants. These persons are known as designated claims examiners.

(2) Each Claims Examiner (CE) is responsible for identifying any potential third party liability during the primary examination of a case in accordance with guidelines contained in FECA PM 2-1100.6, below.

(3) The Designated Claims Examiners (DCE) are responsible for ensuring that third party cases are processed in a timely manner and in accordance with the procedures outlined in this subchapter. This includes the responsibility for timely communications with the appropriate party (i.e., the claimant, the employing agency, SOL, etc.).

(4) Cases in the Branch of Hearings and Review. Where a case has been transferred to the Branch and Review. If the case is one which has not previously been identified as one involving potential third-party liability, the initial notification letter (CA-1045) will be prepared and released by the owning office, but the responsibility for handling the rest of the third-party issues will remain with the normally responsible entity (OWCP office, SOL office, or USPS, as appropriate).

b. SOL. The Division of FEEWC, Office of the Solicitor, Department of Labor, Washington, D.C. is responsible for administering FECA subrogation aspects of any cases referred for that purpose, and for assisting the office in regard to FECA subrogation issues in cases not referred to SOL pursuant to FECA PM 2-1100.7.d.

Pursuant to 20 C.F.R. § 10.705, SOL has been delegated authority to administer the third-party subrogation aspects of certain FECA claims for OWCP. FEEWC has responsibility over all third party claims. In addition, FEEWC coordinates national policy concerning pursuit of refunds due to the United States, and, through the Counsel for FECA Subrogation and the Deputy Associate Solicitor, serves as an adviser to the offices.

c. Inquiries pertaining to a specific third party case will be referred to FEEWC. The CE remains responsible for all other aspects of the case.

4. Letters, Forms and Status Codes.

a. The following letters and forms are used in processing third party cases (Please note that, where the form has been approved by the Office of Management and Budget (OMB); OWCP, SOL, and USPS must use the OMB-approved form):

(1) Ltr. CA-1045, Notice of Third Party Rights and Obligations.

- (2) CA-1121, Request for Information Concerning Third Party Aspect.
- (3) Ltr. CA-1108, Notice of Third Party Obligations (sent by OWCP to attorney).
- (4) Ltr. SOL-1108, Notice of Third Party Obligations (sent by SOL to attorney)
- (5) Form EN-1108, Long Form Statement of Recovery.
- (6) Ltr. CA-1109, Authorization to Anyone to Release Information to Claimant's Attorney.
- (7) Form CA-161, Disbursements Made by the OWCP.
- (8) Form CA-164, Third Party Recovery Worksheet.
- (9) Form CA/EN-1122, Employee's Statement of Recovery Made Without an Attorney - Minor Case, Short Form Statement of Recovery.
- (10) Ltr. CA-1111, Notice to Third Party Insurer.
- (11) Ltr. CA-1044, Notice of Third Party Credit.
- (12) Ltr. CA-1120, Notice of Closure When No Credit Was Created.
- (13) Form CA-160, Referral of Third Party Material.
- (14) Ltr. CA-1110, Request for or Transmittal of Third Party Information.
- (15) CA-1032, Report of Earnings

b. The following status codes are used to track the progress of third party cases:

- 0 No 3rd Party Potential
- 1 Identified as 3rd Party, Not Referred to SOL
- 2 Referred to Solicitor
- 3 USPS Case, Responsibility of USPS
- 4 Closed Minor, Not Economical to Pursue
- 5 Closed Other
- 6 Settled, No Refund Due
- 7 Settled, Refund Not Received
- 8 Settled, Refund Received, No Credit Remaining
- 9 Settled, Refund Received, Credit Against Future Compensation
- 10 Closed, Applicable Statute of Limitations Has Expired
- 11 Closed, Negligent 3rd Party Cannot be Identified
- 12 Closed, Negligent 3rd Party Has Left Jurisdiction
- 13 Closed, Negligent 3rd Party Has No Assets
- 14 Closed, 3rd Party Identified is Clearly Not Liable

5. Definitions.

a. Minor Injury. A minor injury is defined as an injury in which the employee's time lost from work (including sick or annual leave or continuation of pay used to cover the absence) does not exceed 30 days, or total disbursements from the Employees' Compensation Fund do not exceed the current amount for administrative short-form closures.

b. Third Party Case. A third party case is any case in which a third party other than the United States, or an employee of the United States acting within the scope of his or her employment, is potentially liable for an injury, illness, or death which is covered under the FECA.

c. Subrogation Aspects of a FECA Case. The subrogation aspects of a FECA case include the obligation of a FECA beneficiary to prosecute an action against a third party when required by OWCP or SOL, and the obligation of a FECA beneficiary to:

- (1) Report any recovery from a third party; and
- (2) Make the required refund as a result of such recovery.

6. Initial Third Party Screening by the CE. The case creation process includes the entry of certain codes and other information from the Notice of Injury. A predetermined combination of such codes and information automatically marks the computer record as having third party potential and prevents automated administrative closure of the case file. During the primary examination of a case the CE will review the initial claim form and other documents for any indication of potential third party liability which may not have been reflected in the data entered into the computer record at case creation. If the CE believes the injury, illness, or death may have been caused by someone other than a Federal employee acting within the scope of his or her employment, then he or she should refer the case to the DCE with a brief explanation.

The potential for third party liability exists in a variety of situations. Injuries occurring off government premises (a letter carrier slipping on a homeowner's steps or an employee tripping over an uneven pavement surface) or on government premises (a clerk falling over equipment left in a hallway by a contractor) may have third party potential. The use of equipment, or a substance, that causes injury due to faulty manufacture or because it is inherently harmful, may place a liability on the manufacturer or vendor. If the CE sees the existence of third party potential, however doubtful, the CE should refer the case to the DCE for determination.

7. Administration of Third Party Cases by DCE.

a. Initial Actions.

(1) Review the case to determine the status of the third party aspect of the case. If no third party potential actually exists, the third party indicator code will be changed to reflect this. If the Employing Agency (EA) had made an explicit referral for third party action, notify the EA in writing of this decision.

(2) If third party potential exists, release Ltr. CA-1045 (or, in a death case, a narrative equivalent of Ltr. CA-1045) to the claimant, with a copy to the employing agency. If advice is received that the employee has retained an attorney to handle the third party action, the DCE should immediately initiate referral to the FEEWC, consistent with subsection d. of this section, below.

(3) Claims from certain Census Workers – Census Workers (enumerators and field representatives) are required by 13 U.S.C. § 9(a)(2) to maintain the confidentiality of information provided by a resident or establishment, and are subject to criminal penalties including imprisonment under 13 U.S.C. § 214 for the release of information protected by 13 U.S.C. § 9. For this reason, it has been determined that except where an injury is the result of a deliberate act by the resident or the owner of a business establishment, OWCP will not require a Census enumerator or field representative who is injured on the private property of the resident or interviewee to pursue a third party claim against the resident. The Bureau of the Census has been instructed to answer "no" on Form CA-1 in response to the question of whether the injury was caused by a third party. Unless the DCE has confirmed with the Bureau of the Census that the injury was the result of a deliberate act by a resident, or an injury was sustained in transit between interview sites in such a way that the census worker can maintain confidentiality, the DCE should not release Letter CA-1045. For a more detailed discussion, see FECA Bulletin 99-30, issued August 30, 1999.

(4) Develop information needed for the determination of the third party potential, in coordination with the responsible CE, to avoid duplication of effort and confusion on the part of the injured worker. Depending on the situation, such information may include accident reports, names and addresses of witnesses, statements of witnesses, diagrams and photographs, investigative reports, and other similar information that may be helpful in handling the third party aspects of the case. In cases involving dog bites, falls, trips and slips, auto accidents, and product liability, Ltr. CA-1121 should be used to obtain the needed information. The case will be scheduled for review in 30 days.

(5) If no reply to Ltr. CA-1045 is received within 30 days, release another Ltr. CA-1045 with the notation "SECOND REQUEST," and again schedule the case for review in 30 days. If no reply to the second Ltr. CA-1045 is received within 30 days, the DCE should release a letter notifying the claimant that, if a reply is not received within 30 days, the claimant's right to compensation will be suspended pursuant to 20 C.F.R. § 10.708. If no satisfactory response is received within 30 days, the DCE will release a letter notifying the claimant of the suspension of compensation entitlement.

(6) If total OWCP disbursements and/or days of disability have exceeded the established limit for a minor third party case, the case will be set for review by the DCE, with immediate referral to the appropriate office. In addition, any minor third party case should be set for review at three-month intervals. At each review, the DCE should review the case for any new information indicating a possible change in third party status.

(7) Determination Not to Require Action To Be Pursued Against a Third Party. Where a beneficiary makes a written request to OWCP or FEEWC pursuant to 20 C.F.R. § 10.709 to be released from section 8131's requirement that the beneficiary prosecute a claim against a third

party, the beneficiary should include as much detailed information as possible regarding: the circumstances of the injury or death; the extent and amount of damages resulting from the injury or death; the potential for recovery, including, in appropriate cases, an attorney's assessment of the chances of prevailing on the merits, and an attorney's assessment of the costs of suit relative to the potential recovery; and any other considerations the beneficiary or attorney believes to be relevant to OWCP/SOL'S determination whether to release the beneficiary from section 8131's prosecution requirement.

After considering the request of the beneficiary, and any further information or documentation requested from the beneficiary or the attorney, the beneficiary will be provided written notification of the determination on the request. This notification will emphasize that this discharge extends only to the prosecution requirement of section 8131, and that, should a recovery from a third party be received, the refund requirement imposed by section 8132 is still in effect.

b. DCE Action on Receipt of Statement of Recovery (SOR). (The OMB approved SOR, Form EN-1108, must be used.) When the SOR is received along with information concerning the amount of refund, the DCE should take the following actions:

(1) If the SOR has been approved by the SOL, then skip to step (2), otherwise review the claimant's SOR for accuracy. If accurate and complete, approve the SOR by initialing and dating the form.

(2) The DCE should send the appropriate notice to the claimant with a copy to the employing agency and the claimant's attorney. This notice confirms receipt of the refund and informs all parties of any surplus recovery against which future compensation payments must be credited (Ltr. CA-1044 if there is a third party credit, or Ltr. CA-1120 if there is no credit).

(3) If not accurate or complete, the DCE should complete a corrected version of the SOR, scan a copy into the file, and send a copy to the claimant for a new signature, re-submittal, and approval. If necessary, the DCE should request that the claimant provide any sum necessary to satisfy the adjusted amount of the refund. If the claimant has refunded too much money, the DCE should so advise the claimant and process a payment to repay that excess refund. If the SOR is based on old disbursement figures that are no longer accurate because further disbursements have occurred prior to the processing of the SOR, the DCE must revise the SOR to reflect the current (accurate) disbursement figures, and must follow the above procedure for the submission to OWCP of the revised SOR by the claimant, bearing the claimant's signature. Additional disbursements may not be added to the amount of the surplus which must be absorbed prior to reinstatement of compensation benefits.

(4) The DCE follows established procedures for depositing any checks that were directly received and for crediting of the refunded OWCP disbursements to the compensation fund. Where a multi-party check is received which bears proper endorsements of any party or parties in addition to OWCP, the DCE is authorized to endorse and deposit the check on behalf of OWCP, and should not return such a check merely because it is made out to more than one party. When the SOR is received, along with information from the fiscal section concerning the amount

of the refund, the DCE should complete parts A, B, and C of Form CA-164 as appropriate, and forward it to the fiscal section. Form CA-164 allows the DCE to advise the fiscal section of the amount of refund due and the amount of refund actually received, and to indicate needed fiscal actions. The Form CA-164 also serves as documentation of the computation for crediting the refunded OWCP disbursements to the employing agency. The DCE should also ensure that the EN-1108, the completed CA-164, and a copy of the refund check are scanned into the case record.

(5) If the claimant is making a refund in installment payments, the DCE should establish an accounts receivable, and credit each partial payment received against that debt.

c. DCE Action on Receipt of Information Establishing a Recovery (without a completed SOR).

(1) Where a case is being handled directly by OWCP (one not referred to SOL or the USPS), if the DCE determines or has reason to believe that:

- (a) A recovery has occurred, but the claimant has not submitted the required refund; or
- (b) The claimant has not submitted sufficient information to establish the amount of the refund due; or
- (c) The unpaid refund is less than \$2000.00,

the DCE should release a letter notifying the claimant and his/her authorized representative that if the required refund, or requested information needed to determine the amount of the refund, is not received within 30 days, the claimant's right to compensation will be suspended pursuant to 20 C.F.R. § 10.716.

If no satisfactory response is received within 30 days, the DCE will issue a decision advising the claimant of the suspension of compensation entitlement, and provide the claimant with notice of the appropriate rights of administrative review.

(2) On a case not referred to SOL, if the DCE receives information that a recovery has occurred which results in a refund owed by the claimant greater than \$2,000, the DCE will automatically refer the case to SOL. Section 10.716 of 20 C.F.R. provides that the waiver provisions of 20 C.F.R. §§ 10.432 through 10.440 do not apply to actions taken to collect such refunds.

d. Referral to SOL by the DCE.

(1) After a case is identified as a potential third party case, the DCE will refer it to FEEWC. All cases are to be referred to FEEWC. In addition, the following classes of cases are to be referred:

- (a) Cases which were properly not initially referred (because they met the definition of "minor injury"), but which no longer meet that definition;
- (b) Cases where an attorney is involved; and

(c) Cases from the same incident arising in more than one office, such as group injuries, plane crashes, class actions, and similar circumstances.

(2) When a case is identified for referral, the DCE will refer the case to FEEWC using Form CA-160. Copies of the CA forms, as well as copies of other pertinent documents such as witness statements, accident reports, medical reports, correspondence from an attorney, etc., must accompany the Form CA-160. The case record itself will be retained by the office. A copy of the Form CA-160 will be placed into the case record.

(3) When a case is referred to FEEWC, the computer record will be updated to reflect the new third party indicator code.

(4) After initial referral, the DCE will furnish any other pertinent information at the same time. Any material that, in the opinion of the DCE, is urgent should be sent immediately to FEEWC.

e. Action by DCE on Receipt of Information from FEEWC.

(1) Notice of Settlement or Judgment. FEEWC will contact the DCE when notice is received that a settlement or a judgment has been received in a third party case which is expected to result in a surplus. On receipt of this information, the computer record will be updated to reflect the appropriate indicator code, and the DCE will calculate all benefits paid to the FECA beneficiary. The DCE will immediately forward this information to FEEWC, which will advise the FECA beneficiary's attorney, or the FECA beneficiary (if unrepresented) of the total amount of disbursements.

(2) On receipt of a memorandum from FEEWC recommending action by the owning office (such as a memorandum under 2-1100.8.d.(2) recommending sanctions for failure to prosecute an action, file a SOR, or pay the required refund), the DCE will analyze the evidence, information, and recommendations from FEEWC, and will take appropriate action, including forfeiture or suspension of compensation benefits, based on the FEEWC's recommendations.

(3) Where the formal decision denies a request for payment of compensation benefits, or results in payment of past or continuing compensation benefits in an amount less than that requested or anticipated by the claimant, the formal decision should be accompanied by full appeal rights.

(4) Where the decision addresses an issue solely related to the calculation of the statutory right of reimbursement or the refund due to the United States under 5 U.S.C. § 8132, and does not suspend or terminate compensation benefits or deny a request for payment of benefits, the claimant should not normally receive notification of appeal rights. In such circumstances (for example, where there is no continuing compensation entitlement, and OWCP requests that the claimant refund an additional amount beyond that which the claimant has already paid to OWCP), OWCP should notify the claimant that it will evaluate any additional evidence or argument that the claimant wishes to submit supporting a contention that the formal decision is incorrect.

f. Other Duties of the DCE. The DCE performs other duties as set forth in this subchapter. For example, the DCE may be required to take action based on receipt of information or requests from FEEWC (2-1100.8), and is responsible for debt collection on cases that have not been referred to FEEWC. (2-1100.11.a). In addition, paragraphs c. and d. of 2-1100.12 describe the DCE's responsibilities regarding third party cases handled by the USPS pursuant to the memorandum of agreement between OWCP and USPS.

8. SOL Administration and Case Management of Third Party Cases.

FEEWC is responsible for supervising the subrogation aspects of FECA third party damage claims referred by the office. They will monitor the progress of all third party claims transferred to their offices for handling and will keep the FECA beneficiary's attorney, or the FECA beneficiary, if unrepresented, apprised of the current disbursement amounts. When responsibility for administration of third party liability is transferred to the FEEWC, the FECA beneficiary's attorney, or the FECA beneficiary, if unrepresented, will be notified of the transfer, and will be advised of the obligation to prosecute an action for damages against the party responsible for the injury.

a. Once the DO has referred a third party claim to FEEWC, FEEWC will:

(1) Review the claim to verify that there is third party liability and that the claim meets the criteria to be referred to SOL; if either of these requirements is not satisfied, the case will be returned to the owning office, with an explanation for the return;

(2) Advise the claimant or the claimant's attorney of the provisions of 5 U.S.C. §§ 8131 and 8132. Also, the attorney should be advised that if it is the attorney's opinion that the claim is not economical to pursue, the attorney should make a written request under 20 C.F.R. § 10.709 for release of the obligation to pursue a recovery (providing the information described above in 2-1100.7.a.(6)). FEEWC will then make a determination whether to discharge the claimant's obligation under the Act to pursue an action against a third party; and

(3) Provide the claimant or attorney with current disbursements including printouts of the compensation and bill payment histories. In death claims, the disbursements will be reported separately for each beneficiary.

b. Initial FEEWC Action on Receipt of Referral. On receipt of a case, FEEWC will make an initial analysis to ensure that the case receives sufficient attention in advance of the expiration of the statute of limitations. The FEEWC will establish and use an automated reminder system (docket, AR, or similar system) to track cases pending in the office, and will request periodic status reports from the claimant and/or the claimant's attorney.

c. Beneficiary's Failure to Respond. A FECA beneficiary is required to take action against a responsible third party to satisfy the requirements of §§ 8131 and 8132 of the FECA. A FECA beneficiary is also required to provide periodic status updates and any other relevant information in response to requests from OWCP or FEEWC, 20 C.F.R. § 10.707. If a FECA beneficiary refuses or fails to respond to requests for information, it may be determined that he or she has forfeited his or her right to compensation, or that the right to compensation is suspended, under

20 C.F.R. § 10.708. FEEWC will send two warning letters to the FECA beneficiary's attorney or the FECA beneficiary, if unrepresented, before notifying OWCP of its recommendation concerning the appropriate action to be taken due to the FECA beneficiary's failure to respond. Also note that when a FECA beneficiary is represented by counsel, the primary responsibility for providing periodic status updates and any other relevant information is counsel's.

When a FECA beneficiary is represented by an attorney, all SOL contact should be made with the FECA beneficiary's attorney. In such circumstances, FEEWC should not communicate directly with the beneficiary on matters within the scope of the attorney's representation, unless the attorney has provided FEEWC specific written permission for such practice.

If a represented FECA beneficiary contacts FEEWC by telephone, the beneficiary should be advised that FEEWC will not discuss any matters with him or her without the attorney's express permission. If FEEWC receives written correspondence from a represented FECA beneficiary, the written response by FEEWC should be sent to the FECA beneficiary's attorney.

d. Failure to Prosecute an Action.

(1) What constitutes failure to prosecute? 20 C.F.R. § 10.707 sets forth the minimum that is required of a FECA beneficiary who has been notified that action against a third party is required. Paying the required refund alone, after a recovery from a third party has been received, is not the only requirement that must be satisfied. Among other responsibilities, the beneficiary is responsible for providing periodic status reports and other information when specifically requested to do so by OWCP or FEEWC. In addition, as provided by § 10.707(c), unless specific permission is granted by OWCP or FEEWC, the beneficiary may not settle or dismiss a case for any amount less than the refundable disbursements as defined in § 10.714.

(2) Sanctions for Failure to Prosecute. Under 20 C.F.R. § 10.708, OWCP/SOL may determine that a FECA beneficiary who fails to satisfy the statutory and regulatory requirements for prosecution of a third party action has forfeited all past and future compensation benefits. Rather than declare all compensation forfeit, CP/FEEWC may also suspend compensation benefits until the beneficiary complies with the request.

When FEEWC believes that sanctions for failure to prosecute an action are appropriate, FEEWC should prepare a referral memorandum to the owning office which includes suggested findings of fact and statements of reasons for the imposition of sanctions. The memorandum from SOL will also make a specific recommendation whether suspension or forfeiture is the appropriate sanction in the particular case, and should also contain an analysis of the expiration date of the statute of limitations for the filing of the underlying third party action.

e. Release of Obligation to Prosecute an Action. In addressing requests from claimants and/or their attorneys, FEEWC will use the same procedures set forth above in 2-1100.7.a.(6) for the DCEs.

f. Notice of Settlement or Judgment. FEEWC should notify the DCE of all settlements and judgments. If a settlement or judgment is expected to result in a surplus, SOL will notify the

DCE that payment of continuing compensation benefits should therefore be suspended pending exhaustion of the surplus.

g. Approval of the SOR. Once the signed SOR is submitted, SOL will review it for accuracy and compliance with the FECA and these procedures. If the SOR is signed and filled out completely and correctly, it should be approved as submitted. If the claimant or the attorney does not sign the SOR, or if the SOR must be revised or redrafted, it should be returned for a proper signature. However, if a check is received, even if the check is not accompanied by a SOR, or by an incorrect SOR, the check should be forwarded to OWCP. Upon approval of the SOR, it will be forwarded to the claimant or his/her attorney, with a request that the government's refund, if not already received, be submitted within thirty days of the receipt of the letter. Also, an approved copy of the SOR is forwarded to the owning office. Detailed instructions for completing a SOR are contained in 20 C.F.R. § 10.711 and section 2-1100.9 of this subchapter. In case of disputed issues, see subsection i below.

h. Procedures for Processing Refund Checks Received in FEEWC. FEEWC must have, at a minimum, a manual system for maintaining a log of all checks received. In addition, all third-party refund checks received in the office must be kept in a secure location.

Upon receipt of the government's refund by FEEWC, FEEWC will forward the check to the OWCP National Office, which in turn will send the check and the approved SOR to the appropriate lockbox depository. FEEWC should notify the DCE whether completion of this action closes the third party subrogation aspects of the case. For any SOR for which a refund check has not been received, the debt should be collected in accordance with the procedures described in 2-1100.11.

i. Actions on Disputed Issues. Where a claimant or an attorney expresses a disagreement with the action of FEEWC in handling the third party aspects of a claim, and this disagreement cannot be resolved, FEEWC should advise the claimant's attorney to request that a formal determination be issued regarding the disputed issue or issues. Where FEEWC receives such a request, it should prepare a referral memorandum to the owning office. This memorandum should include suggested findings of fact and statements of reasons, as well as a specific recommendation for a course of action. All formal decisions regarding disputed issues arising out of the processing of third party claims will be issued by OWCP. See 2-1100.7.e, above, describing the duties of the DCE on receipt of a recommendation from SOL.

The Department of Labor cannot waive or compromise the statutory right of reimbursement that arises as a result of the language of § 8132. If an attorney requests that the statutory right of reimbursement be waived or compromised, the attorney should be referred to the Employees' Compensation Appeals Board (ECAB) decision in Willie E. Cantrell, 13 ECAB 490, at 493 (1962), in which the ECAB stated that the "terms of the [FECA] are specific as to what shall be charged against the proceeds of a third-party recovery and neither the Bureau (OWCP's predecessor agency) nor the Board has the authority to waive or compromise the requirements of the Act." See also Charles Howell, 38 ECAB 421 (1987), and cases cited therein.

9. Processing the SOR.

a. Submission of the SOR. A FECA beneficiary (or the beneficiary's attorney) is required to submit detailed information about the amount recovered and the costs of suit on the SOR form pursuant to 20 CFR 10.707(e). The FECA beneficiary or attorney should notify OWCP or FEEWC, in writing, within 30 days of receipt of a third party settlement. A SOR must be filed for each recovery received by a FECA beneficiary. When multiple settlements or recoveries after settlement or judgment are obtained from different third parties on account of the same injury or illness, a SOR must be filed and any indicated refund due to the United States must be made within 30 days after receipt of each recovery.

b. Failure or Refusal to Submit a SOR.

(1) Action to be Taken When the Beneficiary Has Failed or Refused to Submit a SOR. Whenever OWCP/FEEWC becomes aware that a FECA beneficiary (or the beneficiary's attorney) has failed or refused to submit a SOR within 30 days of a recovery, OWCP/FEEWC shall issue a letter by certified mail notifying the FECA beneficiary of the failure and allowing the FECA beneficiary or the beneficiary's attorney 30 days from the date of the letter to file a statement of recovery. If good cause is demonstrated by the FECA beneficiary, OWCP/FEEWC can extend that time for 30 days. Should the FECA beneficiary or the beneficiary's attorney fail to file the SOR within the required time frame and OWCP/FEEWC has a copy of the settlement agreement or equivalent information regarding the gross recovery, OWCP/FEEWC shall prepare an approved statement of recovery based on the available information and the appropriate OWCP/FEEWC personnel shall sign it demonstrating the approval. The approved statement of recovery should be mailed by certified mail to the FECA beneficiary and the beneficiary's attorney if any within 30 days after the deadline established for filing the SOR. The approved statement of recovery becomes final unless objected to by the FECA beneficiary or the beneficiary's attorney within 30 days of the date the approved statement of recovery is mailed to the FECA beneficiary and the beneficiary's attorney if any. In filing his or her objections, the FECA beneficiary and the beneficiary's attorney shall request a formal determination as defined in the disputed issues procedures above (2-1100-8(i)) and set forth the reasons for the objections.

(2) Sanctions for Failing or Refusing to File an SOR. The duty to file a SOR is part of a beneficiary's duty to prosecute. Whenever OWCP/FEEWC determines that the beneficiary has failed to timely file a SOR, OWCP/FEEWC may at its discretion utilize the procedures and sanctions listed above in 2-1000-8(d)(2).

c. Allocation of Joint Recoveries. When a settlement or judgment is paid to, or for, one individual, the entire amount is reported as the gross recovery on Line 1 of the SOR. If a settlement or judgment is paid to, or for, more than one individual, or in more than one capacity, such as a joint payment to a husband and wife for personal injury and loss of consortium or a payment to a spouse representing both loss of consortium and wrongful death; the entire amount is still reported as the gross recovery on Line 1 of the SOR, from which certain deductions may be made to arrive at the amount to be allocated to the injured employee. If a judge or jury specifies the percentage of a contested verdict attributable to each of several plaintiffs, that division will be accepted.

In any other case, where a judgment or settlement is paid to or on behalf of more than one individual, a determination will be made concerning the appropriate amount to be allocated to the injured employee, and the FECA beneficiary will be advised of that determination. The FECA beneficiary may accept the determination or demonstrate good cause for a different allocation. Whether to accept a specific allocation is at the discretion of OWCP and FEEWC. Recurring circumstances involving allocations include:

(1) Loss of Consortium. Any proposed deduction (Line 4) from the gross recovery reported on Line 1 of a SOR by attributing a portion of the settlement or judgment to damages for loss of consortium by a family member must be approved by OWCP or FEEWC. A portion of a settlement or judgment may be attributed to a cause of action for loss of consortium and thus not included in the gross recovery of the FECA beneficiary set forth on a SOR only under the following conditions:

- (a) State law in the relevant state provides a cause of action for loss of consortium for the family member to whom the recovery is attributed, and
- (b) A cause of action for loss of consortium was actually asserted by that family member, either in the same action or in separate actions, or in negotiation of the settlement where a settlement was obtained without the actual filing of litigation. In support of a request for an allocation of a portion of a settlement or judgment to a spouse or a child or children, the FECA beneficiary must demonstrate that the above referenced conditions are met by citation to appropriate state case law or statutes and by submission of a copy of the complaint filed on behalf of the spouse and/or children, or other relevant evidence.

Upon receipt of such a request, absent unusual circumstances, an allocation of a joint settlement or judgment to loss of consortium in an amount of 25% or less for the spouse and 5% or less for each child up to a maximum of 15% for all children will be approved. In the event a FECA beneficiary seeks to justify an allocation in excess of these figures, it will be necessary for him or her to establish to the satisfaction of OWCP or FEEWC, through submission of evidence and legal argument, that a higher percentage is appropriate. Use of this formula is generally not appropriate in circumstances where a FECA beneficiary has died prior to settlement or judgment.

(2) Death Cases. Under appropriate circumstances, an injury to an employee of the United States can result in payments to the employee and/or his or her estate, spouse, and children. Thus, in the event an employee incurs an illness or injury covered by FECA and subsequently dies, separate causes of action may exist for his or her pain and suffering, for a spouse or a child's loss of consortium and for wrongful death. A recovery attributable to each of these causes of action must be reported by means of a SOR filed on behalf of the person receiving the recovery (e.g. estate, spouse or child) if that person received any benefits under FECA.

- (a) A SOR filed on behalf of the deceased employee should report all funds received by the estate attributable to any causes of action possessed by the employee. This would include a cause of action for pain and suffering while the employee was alive.

(b) A surviving spouse who received FECA benefits on account of the death of a federal employee becomes a FECA beneficiary obligated to file a SOR upon receiving a third party recovery as a result of the death of his or her spouse. This would include a cause of action for the wrongful death of the employee. A surviving child who receives FECA benefits and a third party recovery is in the same situation and has the same obligation as the surviving spouse. A surviving spouse and/or child who receives an award for loss of consortium/society during the deceased employee's life is not required to file a SOR reporting that award or to include that recovery in the gross recovery reported on a SOR otherwise required to be filed.

c. Any apportionment made by the court or by a jury in a contested judgment will be accepted. However, joint judgments or settlements in other circumstances are subject to SOL review for purposes of determining any appropriate allocation for FECA purposes. FECA beneficiaries may utilize certain allowable percentages in any case involving a deceased federal employee and a surviving spouse or child where it is determined that the settlement or judgment represents causes of action attributable to more than one person.

(1) In order to utilize the following acceptable percentage allocations below in (2) and (3), a FECA beneficiary must demonstrate that:

(a) State law in the relevant state recognizes each cause of action to be utilized in the allocation; and

(b) Each cause of action was asserted by the family member, either in the same action or in a separate action, or in negotiations of the settlement in situations where a settlement was obtained without filing litigation.

(2) Upon such demonstration, in cases where causes of action were asserted for pain and suffering of the employee prior to his or her death and for loss of consortium, but not for wrongful death, the following standard allocation percentages will be allowed:

(a) 25 percent of the total to be allocated to the spouse;

(b) 5 percent of the total to be allocated to each child, up to a total of 15 percent for all children; and

(c) The remainder to be allocated to the deceased federal employee.

(3) In cases where causes of action are asserted for pain and suffering of the employee prior to his or her death, for loss of consortium, and for wrongful death, the following standard allocation percentages will be allowed:

(a) 15 percent of the total to be allocated to the spouse's claim for loss of consortium;

(b) 5 percent of the total to be allocated to each child up to a total of 10 percent for all children for loss of consortium;

(c) 35 percent of the remainder after subtraction of the amounts attributed to loss or consortium to be allocated to the deceased federal employee, survival claim; and

(d) 65 percent of the remainder after subtraction of the amounts attributed to loss of consortium to be allocated to the spouse, wrongful death claim.

d. Malpractice.

(1) Medical Malpractice. When a FECA beneficiary's FECA-covered injuries are aggravated by medical malpractice, any settlement or judgment relating to the malpractice is a recovery subject to §8132. In computing the required refund, a claimant may request to utilize only the disbursements attributable to the medical malpractice in filing his or her SOR. The claimant must provide probative evidence and analysis to allow a determination to be made by OWCP/FEEWC regarding the amount of the disbursements that would have been paid absent the malpractice, in order to subtract that amount from the total disbursements actually paid.

Where none of the expenses properly attributable to the malpractice have been paid for or reimbursed by OWCP under the FECA, the claimant is still required to file a SOR for the malpractice recovery. This will normally result in a substantial third party surplus, which is unlikely to be absorbed (because any subsequent medical expenses and compensation benefits properly borne by OWCP would be attributable to the original compensable injury, rather than the injury caused by the malpractice).

(2) Legal Malpractice. A recovery from a third party for legal malpractice is not considered a recovery subject to § 8132.

e. Structured Settlements. One particular type of settlement agreement, generally referred to as a structured settlement, in which a third party makes an initial cash payment and also arranges, usually through the purchase of an annuity, for periodic payments over an extended period of time, raises a number of issues that must be carefully considered. The dollar amount to be included on Line 1 is the present value of the right to receive all of the payments included in the structured settlement, allocated in the case of multiple recipients in the same manner as single payment recoveries. See (20 CFR § 10.713). In situations where the periodic payments are funded by the purchase of an annuity by the responsible third party, the cost of the annuity to the third party will be accepted by OWCP and FEEWC as the present value of the right to receive the future payments. If the FECA beneficiary (or the beneficiary's attorney) wishes to use a different method of computing the present value, the beneficiary should make a written request for a formal determination on this issue. For purposes of filling out the SOR and making the required refund, it is the beneficiary's burden to provide probative evidence and analysis to allow a determination to be made by OWCP/FEEWC regarding the use of a different method of computing the present value of the right to receive periodic payments.

f. Refundable Disbursements. The refundable disbursements of a claim consist of the total money paid by OWCP from the Employees' Compensation Fund. However, charges for medical file review done at the request of OWCP are excluded. Any medical file review charges will automatically be deducted from the bill pay history. See (20 C.F.R. § 10.714). Continuation of

pay is not compensation and is not subject to the subrogation and refund provisions of FECA. See Paul L. Dion, 36 ECAB 656 (June 19, 1985; petition for reconsideration denied, November 14, 1985).

Where the FECA beneficiary requests that the total disbursements be reduced by the cost of medical examinations required to be made available to the employee by the employing agency or at the employing agency's cost under a statute other than the FECA, the beneficiary has the burden of establishing that the examinations were so required. OWCP or FEEWC will notify the beneficiary in writing of its determination on this matter. See (20 C.F.R. § 10.714).

g. Attorney's Fees. Reasonable attorney's fees can be deducted from the gross recovery and from the refundable disbursements. Attorney's fee percentages are computed by dividing the amount of fees actually paid by the net recovery listed on Line 7. The percentage must be considered reasonable by OWCP or FEEWC. Generally, any fee in excess of 40% would be deemed inappropriate and such deduction would be disallowed. If an attorney representing a FECA beneficiary reduces his or her fee from the amount originally agreed to by the FECA beneficiary, the reduced percentage would apply to the OWCP refundable disbursements.

h. Costs of Suit. The costs of suit, as allowed by OWCP or FEEWC, may be deducted on the SOR and must be itemized when submitted to OWCP or FEEWC. If such itemization of costs is not received by OWCP or FEEWC, those costs will be disallowed. Examples of costs which are permitted are out of pocket expenditures that are not part of the normal overhead of a law firm's operation, e.g., filing fees, travel expenses, record copy services, witness fees, court reporter costs for transcripts of hearings and depositions, postage, and long distance telephone calls. Examples of costs which are not permitted are normal overhead costs of a firm, e.g., in-house record copying, secretarial or paralegal services, and co-counsel fees. If, for example, a firm lists as a separate cost item a specific charge (for computer time or metered access time for legal research on Westlaw or some other legal research provide), and this charge is specific to the individual case, this would be an allowable cost. On the other hand, a cost item for a "percentage" of a firm's legal research costs would not be allowable, because this amounts to the firm attempting to recover for overhead costs.

To determine the amount to be listed on Line 10 of the SOR, multiply the court costs allowed by the percentage shown at Line 4, and subtract this amount from the allowed court costs. Multiply the balance by the percentage shown at Line 6 and enter this amount on Line 10. The United States does not contribute to or pay costs associated with the third party action. The FECA does not provide for or authorize the payment of costs other than as a deduction from the third party recovery. See Alonzo R. Witherspoon, 43 ECAB 1120, 1124 (1992).

i. Releases. In any case where a claimant requests that OWCP execute a release in connection with the subrogation aspects of a third-party case, that request should be referred to FEEWC. Since the United States is not a party to the underlying litigation between the claimant and the third party, it is not appropriate to execute a release of the liability of the third party to the FECA claimant. It is appropriate, however, to furnish the claimant a letter acknowledging compliance with the provisions of 5 U.S.C. §§ 8131 and 8132.

10. Compensation Status Following Refund to the United States.

a. Under section 8116(a) of the FECA (5 U.S.C. § 8116(a)), a beneficiary may not receive compensation under the FECA simultaneously with salary, pay, or remuneration from the United States. With certain exceptions, a beneficiary must elect whether to receive benefits under the FECA, or benefits to which the beneficiary is entitled by virtue of the employee's status as a federal employee. A beneficiary may receive OPM benefits for any period for which a refund has been made, and is not considered in receipt of compensation during any such period (see Program Memoranda Nos. 90, 130, and 277).

b. Exhaustion of Surplus.

(1) During the period of exhaustion of the third party surplus, the beneficiary is not considered to be in receipt of compensation. If he or she elects OPM retirement benefits, payment of this annuity does not constitute a prohibited dual benefit. When the surplus has been exhausted, the beneficiary should be given the opportunity to elect between FECA benefits and the OPM annuity. Compensation benefits may be elected effective the day after the absorption of the third party surplus (see Program Memorandum No. 130).

(2) Where a beneficiary who has received a recovery from a third party has made the required refund, but subsequent events result in payment of compensation benefits (including medical benefits) for a period of time during which a third party surplus was in the process of being absorbed from continuing compensation entitlement, this results in an overpayment of compensation. Such an overpayment of compensation should be adjudicated and processed by OWCP according to the usual overpayment procedures set forth in Part 6 of the Procedure Manual.

(3) Where a beneficiary has received a third party recovery resulting in a surplus, this surplus is noted in the computer record, and the adjudication status code is changed to A0 to prevent the further payment of benefits. Compensation payments are calculated and continue to be charged against the surplus, as are medical expenses that have been paid by the claimant and submitted for reimbursement. Claimants should be encouraged to submit reimbursement requests for medical expenses as they are incurred, even though the amounts paid for such expenses will result in reduction of the surplus, rather than actual payment of additional benefits.

(4) Directed Medical Exams and File Reviews in Third Party Cases. Although benefits are not otherwise payable when a third party surplus exists, if the responsible CE finds it necessary, in the course of normal case management, to obtain a Second Opinion Exam, a Referee Exam, or a medical file review, then the costs will be directly paid by OWCP and any reasonable expenses incurred by the claimant will be reimbursed. These expenses should not be added to the surplus against future compensation entitlement.

(5) Vocational Rehabilitation in Third Party Cases. Vocational rehabilitation expenses are not payable if a third party surplus exists (see Program Memorandum No. 34). The claimant may pay for a rehabilitation counselor, training, and related expenses in an approved vocational

rehabilitation program. If approved by OWCP after its review, such expenses may be used to reduce the amount of the third party surplus.

(6) Section 8133(a) of the FECA provides differing percentage distributions depending on the existence of certain eligible beneficiaries; § 8133(b) specifies that entitlement to compensation ceases upon the occurrence of certain events; and § 8133(c) provides for reapportionment of compensation "on the cessation of compensation under this section to or on account of an individual." Only the occurrence of one of the events described in §8133(b) (e.g., remarriage of a widow prior to age 55) can trigger the reapportionment of compensation among the other beneficiaries. The stoppage of compensation payments to an eligible beneficiary to offset a third party surplus is not one of the events enumerated in § 8133(b), and thus does not constitute a basis for reapportionment under §8133(c). The percentage rates to be used are those specified in § 8133(a), regardless of whether the compensation otherwise payable to another eligible beneficiary is being credited against a third party surplus. As an example, if a widow participated in a third party recovery and is offsetting a third party surplus, and a minor child did not participate in the recovery, or participated but has offset his or her portion of the surplus, compensation for the child would continue to be paid based on 15 percent of monthly pay. See Beverly Grunder, claiming as widow of Franklin W. Grunder, 36 ECAB 456 (1985).

11. Establishment of Debt and Debt Management. When a debt to the United States is established by OWCP/SOL's approval of a SOR, OWCP/SOL has an obligation to collect the debt. Each office (office, FEEWC) should maintain a log of every debt (i.e., a collection docket) which has been established as a result of a recovery from a third party.

a. OWCP Office Responsibility for Debt Collection in Non-Referred Cases. Upon establishment of the debt, OWCP should advise the claimant that a debt is owed to the United States, and make an initial demand for payment of this debt. For non-referred cases, the DCE is responsible for releasing the initial demand letter. This initial demand letter must notify the debtor of:

- (1) The basis for the debt;
- (2) The applicable standards for imposing interest, penalties, or administrative costs;
- (3) The date by which payment should be made;
- (4) The name, address and telephone number of a contact person or office within the agency;
- (5) That the debtor may enter into a mutually agreeable written repayment agreement; and
- (6) That the debtor may make a written request for a review of the determinations regarding the amount of the debt, its past-due status, and its legal enforceability.

The initial demand letter in any non-referred case should also note that, unless payment is received within 30 days, interest shall accrue as of the date of the initial demand letter. If payment is not received on such case, a second letter will be released notifying the claimant that the debt remains outstanding and that entitlement to compensation is subject to suspension for

failure to satisfy the debt. The computer record will be updated to reflect the fact that the debt remains unpaid. If a claim for further benefits is received prior to the payment of the debt, the CE should consider whether to issue a formal decision suspending or forfeiting entitlement to benefits, under 20 C.F.R. §10.708.

Pursuant to 20 C.F.R. § 10.715, interest shall accrue, at the U.S. Treasury rate (Current Value of Funds), on the refund due to the United States from the date of the request, if the refund is not submitted in full within 30 days of the receipt of the request for payment. OWCP or SOL may waive the collection of interest in accordance with 29 C.F.R. § 20.61.

b. SOL Responsibility for Debt Collection in Referred Cases.

(1) For referred cases, FEEWC should advise the claimant and/or the attorney that a debt is owed to the United States, and make an initial demand for payment of this debt. The initial demand letter must notify the debtor of:

- (a) The basis for the debt;
- (b) The applicable standards for imposing interest, penalties, or administrative costs;
- (c) The date by which payment should be made;
- (d) The name, address, and telephone number of a contact person or office within the agency;
- (e) That the debtor may enter into a mutually agreeable written repayment agreement; and
- (f) That the debtor may make a written request for a review of the determinations regarding the amount of the debt, its past-due status, and its legal enforceability.

(2) The initial demand letter in any referred case should also note that, unless payment is received within 30 days, interest shall accrue, at the U.S. Treasury rate (Current Value of Funds), as of the date of the initial demand letter. If payment is not received on such case within 30 days, a second letter should be released notifying the debtor that the debt remains unpaid, and that the attorney, firm, and client are subject to the provisions of 5 U.S.C. § 8132 which apply to any individual who disburses funds received from a third party recovery without satisfying, or assuring the satisfaction of, the interest of the United States. If payment is not received within 30 days of this second letter, FEEWC should make a determination whether to collect the debt, plus applicable interest, through any of the following options:

- (a) Periodic payments (installment payment plan);
- (b) Deduction from continuing compensation;
- (c) Suspension or forfeiture;
- (d) Referral to the Department of the Treasury;

- (e) Referral to the Department of Justice; or
- (f) Salary offset.

(3) The following is a concise description of the details regarding these six options for FEEWC collection of debts:

(a) Periodic payments – if a debt can be collected through periodic payments within three years, FEEWC may enter into an agreement with the debtor for periodic payments. Such agreements shall provide that the payments will be made directly to OWCP; once the agreement is signed, FEEWC will notify OWCP of the terms of the agreement, and will close the file and delete it from the collection docket. OWCP will then enter the debt into its system.

(b) Deduction from continuing compensation – in appropriate cases, FEEWC will prepare a memorandum to the DCE recommending collection of the debt from continuing compensation entitlement. On receipt of such a memorandum, the DCE will enter the debt into the system, will request financial information from the claimant, and will then make a determination regarding the amount to be collected from each continuing compensation payment. In making such determination, the DCE should follow the procedures set forth in the Federal (FECA) Procedure Manual, Part 6-Debt Management, except that the waiver provisions of Part 6 do not apply to these determinations. After referral to the DCE, FEEWC will close the file and remove it from the collection docket.

(c) Suspension or forfeiture – where FEEWC concludes that suspension or forfeiture is an appropriate response to nonpayment of the debt, FEEWC will prepare a memorandum to the DCE recommending suspension or forfeiture. After evaluation of this memorandum, the DCE will issue a formal decision with appropriate appeal rights.

(d) Referral to Department of the Treasury – where payment is not received within 60 days of the date of the initial demand letter, and FEEWC concludes that referral to the Department of the Treasury is appropriate, FEEWC will send a third letter which notifies the debtor(s) of its intent to collect the debt by referral to Treasury, and will prepare a memorandum to OWCP's National Office requesting referral of the debt to Treasury for collection. FEEWC will prepare the necessary background materials and refer these materials to OWCP. The debt will remain on the FEEWC's collection docket until SOL receives notice from Treasury that the debt has been collected, or that Treasury has ceased collection efforts. Where Treasury notifies OWCP/FEEWC that it has ceased collection efforts, FEEWC will make a determination whether to close the file and remove it from the collection docket.

(e) Referral to the Department of Justice – where payment is not received within 60 days of the date of the initial demand letter, and FEEWC concludes that referral to the Department of Justice is appropriate, FEEWC will prepare a memorandum to the Department of Justice, and will submit a Claims Collection Litigation Report to the Department of Justice Intake Facility in Silver Spring, Maryland. With respect to filing suit to enforce collection of a debt, 28 U.S.C. § 2415(a) provides that any such action must be filed within 6 years after the right of action accrues or within 1 year after a final administrative decision has been rendered on the matter,

whichever is later. The debt will remain on the FEEWC collection docket until FEEWC receives notice from Justice that the debt has been collected, or that Justice has ceased litigation efforts. Where Justice notifies OWCP/FEEWC that it has ceased litigation efforts, FEEWC will make a determination whether to close the file and remove it from the collection docket.

(f) Salary offset – In an appropriate case, FEEWC may initiate salary offset proceedings, and must follow the Department of Labor Salary Offset regulations set forth in 29 C.F.R. §20.74 through 20.90.

12. USPS Cases.

a. General responsibilities for the processing of third party cases under 5 U.S.C. §§ 8131 and 8132 are outlined above in FECA PM 2-1100.3. However, to more efficiently and effectively accomplish the stated purpose of the FECA with regard to third party recoveries, the Director of OWCP has entered into a memorandum of agreement with the USPS whereby the OWCP has agreed that the USPS may supervise the third party aspects of certain cases. The USPS cannot enter into litigation on behalf of the United States under 5U.S.C. § 8131, and may not make direct referral to the Department of Justice for litigation on behalf of the United States.

The USPS may pursue the collection of damages from the responsible third party by administrative means, including obtaining the employee's assignment to the USPS of any right of action the employee may have to enforce the liability, provided that such assignment is voluntary on the part of the employee. The USPS cannot require the employee to make such assignment. The USPS must follow the guidelines established by OWCP for processing any funds recovered from the third party, including the use of the OMB-approved SOR (Form EN-1108).

Pursuant to the memorandum of agreement, the USPS supervision of the third party aspects of FECA cases is limited to cases of traumatic injury, except those traumatic injury cases which fall within one or more of the following categories:

- (1) Where the traumatic injury results in the death of the employee;
- (2) Where the injury occurred outside of the United States or Canada;
- (3) Where the injury occurred when the employee was a passenger in a common carrier conveyance;
- (4) Where malpractice or product liability is involved;
- (5) Where injuries are sustained by more than one employee in the same incident (group injuries).

b. The USPS is responsible for sending OWCP an initial status report within 3 months of the date the employee files any notice of injury on which the official superior has marked the injury as being caused by a third party. This report may be a copy of correspondence to the injured worker or memorandum directed to OWCP documenting the initial actions of the USPS regarding

pursuit of recovery from the third party. If the USPS has decided not to pursue recovery from a third party, this should be stated in the initial report. If the USPS does pursue recovery, then it should provide a status report each 6 months after the initial report.

c. Responsibilities of the DCE for USPS Cases.

(1) The DCE takes no action unless the USPS reports it is pursuing recovery, or the DCE receives information from some other source that the FECA beneficiary is pursuing recovery.

(2) If information is received that the third party aspect has been or will be pursued by the USPS, the computer record will be updated to reflect this. The DCE will monitor the case on a periodic basis (every 6 months) until the case is closed. During this period, the DCE will cooperate with the USPS and will provide any needed assistance, including the furnishing of a statement of disbursements (Form CA-161) within five working days of receipt of a request from the Postal Service.

(3) If information is received indicating the FECA beneficiary is pursuing recovery, the DCE will send a letter to the USPS asking for the status. If the USPS responds that it is pursuing recovery, the DCE proceeds as described above. If the USPS fails to respond within 30 days or states it is not pursuing recovery, then the DCE assumes jurisdiction of the case. The DCE should proceed in accordance with the established procedures for initiating third party recovery action, and so notify the USPS.

(4) If the USPS refers the third party case back to OWCP for any reason, the DCE will accept the referral without question and follow existing procedures for regular third party cases.

(5) While the third party aspect of a case is being pursued by the USPS, the case should not be referred to the FEEWC until the USPS has exhausted its options and the third party activity comes back within the jurisdiction of the OWCP, unless referral to the FEEWC is otherwise indicated. An example of such a situation would be if an attorney advises that a settlement is imminent but there are communication or logistical issues with the USPS. In this instance, the DCE should assume jurisdiction for OWCP, provide disbursement figures and make immediate referral to the FEEWC.

d. Settlements.

(1) If, while the third party aspect is being handled by the USPS, information is received that a recovery or settlement has been received and will result in a third party surplus, the DCE will suspend all payments and will furnish the USPS with a final disbursement statement.

(2) After settlement has been made, the USPS will furnish the DCE with a completed SOR (Form EN-1108) and a check representing the refund of OWCP disbursements. Following receipt, the DCE will finalize the process in accordance with established procedures, including the release of Ltr.CA-1044 or Ltr. CA-1120, as appropriate.

Chapter 2-1200, Representatives' Services

1. Purpose and Scope. This chapter sets forth the procedures to use when advising representatives of the status of cases and the requirements of the Federal Employees' Compensation Act (FECA), as well as the procedures and standards to use when evaluating a representative's fee application.

2. Authority and Citations.

a. Under 5 U.S.C. 8127(a), and in accordance with 20 C.F.R. §10.700, a claimant may authorize an attorney or other individual to represent his or her interests in any proceeding before OWCP.

b. 20 C.F.R. §10.700 also provides the following guidance with regard to representatives:

(1) A statement signed by the claimant is required to establish the representative's appointment. 20 C.F.R. §10.700(a).

(2) As there can only be one representative at any given time, OWCP will not recognize another person as representative until the claimant has withdrawn the authorization of the first individual. 20 C.F.R. §10.700(b).

(3) If the representative is an attorney, OWCP may communicate with any member of that attorney's recognized law firm. 20 C.F.R. §10.700(b).

c. 20 C.F.R. §10.701 sets forth restrictions on who may act as a representative. A claimant may authorize any individual to act as his or her representative, provided that the individual's service would not violate any applicable provision of law (such as 18 U.S.C. 205 and 208).

(1) A Federal employee may act as a representative only:

(a) On behalf of immediate family members, defined as a spouse, children, parents, and siblings of the representative, provided no fee or gratuity is charged; or

(b) While acting as a union representative, defined as any officially sanctioned union official, and where no fee or gratuity is charged.

(2) Should any documentation be received identifying a representative as a Federal employee, the claims examiner (CE) should issue a letter to the claimant inquiring as to the nature of the relationship between the claimant and representative, and whether remuneration is involved for the representative's services. If necessary, the representative's federal agency may be contacted for additional information.

3. Correspondence with Representatives.

a. Once OWCP has received the claimant's signed authorization letter, the following actions should be taken:

(1) The representative's name and address should be entered into the case management system.

(2) Both the claimant and the designated representative should be advised of the procedures relating to fee applications. The "attorney fee" letter in Correspondence Library should be used for this communication. At that time, if the representative has asked specific questions pertaining to the status of the case, the CE should prepare a letter responding to the issues presented. If information is needed from the claimant, the letter should also advise the representative of the information needed.

b. Copies of Letters. Although the FECA and its implementing regulations do not require every communication with a claimant to be copied to the representative, the CE should make every effort to copy the representative on substantive correspondence that may affect a claimant's entitlement to compensation. This includes development letters that specify deficiencies in the evidence, or notices of OWCP-directed medical examinations.

(1) Regulatory Citations.

(a) 20 CFR §10.115 states that OWCP "may send a request for additional evidence to the claimant and to his or her representative."

(b) 20 CFR §10.119 states that "OWCP will consider all evidence submitted appropriately, and OWCP will inform the employee, the employee's representative, if any, and the employer of any action taken."

(c) 20 CFR §10.127 states that "a copy of the decision will also be mailed to the representative." See also 20 CFR §10.440; §10.617.

(d) 20 CFR §10.912 states that OWCP "may send any request for additional evidence to the claimant and to his or her representative" in the FECA death gratuity process.

(2) Copies of medical examination notices and notices of proposed decisions and final decisions should be sent to both the claimant and the authorized representative. 20 C.F.R. §10.127 ("If the employee has a designated representative before OWCP, a copy of the decision will also be mailed to the representative."); see, S.T., Docket No. 11-723 (issued December 16, 2011) (ECAB held that OWCP did not properly issue the termination decision because it did not send a copy of that decision to the authorized representative on that date); I.H., Docket No. 09-141 (issued August 6, 2009) (ECAB held that appellant's counsel was not properly notified of Dr. Taylor's July 19, 2007 impartial medical examination, thereby rendering the corresponding medical report insufficient to resolve the conflict of medical opinion, and remanded the case for referral of appellant for another impartial medical examination to resolve the existing conflict of medical evidence); Travis L. Chambers, 55 ECAB 138 (2003) (ECAB held that decisions under

the FECA are not deemed to have been properly issued unless both appellant and the authorized representative have been sent copies of the decision).

(3) One document that a representative is not copied on is the CA-1032 form that requires a claimant to report earnings, employment activities, third party settlements, other government benefits, and changes in dependents. This form is generated for cases on the periodic roll and failure to complete this form may result in suspension of compensation until OWCP receives the form. Although a claimant may seek advice or counsel from a representative on completion of this form, the FECA statute places the responsibility to report earnings directly on the claimant. Completion of this form (which may form the basis of a criminal prosecution in the event that false statements are made by the claimant) remains the sole responsibility of the claimant, and the form must be signed by the claimant.

4. How Fees for Services are Paid. A representative may charge the claimant (except as noted above in 2.c(1) - a federal employee who is an immediate family member or is acting as a union representative) a fee in addition to other costs associated with the representation before OWCP. The claimant is solely responsible for paying the fee and other applicable charges. OWCP will not reimburse the claimant, nor is OWCP in any way liable for the cost of the representation. 20 C.F.R. §10.702(a).

a. Under 5 U.S.C. 8127(b), and in accordance with 20 C.F.R. §§10.702(b) and 10.704, fees for representatives' services must first be approved by the Secretary. Fees may not be collected by the representative without such approval. Collecting a fee without this approval may constitute a misdemeanor under 18 U.S.C. 292. A representative can be prosecuted under 18 U.S.C. 292, which carries criminal penalties upon conviction of not more than \$1000 or imprisonment not to exceed one year, or both.

b. Funds deposited into an appropriately segregated account, such as a client trust or escrow account, until receipt of the Secretary's approval will not be considered receipt or collection of a fee by the representative. Under these circumstances, the representative's claim for services will be considered valid.

c. OWCP is not prohibited from approving a fee after a fee has been collected. In Eugene F. Carbonneau, 39 ECAB 392 (1988), the ECAB ruled that applicable law only provides that a fee collected prior to approval is not a valid fee, and that the person who collected the fee is subject to criminal prosecution. Consequently, OWCP is permitted to approve a fee even when the representative is withholding money from the claimant in violation of 18 U.S.C. 292 and 20 C.F.R. §§10.702(b) and 10.704. As ECAB noted in the above decision, the "remedy against a representative who collects a fee without the prior approval by the Office is not withholding approval of a fee but rather the criminal sanctions" imposed by 18 U.S.C. 292.

5. Fees Which May Not Be Approved. OWCP may not approve fees for certain services or in certain situations.

a. Fees for service in matters which have no relation to the claim, or for work done before another government agency or before the ECAB, will not be approved. Representatives who

inquire about payment for work done before the ECAB should be instructed to submit their request for fee approval to the ECAB. See 20 C.F.R. §501.9(e).

(1) Administrative expenses (mailing, copying, messenger services, travel, and the like, but not including secretarial services, paralegal, and other activities) need not be approved before the representative collects them. 20 C.F.R. §10.702(b). However, if they are included in the fee application, the representative should be informed that OWCP does not rule on administrative expenses. Consequently, such expenses must not be included in any fee total that is approved by OWCP. See Francesco C. Veneziani, 48 ECAB 572 (1997) (ECAB ruled: "The matter of expenses are a matter between appellant and his attorney and are not the appropriate subject of a fee application."). A representative may, however, use the services of a paralegal, legal assistant, legal intern, or secretary and include the charges for those services in the fee request.

(2) Time spent in preparing the request for fees, writing letters, holding conferences, or any other activity connected with the preparation and filing of a claim for fee approval may not be considered. See Robert G. Anderson, 21 ECAB 344(1970), and William Lee Gargus, 25 ECAB 187 (1974). Additionally, there is no recognition of fee work performed before a Federal Court or spent in preparing and prosecuting a Federal tort claims case. See Cecilia Kalinski, 47 ECAB 160 (1995).

b. "Contingency fees are not allowed in any form." 20 C.F.R. §10.702(a). OWCP does not recognize any contract or agreement between representatives and clients for payment of a fee for services on a contingency basis (any agreement where a client agrees to pay a representative a percentage of any monies paid or recovered as part of an OWCP claim).

Pursuant to 20 C.F.R. §10.703(a), a fee application must be in the form of an itemized statement showing the representative's hourly rate, the number of hours worked, and specifically identifying the work performed and a total amount charged for the representation (excluding administrative costs). Therefore, it is unacceptable for a representative to create what amounts to a contingency fee in regard to any FECA matter, including schedule awards, or to manipulate extremely high hourly rates after the fact in a manner that guarantees a certain percentage fee. Such arrangements essentially amount to contingency fee agreements and do not comport with OWCP's procedural requirements. See Angela M. Sanden, Docket No. 04-1632 (issued September 20, 2004) (ECAB found the representative's contingency fee arrangement illegal and ruled that the representative must calculate the money owed for services rendered on an hourly

6. Fee Approval. See 20 C.F.R. §10.703.

a. Jurisdiction. It is sometimes the case that services have been provided before both the custodial office and the Branch of Hearings and Review during the life of a claim. As a result, representatives will often present one application for fee approval containing services performed before both the office and the Branch of Hearings and Review. It is not uncommon that the application will be presented to either or both of these offices. In light of this, the jurisdiction of the case record at the time the fee application is received will determine who should consider the request and issue the decision. There is no need to split fee charges based upon where services

were provided. If, however, questions arise regarding the propriety of any contested charge for services performed before another office, that office should be consulted.

b. Fee application. Pursuant to 20 C.F.R. §10.703(a), the fee application must contain each of the items listed below.

(1) An itemized statement showing:

- (a) The representative's hourly rate,
- (b) The number of hours worked,
- (c) A description of the specific work performed, and
- (d) The total amount charged for the representation, exclusive of administrative costs.

(2) A statement of agreement or disagreement with the amount charged, signed by the claimant. The statement must also acknowledge that the claimant is aware that he or she must pay the fee, and that OWCP is not responsible for paying (or reimbursing) the fee or other costs associated with the representative's services. See 20 C.F.R. §10.703(a)(2).

c. Should an application be submitted which is missing any item cited in 6.b(1) above, it will be returned to the representative with a letter advising him or her to resubmit the fee application with the identified missing item(s).

However, if the application is missing the claimant's signed statement of agreement or disagreement (as described in 6.b(2) above), the CE must submit the fee application directly to the claimant and provide him or her with an opportunity (30 days) to agree with, or submit a statement or evidence disputing, said application. If a statement is received, the CE will follow the procedures outlined at either 6.e or 6.f below, depending on the nature of the claimant's response. If no response is received, the CE will then either approve or deny the fee request on the basis of "whether the amount of the fee is substantially in excess of the value of services received" by evaluating the factors outlined at 20 C.F.R. §10.703(c). (See also 6.f below.)

d. Any fee application submitted by a representative in the form of a contingency fee must be returned to the representative with instructions to calculate the money owed for services rendered on an hourly basis and resubmit the fee application in the proper format as described in 6.b above. When the representative resubmits the fee request, the attorney must submit a contemporaneously dated statement from the claimant that acknowledges concurrence with the fee and lists the hourly rate being charged in order for the deemed approved process to apply. 20 C.F.R. §10.703(b) ("no contingency fee arrangement may be considered approved through this process.")

e. Deemed Approved Applications (Approval Where There is No Dispute). Where a proper fee application is accompanied by a signed statement indicating the claimant's agreement with the

fee (as described in paragraph 6.b(2)), the application will be deemed approved. See 20 C.F.R. §10.703(b).

While this is similar to the procedures prior to the regulatory change effective January 4, 1999, in those instances where the claimant has specifically agreed to the charges as submitted by the representative, OWCP personnel are no longer required to evaluate the services provided or the hourly rate at which the claimant was charged in order to determine the propriety of the representative's fees. Instead, the fees will be deemed approved, and a simple notice confirming such approval will be issued to avoid any confusion on this matter.

Note: A contingency fee arrangement does not comport with OWCP fee approval requirements and cannot be "deemed approved" even where the claimant does not object.

f. Disputed Requests. Where the claimant disagrees with the amount of the fee, as indicated in the statement accompanying the application, OWCP will evaluate the objection and issue a formal decision that approves, modifies, or denies the fee. 20 C.F.R. §10.703(c). In order to make this determination, OWCP will provide a copy of the fee request to the claimant and ask him or her to provide any additional information in support of his or her objection within 15 days from the date the fee request was forwarded to the claimant. See 20 C.F.R. §10.703(c)(1).

After that period has passed, OWCP will evaluate any information received to determine whether the amount of the fee is substantially in excess of the value of the services received by examining the following factors:

(1) Usefulness of the Representative's Services. The CE should take into account the advantages which the claimant received by having a representative. What was at issue? Was the representative, by reason of knowledge, experience, etc., able to accomplish that which would have been difficult or unlikely for the claimant to accomplish without such aid? The impediments to the claim, and the evidence submitted to overcome them, should be discussed briefly, as well as any other pertinent facts about the worth of the representative's services.

(2) The Nature and Complexity of the Claim. Representatives appear in all types of cases, from the routine and simple to the unusual and complicated. The decision should discuss whether any unusual or complex questions of law or medicine were involved, discuss the issues in general, and describe what the representative did to overcome the defects in the claim. Any unusual measures needed to obtain factual or medical evidence should be noted.

(3) The Actual Time Spent on Development and Presentation of the Claim. The CE must consider not only the time spent in conferences with the claimant (and others) which had a bearing on the claim, but the time spent on investigations, study of the case record, travel, and appearances at hearings as well. In addition, the accuracy of the representative's description of letters written and phone calls made to OWCP, as well as any other evidence submitted, should be verified by a thorough review of the case record. The time claimed by the representative should be commensurate with the actual services performed. The CE should bear in mind, however, that the ECAB has found that a representative has broad latitude in exercising

professional judgment in connection with the preparation of a client's case. A representative has the responsibility to study and research the client's case.

Such work, insofar as it is within reasonable bounds, is entitled to consideration in fixing the fee, even though all the work may not prove helpful in producing relevant evidence or legal precedent. The test of necessary services is whether such services seemed reasonably necessary at the time they were performed (Anna Palestro/Vincent Palestro), 15 ECAB 241 (1964)).

(3) Customary local charges for similar services. The CE should also consider the customary charges for similar services in the representative's locality. Consequently, in the event of a disputed fee, the CE may ask the representative to state the customary local charges for services of the type he or she has rendered. If necessary, the CE may request this information from the local bar association, state compensation boards and commissions, or any other appropriate source, including Internet research that is documented.

g. Fee Reduction. In each instance where a claimant disputes the representative's fee request and files an objection (the signed statement of disagreement is sufficient), OWCP will make a formal determination and issue an appropriate decision. This decision will include appeal rights for both the claimant and the representative. 20 C.F.R. §10.703(c)(2).

Therefore, in these instances, OWCP will issue a letter to the representative explaining the reasons for the proposed fee reduction, and advise him or her to submit evidence or argument against the reduction within 30 days from the date of the letter. K.C., Docket No. 06-2130 (issued July 24, 2007) (ECAB held that where OWCP proposes to reduce a requested fee for representative's services, including the hourly rate the representative may charge, the representative is entitled to notice of the reasons for the proposed reduction and an opportunity to respond with written comments and by affidavit prior to decision.); Edgar Aikman, 32 ECAB 1570 (1981)(ECAB ruled: "where the Office proposes to reduce a requested fee, including the hourly rate the representative may charge, the representative is entitled to notice of the reasons for the proposed reduction and an opportunity to respond with written comments and by affidavit prior to a decision [being issued]").

If the representative's services are totally or mostly of a routine nature, and there is no novel point of law or medicine, the determination of a reasonable fee rests largely upon the time spent in necessary services on the claimant's behalf. In these situations, the CE should prepare an annotated copy of the representative's itemized statement, or an entirely separate statement showing the time claimed but not approved, and the reasons for the reduction. The statement should accompany the formal decision, and both the claimant and the representative should be provided a copy.

In all cases, the decision must clearly show the precise reasons for the final determination. Rationale must be given for any reduction in hours or exclusion of other items, such as expenses. If the claimant contested the amount of fee requested as excessive or unreasonable, the decision must also provide rationale for the amount of fee allowed.

7. Authority to Approve Fees.

a. Office personnel are authorized to evaluate and approve disputed fee requests in the following amounts:

- (1) GS-12 Claims Examiners: Up to \$10,000
- (2) Quality Assurance and Mentoring Examiners: Up to \$15,000
- (3) Supervisory Claims Examiners: Up to \$50,000
- (4) Assistant District Director or District Director: Over \$50,000

b. The Supervisory CE may delegate in writing the authority to approve disputed fee requests to GS 9-11 CEs in amounts up to \$5,000.

c. The formal decision should be signed and released by a CE, Quality Assurance and Mentoring Examiner, Supervisory CE, Assistant District Director, or District Director, depending upon who approved the fee request.

8. Timely Case Action.

a. Notice of Award. Where the representative has submitted an application for fee approval prior to or at the time of submission of the evidence needed to reach a decision in the case, the CE should issue the notification of case acceptance, the notice of payment of compensation, or notice of award along with the ruling on the fee request. Compensation should be coordinated with the decision on the fee request when possible. Otherwise, the representative's chances of collecting the fee may be jeopardized.

b. Payment. Compensation checks will not be forwarded routinely to a representative, either with or without the claimant's approval, since this would provide an element of assistance in collecting the fee. Such assistance is prohibited by the regulations and the spirit of 5 U.S.C. 8130, exempting compensation payments from the claims of creditors.

In some instances, however, it may be appropriate to send the compensation check in care of another party, i.e. court-appointed guardian, executor, or administrator of an estate. In questionable instances, the CE should refer the case to the District Director with an appropriate recommendation. Additionally, under 20 CFR §10.424, OWCP may appoint a representative payee to receive benefits for the claimant's use where a beneficiary is incapable of managing his or her benefits. The District Director should seek advice from the Office of the Solicitor as needed.

9. Fee Requests in Disallowed Claims. Where a compensation claim is disallowed, a formal decision will be made on the representative's fee application. It will be sent to the representative with a copy of the disallowance. In such cases, a reasonable representative's fee

may be approved after full consideration is given to all factors discussed in paragraph 6 above. The fact that the compensation claim is disallowed is insufficient to deny a representative a reasonable fee for services necessary to pursue the claim. See Robert D. Shaw, 30 ECAB 257 (1978).

10. Inquiries From State Bar Associations Relating to FECA

Representative. Where an inquiry is received from a State Bar Association relating to a FECA representative's conduct, the CE should provide the applicable citations to regulations and procedures concerning representative fees to promote understanding of the process. The CE should exercise utmost care regarding the disclosure of evidence from the FECA file. In most instances, especially where the inquiry was the result of a complaint from the individual claimant who is the subject of the file, the investigating authority will have already received a Privacy Act waiver signed by the claimant, which authorizes OWCP to disclose information from the file to the investigator. However, the CE should ensure that a copy of the waiver is placed into the case file. If there are any questions about the parameters of the waiver, the CE should consult with the supervisor or the District Director, who may request assistance from the Solicitor's Office. The fact that the State Bar Association or other investigatory body has authority to conduct an investigation does not automatically mean that information from the FECA file may be disclosed.

Chapter 2-1300, Lump Sum Payments

1. Purpose and Scope. This chapter describes the provisions of 5 U.S.C. 8135(a) concerning the issue of lump-sum payments, and describes the limits on considering such payments in effect as of September 10, 1992 as a result of the Office's revised regulations at 20 CFR 10.311.

2. Authority. Section 8135(a) provides that the liability of the United States for compensation to a beneficiary in the case of death or of permanent total or permanent partial disability may be discharged by a lump-sum payment equal to the present value of all future payments of compensation computed at four percent true discount compounded annually. A lump-sum payment may not be made, however, unless: (a) compensation to the beneficiary is less than \$50 a month; or b) the beneficiary is or is about to become a non-resident of the United States; or c) the Secretary of Labor determines that it is for the best interest of the beneficiary.

However, in the revised regulations (originally published as 20 C.F.R § 10.311 and effective September 10, 1992), the Secretary determined, in the exercise of discretion afforded under section 8135(a), that lump-sum payments of wage-loss compensation will no longer be made. Thus, compensation which is based on loss of wages will be paid in periodic payments only. The implementing regulation, now found at 20 C.F.R. § 10.422(a), provides:

(a) In exercise of the discretion afforded by section 5 U.S.C. 8135(a), OWCP has determined that lump-sum payments will not be made to persons entitled to wage-loss benefits (that is, those payable under 5 U.S.C. 8105 and 8106). Therefore, when OWCP receives requests for lump-sum payments for wage-loss benefits, OWCP will not exercise further discretion in the matter. This determination is based on several factors, including:

- (i) The purpose of the FECA, which is to replace lost wages;
- (ii) The prudence of providing wage-loss benefits on a regular, recurring basis; and
- (iii) The high cost associated with the long-term borrowing that is needed to pay out large lump sums.

However, a lump-sum payment may be made to an employee entitled to a schedule award under 5 U.S.C. 8107 where OWCP determines that such a payment is in the employee's best interest. Lump-sum payments of schedule awards generally will be considered in the employee's best interest only where the employee does not rely upon compensation payments as a substitute for lost wages (that is, the employee is working or is receiving annuity payments). An employee possesses no absolute right to a lump-sum payment of benefits payable under 5 U.S.C. 8107.

It should be noted that upon remarriage prior to age 55, a widow or widower entitled to compensation under section 8133 shall be paid in accordance with section 8135(b) of the FECA. See details in paragraph 3(c) below.

3. Requests for Lump-Sum Payments. When an application for a lump-sum payment is received, the Claims Examiner (CE) should first determine whether the benefit being paid the claimant or survivor is for compensation under sections 8105 or 8106; a schedule award under section 8107; survivor's benefits under section 8135; or, survivor's benefits under section 8133--as described in section 8135(b). The claimant should then be advised by the appropriate letter (see exhibits and details below) about the regulations and how they affect the question of lump-sum payments.

a. **Wage Loss Benefits.** A beneficiary who initially inquires about the availability of a lump-sum payment of his or her claim for wage-loss benefits should be advised that such lump-sum payments will not be considered. The letter should refer the claimant to the rules at 20 C.F.R. § 10.422, which state that "OWCP has determined that lump-sum payments will not be made . . ." and that "OWCP will not exercise further discretion in the matter." A sample letter to the claimant is provided as [Exhibit 1](#) for inquiries concerning wage-loss benefits. No appeal rights should accompany the letter of explanation to the claimant.

However, should the claimant or representative persist in requesting a lump-sum award, a decision with appeal rights will be issued. This decision should simply refer to the regulation (20 C.F.R. § 10.422(a)) and deny consideration of the lump-sum request, as set forth in [Exhibit 2](#).

b. **Schedule Benefits.** A lump-sum payment of schedule award benefits may still be made where the evidence shows that such a payment would be in the claimant's best interest. The regulations

make it clear that there is no absolute right to a lump-sum payment of schedule benefits and every case must be considered on its individual merits using the best interest test. The regulations also state that a lump-sum payment of schedule benefits will not generally be considered in the claimant's best interest where the compensation payments are relied upon as a substitute for lost wages.

In cases where the claimant is back to work or is receiving an OPM annuity of a sufficient amount, the schedule award is not replacing the claimant's regular income which is necessary to meet his or her living needs, and consequently a lump-sum settlement may well be in his or her best interest. Any decision denying a request for a lump-sum payment of schedule benefits should include an analysis of the facts in the case considered when exercising discretion.

One factor precluding payment of a lump-sum schedule award is garnishment of compensation benefits. Although schedule award payments may be garnished, no future payment may be garnished. Because a lump sum award is a payment of future benefits, the party entitled to payments from garnishment would no longer be able receive these payments. Therefore, a claimant whose benefits are being garnished should not be awarded a lump sum for schedule benefits.

For administrative convenience, where the claimant is working or receiving an OPM annuity adequate to meet living expenses, the CE should advise the claimant of his or her eligibility for a lump-sum payment in cases where a schedule award is being paid. Payment of a lump sum for a schedule award should be considered as early in the period of the award as possible. When a schedule award letter is issued in a case meeting the above requirements, the CE should routinely notify the claimant of the lump-sum option and the commuted value of the remaining period of the award. A sample letter to the claimant is shown at [Exhibit 3](#).

In a case where the claimant is receiving a schedule award and requests a lump-sum payment, yet it has not been established that the schedule award is not the claimant's source of regular income, the CE must obtain the necessary information. In a letter, the CE should advise the claimant of the best interest standard and request the information which would establish whether or not the claimant has another source of regular income sufficient to meet his or her living needs. [Exhibit 4](#) provides a sample letter for this purpose.

The CE should further advise the claimant that if he or she elects a lump-sum payment of a schedule award, it will be paid at the four percent discount rate, and that it represents full and final compensation payment for the period of the award, even if he or she suffers a recurrence of total disability. The claimant must sign an agreement to this effect before any lump-sum award is issued. [Exhibit 3](#).

c. Death Benefits. A beneficiary in a death case should be advised that the lump-sum payment to a spouse of a deceased employee may not exceed 60 months of compensation. Any such lump-sum award would also be subject to the proviso that the periodic payment of survivor's benefits was not the main source of income for the beneficiary.

However, a surviving spouse who remarries before age 55 is still entitled as a matter of right to a lump-sum payment equal to 24 months of compensation. There is no discretion in the application of section 8135(b) of the Act.

If applicable, the CE should also advise the claimant that a lump-sum payment to a widow or widower under section 8135(a) will not result in an increase in the amount of compensation paid to dependent children. On the other hand, in cases of a lump-sum payment under subparagraph (b), which relates to remarriage before age 55, the claimant should be advised in the letter from the CE that the lump-sum payment to the widow or widower does result in an increase in the periodic compensation payments to the dependent children.

4. Calculating Lump-Sum Schedule Awards. The responsible CE will determine the commuted value of the schedule award using the Lump-Sum Schedule Award Calculator.

a. The CE will need the following information to correctly compute the amount of the lump-sum payment:

- (1) Claimant's file number;
- (2) Name of the claimant;
- (3) Total period of the award;
- (4) Total number of days of the award (including fraction of a day);
- (5) Amount of four-week compensation being paid; and
- (6) Actual commutation (start) date of the lump-sum award.

The CE will enter a commutation date that is at least one FULL, periodic roll cycle in the future from the date the actual lump-sum calculation is made. Once the CE has printed out a copy of the completed lump-sum calculation document, it must be reviewed and approved by both a Quality Assurance and Mentoring Examiner and an SCE before the lump-sum payment agreement letter is issued to the claimant, regardless of the amount of the lump-sum award. (A journey-level CE (GS-12) may certify another journey-level CE's lump-sum award calculation document; however, an SCE must still approve the calculation, as the three signature requirement is mandatory.)

b. When recalculating a lump-sum award payment (due to an amended award, additional award for a different body part, etc.), the CE enters the original start date in the "Period of Award" field, but then keys in the appropriate new ending date (and fraction of day, if applicable). The CE must then subtract the total amount previously paid from this newly calculated lump-sum total to correctly obtain the additional amount due the claimant.

5. Requests for Reconsideration of Lump-sum Decisions. If a petition for reconsideration is made of a lump-sum decision where the claimant is receiving benefits under section 8105 or 8106 and that decision was issued prior to September 10, 1992, the Office should reopen the case on its merits and issue a denial of the lump-sum request on the basis of the new regulation. This decision should recite the language of the regulation as set forth at 20 C.F.R. § 10.422(a). A sample decision for this purpose is provided as [Exhibit 2](#). This action should be taken notwithstanding the timeliness of the request.

If a petition for reconsideration is made of a decision issued after September 10, 1992, such request should be handled in accordance with the Office's standard procedures for handling such petitions.

Exhibit 1: Sample of Initial Response Letter to Claimant who Inquires About Lump-Sum Disability Payment

Dear CLAIMANT NAME:

I am writing in response to your inquiry concerning receipt of a lump-sum payment of wage-loss benefits in your case under the Federal Employees' Compensation Act (FECA).

Pursuant to regulations governing the administration of the FECA at 20 CFR 10.422, lump-sum payments of wage-loss compensation are no longer considered. The rule states that the Director has determined that lump-sum payments will no longer be made for benefits under sections 8105 and 8106. See 20 CFR 10.422(a).

Although no lump-sum payments are made under the FECA for wage-loss benefits, please note that monthly compensation benefits will continue for the period of your entitlement.

Sincerely,

CLAIMS EXAMINER

Exhibit 2: Sample Appealable Decision Letter for Claimant Who Request Lump-sum Disability Payment

Dear CLAIMANT NAME:

Your request for a lump sum payment of your wage-loss benefits under section 8105/8106 of the Federal Employees' Compensation Act (FECA) has been received by this office. Regulations governing the administration of the FECA at 20 CFR 10.422(a) provide:

(1) In the exercise of the discretion afforded by section 8135(a), the Director has determined that lump-sum payments will no longer be made to individuals whose injury in the performance of duty as a federal employee has resulted in a loss of wage earning capacity. This determination is based on, among other factors:

- (i) The fact that FECA is intended as a wage-loss replacement program;
 - (ii) The general advisability that such benefits be provided on a periodic basis; and
 - (iii) The high cost associated with the long-term borrowing that is necessary to pay out large lump sums.
- (2) Accordingly, where applications for lump-sum payments for wage-loss benefits under section 8105 and 8106 are received, the Director will not exercise further discretion in the matter.

Based on the foregoing, your request for a lump-sum payment will not be considered and is hereby denied. Your appeal rights are attached.

Sincerely,

CLAIMS EXAMINER

Case Number:

FEDERAL EMPLOYEES' COMPENSATION ACT APPEAL RIGHTS

If you disagree with the attached decision, you have the right to request an appeal. If you wish to request an appeal, you should review these appeal rights carefully and decide which appeal to request. There are 3 different types of appeal: HEARING (this includes either an Oral Hearing, or a Review of the Written Record), RECONSIDERATION, and ECAB REVIEW. YOU MAY ONLY REQUEST ONE TYPE OF APPEAL AT THIS TIME. Place an "X" on the attached form indicating which appeal you are requesting. Complete the information requested at the bottom of the form. Place the form on top of any material you are submitting. Then mail the form with attachments to the address listed for the type of appeal that you select. Always write the type of appeal you are requesting on the outside of the envelope ("HEARING REQUEST", or "ECAB REVIEW"). Your appeal rights are as follows:

1. HEARING: If your injury occurred on or after July 4, 1966, and you have not requested reconsideration, as described below, you may request a Hearing. To protect your right to a hearing, any request for a hearing must be made before any request for reconsideration by the District Office (U.S.C. 8124(b) (1)). Any hearing request must also be made in writing, within 30 calendar days after the date of this decision, as determined by the postmark of your letter.

(20. C.F.R. 10.616). There are two forms of hearing. You may request either one or the other, but not both.

a. One form of Hearing is an Oral Hearing. An informal oral hearing is conducted by a hearing representative at a location near your home. You may present oral testimony and written

evidence in support of your claim. Any person authorized by you in writing may represent you at an oral hearing.

b. The other form of a Hearing is a Review of the Written Record. This is also conducted by a hearing representative. You may submit additional written evidence, which must be sent with your request for review. You will not be asked to attend or give oral testimony.

2. RECONSIDERATION: If you have additional evidence or legal argument that you believe will establish your claim, you may request, in writing, that OWCP reconsider this decision. The request must be made within one calendar year of the date of the decision, clearly state the grounds upon which reconsideration is being requested, and be accompanied by relevant evidence not previously submitted. This evidence might include medical reports, sworn statements, or a legal argument not previously made, which apply directly to the issue addressed by this decision.

In order to ensure that you receive an independent evaluation of the new evidence, persons other than those who made this determination will reconsider your case. (20 C.F.R. 10.605-610)

3. REVIEW BY THE EMPLOYEES' COMPENSATION APPEALS BOARD (ECAB): If you believe that all available evidence that would establish your claim has already been submitted, you have the right to request review by the ECAB (20 C.F.R. 10.625). The ECAB will review only the evidence received prior to the date of this decision (20 C.F.R. Part 501). Any request for review by the ECAB should be made within 90 days from the date of this decision. The ECAB may waive failure to file within 90 days if you request review within one year of the date of this decision and show a good reason for the delay.

If you request reconsideration or a hearing (either oral or review or the written record), OWCP will issue a decision that includes your right to further administrative review of that decision.

Case Number:

Employee:

APPEAL REQUEST FORM

If you decide to appeal this decision, read your Appeal Rights and these instructions carefully. Specify which procedure you request by checking one option below. Place this form on top of any materials specified below that you are submitting. Mail THIS FORM, along with any additional materials TO THE APPROPRIATE ADDRESS. YOU MAY REQUEST ONLY ONE TYPE OF APPEAL AT THIS TIME.

_____ HEARING - ORAL

_____ HEARING - REVIEW OF THE WRITTEN RECORD:

1) Submit this form within 30 calendar days of the date of the decision

2) You may submit additional written evidence with your request.

Write "HEARING REQUEST" on the outside of your envelope and mail it to:

Department of Labor - OWCP
Branch of Hearings and Review
200 Constitution Ave. NW Room C-3523
Washington, DC 20210

_____ RECONSIDERATION:

- 1) Submit your request within 1 calendar year of the date of the decision.
- 2) You must state the grounds upon which reconsideration is being requested. Your request must include relevant new evidence or legal argument not previously made.

Write "RECONSIDERATION REQUEST" on the outside of your envelope and mail it to:

DOL DFEC Central Mailroom
P.O. Box 8300
London, KY 40742

_____ ECAB APPEAL:

- 1) Submit this form within 180 calendar days of the date of the decision.
- 2) No additional evidence after the date of the decision will be reviewed.
- 3) To expedite the processing of your ECAB appeal, you may include a completed copy of the AB 1 form used by ECAB to docket appeals available on the Department of Labor Web Site at www.dol.gov/ecab

Write "ECAB REVIEW" on the outside of your envelope and mail it to:

Employees' Compensation Appeals Board
200 Constitution Avenue NW, Room N-2609
Washington, DC 20210

SIGNATURE _____ TODAY'S DATE _____

PRINTED NAME _____ DECISION DATE _____

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

Exhibit 3: Sample Letter to Claimant Offering to Payoff Balance of Schedule Award

Dear CLAIMANT NAME:

I am writing in reference to the schedule award you have been granted by this office. As the enclosed award notice indicates, the award will run through DATE. If you wish, however, the amount of the remaining schedule may be paid in a lump sum if you are working or receiving benefits from the Office of Personnel Management or a comparable Federal retirement system. You may, of course, choose to receive the remaining schedule award in regular payments each 28 days as stated in the award notice.]

The law provides that the liability of the United States for compensation may be discharged by a payment equal to the present value of all future payments of compensation computed at a four percent true discount rate compounded annually. In your case this would be \$0000.00, as of DATE. Additional benefits which may be awarded at a later date for temporary total disability or LWEC will not be considered in computing any lump-sum entitlement.

Any lump-sum payment will represent full and final compensation payment for the period of the award even if you suffer a recurrence of total disability. If you elect to receive your schedule award in this form, please sign the attached agreement and return it to this Office.

Sincerely,

CLAIMS EXAMINER

Date of Injury:

AGREEMENT TO ACCEPT LUMP SUM SETTLEMENT OF SCHEDULE AWARD

To proceed with my claim for a lump-sum settlement of my schedule award in accordance with 5 U.S.C. 8135(a), I wish to enter into the following agreement:

1. That I CLAIMANT NAME, agree to accept the sum of \$0000.00 in payment of compensation for the remainder of the schedule award payable from (DATE) to (DATE).
2. That I understand and agree that payment of such lump sum will represent full and final settlement of my schedule award for the period noted above in connection with my injury of (DATE), and that no further monetary compensation benefits will be extended to me for the duration of the schedule award.

Signature _____ Date _____

Exhibit 4: Sample Letter to Claimants Requesting Lump-sum Payments for Schedule Awards

Dear CLAIMANT NAME:

We have received your request for a lump-sum payment of your schedule award benefits under the Federal Employees' Compensation Act (FECA). Lump-sum payments are made at the discretion of the Director, based on a determination of whether such a payment would be in your best interest.

To show that such a payment would be in your best interest, you should submit evidence which shows that the schedule benefits are not a substitute for wages. Compensation payments are

intended as income replacement. As such, it is generally advisable that those payments be made on a periodic basis, since this form of payment is consistent with the wages these benefits are designed to replace. As such, it is generally advisable that those payments be made on a periodic basis, since this form of payment is consistent with the wages these benefits are designed to replace. If you have returned to work or receive a retirement annuity from the Office of Personnel Management at a level which can meet your basic living needs, then a lump-sum payment may be in your best interest. In the event you wish to receive a lump-sum payment of your schedule award, please submit a signed statement indicating you have returned to work or currently receive income from OPM sufficient to meet your basic living expenses.

Please be advised that any lump-sum payment will represent full and final compensation payment for the period of the award even if you sustain a recurrence of total disability.

Sincerely,

CLAIMS EXAMINER

Chapter 2-1400, Disallowances

1. Purpose and Scope. This chapter furnishes the information and instructions necessary to implement the provisions of 5 U.S.C. § 8124(a) of the Federal Employees' Compensation Act (FECA), which requires the Office of Workers' Compensation Programs (OWCP) to make findings of fact with respect to each claim filed and to make an award for or against the payment of compensation. When the outcome is negative, the OWCP must issue a formal disallowance.

After the initial adjudication of a case, various benefits are claimed that may result in a formal disallowance. A formal disallowance is a notice to the claimant of an adverse decision made concerning a claim which includes the reasons for the decision. Formal disallowances may be issued regarding any denial of FECA benefits.

This chapter describes various types of post-adjudicatory disallowances that the Claims Examiner (CE) may issue, and details how to prepare and issue the formal decision. While this chapter focuses on post-adjudicatory disallowances, the general requirements outlined in this chapter pertain to all types of formal decisions issued by the OWCP.

- a. Denials of initial injury/illness claims are discussed in PM 2-1401.
- b. Forfeiture decisions are discussed in PM 2-1402.
- c. Suspensions for failure to appear for a medical appointment are discussed in PM 2-0810.

- d. Suspensions for failure to submit reports of earnings are discussed in PM 2-0812.
- e. Suspensions for failure to cooperate with vocational rehabilitation efforts are discussed in PM 2-0813.
- f. Denial of Continuation of Pay (COP) is discussed in PM 2-0807.
- g. Sanction decisions for failure to accept suitable employment are discussed in PM 2-814.

2. Regulatory Provisions.

20 C.F.R. § 10.540 provides the following:

- (a) Except as provided in paragraphs (c), (d), and (e) of this section, where the evidence establishes that compensation should be either reduced or terminated, the OWCP will provide the beneficiary with written notice of the proposed action and give him or her 30 days to submit relevant evidence or argument to support entitlement to continued payment of compensation.
- (b) Notice provided under this section will include a description of the reasons for the proposed action and a copy of the specific evidence upon which the OWCP is basing its determination. 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.
- (c) The OWCP will not provide such written notice when the beneficiary has no reasonable basis to expect that payment of compensation will continue. For example, when a claim has been made for a specific period of time and that specific period expires, no written notice will be given.
- (d) Written notice will also not be given when a beneficiary dies, when the OWCP either reduces or terminates compensation upon an employee's return to work, when the OWCP terminates only medical benefits after a physician indicates that further medical treatment is not necessary or has ended, or when the OWCP denies payment for a particular medical expense.
- (e) The OWCP will also not provide such written notice when compensation is terminated, suspended or forfeited due to one of the following: A beneficiary's conviction for fraud in connection with a claim under the FECA; a beneficiary's incarceration based on any felony conviction; an employee's failure to report earnings from employment or self-employment; an employee's failure or refusal to either continue performing suitable work or to accept an offer of suitable work; or an employee's refusal to undergo or obstruction of a directed medical examination or treatment for substance abuse.

Note: As discussed in more detail below, in some cases such as FECA fraud conviction or felony incarceration, the right to further compensation is extinguished by operation of law. In other cases, such as the process for terminating compensation for refusal of suitable employment, the notice process is different (see 20 C.F.R. § 10. 516), providing an additional opportunity to

accept suitable employment or for suspension of compensation for refusal to undergo medical examination [see 20 C.F.R. § 10.323 (b)], providing a 14-day period to explain such refusal.

20 C.F.R. § 10.541 provides the following:

(a) If the beneficiary submits evidence or argument prior to the issuance of the decision, the OWCP will evaluate it in light of the proposed action and undertake such further development as it may deem appropriate, if any. Evidence or argument which is repetitious, cumulative, or irrelevant will not require any further development. If the beneficiary does not respond within 30 days of the written notice, the OWCP will issue a decision consistent with its prior notice. The OWCP will not grant any request for an extension of this 30-day period.

(b) Evidence or argument which refutes the evidence upon which the proposed action was based will result in the continued payment of compensation. If the beneficiary submits evidence or argument which fails to refute the evidence upon which the proposed action was based but which requires further development, the OWCP will not provide the beneficiary with another notice of its proposed action upon completion of such development. Once any further development of the evidence is completed, the OWCP will either continue payment or issue a decision consistent with its prior notice.

3. Responsibilities.

a. Identifying the benefit claimed. The CE is responsible for identifying the benefit(s) claimed that requires formal adjudication. Requests may be received on formal claim forms such as a CA-7 (Claim for Compensation) or CA-2a (Claim for Recurrence), or in other written formats such as a letter from the claimant or the claimant's authorized representative. The impetus for other formal decisions may stem from CE review of the file for continuing eligibility.

b. Burden of Proof. Once an initial claim is accepted and medical and/or compensation benefits are determined to be payable, the burden of proof shifts from the claimant to the OWCP.

Therefore, in most instances, before preparing a disallowance of benefits, the CE has the responsibility to either provide written notice to the claimant of any evidence necessary to establish the benefit claimed, or develop the evidence (to treating physician, District Medical Advisor (DMA), second opinion examiner, etc.) to reach a decision on the benefit claimed.

Where ongoing benefits are an issue, the CE is responsible for advising the claimant of the basis of the proposed decision and providing an opportunity to respond in writing and submit evidence. The burden of showing that benefits are no longer payable becomes the responsibility of the OWCP.

c. Adjudication. When development shows that the claim, or some portion of the claim, does not meet the requirements for medical or compensation benefits under the FECA, the CE is responsible for issuing a formal disallowance that details the adverse finding.

(1) Proposed Decision. The CE must determine whether a notice of proposed decision is required prior to issuance of a final decision. See paragraph 4 of this chapter for a detailed discussion of when a proposed decision is required and when it is not.

(2) Final Decision. The CE must also choose the proper format for the disallowance, whether it be a Letter Decision or a formal Notice of Decision. See paragraphs 5 of this chapter for a full discussion of each.

The disallowance should summarize the evidence received with the claim for benefits, and any new evidence received after the development letter or proposed decision has been released. If no evidence has been received in support of the claimed benefit or in response to the proposed decision, the CE should issue a decision consistent with his/her prior notice, and should state in the decision that no evidence was received. After summarizing the evidence received (or lack thereof), the CE should explain why it is insufficient to support the claim.

Writing the decision is discussed in paragraph 6 of this chapter, and a more thorough explanation of various types of decisions is provided in paragraphs 7 et seq. of this chapter.

d. Timeframes. Per 20 CFR § 10.540, the claimant is afforded 30 days for submission of additional evidence after a development letter or proposed decision is issued. The specific time allotted should be stated in the development letter or proposed decision so that the claimant is put on notice regarding how much time he/she has to submit the evidence before a formal disallowance will be issued.

The date of the development letter or proposed decision is equivalent to "day zero" when counting the 30 days permitted for a response. The due process period begins with the first day after the development letter or proposed decision is issued. The due process period ends after the claimant has been afforded the full 30 days. Thus, the earliest the decision can be issued is day 31; the decision cannot be issued on the 30th day. If the 30th day falls on a weekend or holiday, the decision cannot be issued until the following work day.

Example: A development letter was issued on June 1st. Therefore, June 2nd is day one of the 30-day period for submission of evidence. 30 days from June 2nd is July 1st. Therefore, the decision should not be issued until July 2nd.

e. Signature and Date. Formal disallowances require the signature of GS-12 CE or higher authority. See Exhibit 1, Signature Authority, for the specific signature authority requirements for various types of decisions.

Where the CE has signature authority to release a decision, his/her name and title should appear at the end of the decision. Where the CE does not have signature authority, the decision is prepared for review by an examiner with the requisite signature authority. The CE's name and title should appear at the end of the decision, as he/she authored the decision, along with the certifier's name and title.

f. Appeal rights. All formal decisions and disallowances require appeal rights. The CE must attach proper appeal rights and the appeal request form to both the Notice of Decision and the Letter Decision, whether the claim is denied in full or in part. Most decisions (initial decisions, awards, or *de novo* decisions) afford three avenues of appeal: reconsideration, hearing before the Branch of Hearings and Review (oral hearing or written review), or an appeal to the Employees' Compensation Appeals Board (ECAB). As noted in 20 C.F.R. § 10.600, for each appeal method there are time limitations and other restrictions that may apply. An overview of the appeals process can be found in PM 2-1600.

(1) Reconsideration. A reconsideration is performed by the Quality Assurance and Mentoring Examiner (QAM) within the Office. To support a request for reconsideration, new evidence or argument for error in fact or law must be submitted. See 5 U.S.C. § 8128; 20 C.F.R. § 10.605-609; PM 2-1602.

(2) Hearing. The claimant may request a hearing as a matter of right within 30 days if the injury or death occurred after July 4, 1966. 5 U.S.C. § 8124 provides, however, that the hearing as a matter of right must be requested before any reconsideration is undertaken. The claimant may submit new evidence in connection with a hearing, but new evidence is not required. See 5 U.S.C. § 8124 (b); 20 C.F.R. 10.615-622; PM 2-1601.

(3) ECAB. The ECAB will not consider any new evidence submitted by the claimant. Therefore, any appeal to the ECAB must proceed on the basis of the existing case record as it stands at the time of the OWCP's decision. See 20 C.F.R. Part 501, PM 2-1603.

g. Copies. A copy of the Notice of Decision or Letter Decision should be sent to the following parties:

(1) The claimant.

(2) The employing agency.

(3) The claimant's authorized representative, if applicable. Copies of proposed decisions and final decisions are to be sent to the authorized representative. See 20 C.F.R. § 10.127 ("If the employee has a designated representative before the OWCP, a copy of the decision will also be mailed to the representative."); and see, S.T., Docket No. 11-723 (issued December 16, 2011) (the ECAB held that the OWCP did not properly issue the termination decision because it did not send a copy of that decision to the authorized representative on that date).

See PM 2-1200 for further information regarding when the OWCP sends documents to authorized representatives.

h. Coding. Once the formal disallowance has been issued, the denial should be reflected in the case management system (iFECS). Case Maintenance should be updated, if necessary, to reflect the proper case status, and adjudication codes and Decision Registry should be updated to record the specific decision issued. The date of the disallowance should match the date of the applicable coding.

In some instances, only particular aspects of the claim will be denied as opposed to all benefits, e.g. compensation benefits are terminated but not medical benefits. Under these circumstances, the codes will reflect an accepted status. When all benefits of the claim have been disallowed, the codes will reflect a denied status. These codes are discussed in PM 2-0401.

i. Terminating Compensation. When issuing any disallowance decision that results in a termination, reduction, or suspension of compensation, compensation should be terminated, reduced, or suspended effective of the date of the final decision. The only exceptions are those cases involving termination for FECA fraud and suspensions due to incarceration. See paragraphs 17 and 18, below.

4. Whether Pre-Termination Notices are Required. After initial adjudication, it may be determined that the claimant is no longer entitled to compensation or medical benefits, or any portion of those benefits. Per 20 C.F.R. § 10.540 (c) through (e), some terminations require notice prior to final cessation of benefits, while others do not. The OWCP will not provide such written notice when the beneficiary has no reasonable basis to expect that payment of compensation will continue.

a. Terminations that DO NOT Require Notice. Some terminations of medical and/or compensation benefits do not require notice. Under these circumstances, the CE can proceed with termination without providing prior notice to the claimant of the reasons for the termination. Pre-terminations are not required in the following instances:

(1) The claimant dies. If a claimant dies while in receipt of medical and/or compensation benefits, benefits should be terminated as soon as notification of the death is received. No formal disallowance is required in such cases, but should a Form CA-5 claim be filed claiming the death was as a result of the work-related injury/illness, the CE should develop and adjudicate the claim in accordance with proper death claim procedures. See PM 2-0700. Additionally, if compensation was paid past the date of death, the CE should take prompt action to recoup those monies from the estate. See PM 6-0300-19.

(2) The claimant returns to work. If a claimant returns to work while in receipt of compensation, benefits should be terminated as soon as notification of the return to work is received. No formal disallowance is required in this instance. However, if the claimant received overlapping dates of compensation from the OWCP and wages from the employing agency, an overpayment may need to be declared. See PM 6-0200. Also, if the claimant returned to work only part time or with wage loss, reduced benefits may be payable.

If an LWEC decision is in place, the CE must review the case to determine whether the LWEC should be modified prior to terminating benefits.

(3) Ending daily roll payments that have continued for less than one year. If compensation has been paid on the daily roll for less than one year, but the weight of evidence of record establishes that the claimant is no longer entitled to wage-loss benefits for the work-related injury/illness, no pre-termination notice is required.

Note, however, that extended daily roll for periods approaching one year should be rare. See PM 2-901-7, which outlines that when the medical evidence indicates that disability is expected to continue for more than 60-90 days, compensation should usually be paid on the periodic roll (PR).

(4) The claimant fails to submit Form CA-1032 and report earnings and or/dependency. If extenuating circumstances are not present, benefits should be suspended entirely, or reduced to the basic rate if only the entitlement based on dependents is at issue. See FECA PM 2-812-14.

(5) Termination of augmented compensation (from 3/4 to 2/3) because a sole dependent ceases to qualify as such due to age, death, divorce, change in student status, etc.

(6) The claimant is convicted of FECA fraud. If the claimant has been convicted of, or pleads guilty to, defrauding the FECA, no pre-termination notice is required. Once the court documents detailing the fraud conviction have been received, the CE should terminate compensation and medical benefits effective the date of the conviction, or the date the plea agreement is filed in open court, and prepare a formal decision for the signature of the District Director (DD). See paragraph 17 of this chapter for more detailed information.

(7) The claimant is incarcerated based on any felony conviction. If the claimant is incarcerated based on a felony conviction (non FECA fraud related), no pre-termination notice is required. Once the court documents detailing the date of incarceration have been received, the CE should suspend benefits effective the first date of post-conviction imprisonment. If, however, the claimant has eligible dependents, reduced compensation may be payable to those dependents. See paragraph 18 of this chapter for more detailed information.

(8) The treating physician indicates further medical treatment is not necessary or treatment has ended. If the claimant's treating physician has indicated that medical treatment for the work-related condition has ended, or states that further medical treatment is not necessary for the work-related condition, medical benefits may be terminated without providing the claimant prior notice. (However, if the claimant is in the receipt of compensation benefits, a pre-termination notice is needed to terminate such benefits.)

(9) Payment for a particular charge. If a bill is received for treatment that was not provided for the accepted condition, the bill can be disallowed. This does not represent a termination of authorization of medical benefits, so a pre-termination notice is not required.

b. Terminations/Reductions that DO Require Notice. Some terminations require that the claimant be given notice before taking action. Under these circumstances, the CE cannot proceed with termination without first providing notice to the claimant, and affording him or her an opportunity to submit evidence or argument to the contrary. Payment of compensation should continue until all documentation submitted has been reviewed and an appropriate decision has been issued. See 20 C.F.R. § 10.540 (b).

Pre-terminations ARE required in the following instances:

- (1) Cases in which compensation is being paid on the periodic roll.
- (2) Termination of all medical benefits, if based upon the opinion of a second opinion or referee examiner, as opposed to the treating physician – see a(8) above.
- (3) Termination of all compensation benefits, if in the receipt of compensation on the daily roll for over a year (or on the periodic roll as indicated above).
- (4) Termination of both medical and compensation benefits.
- (5) Termination of augmented compensation (from 3/4 to 2/3) because a dependent unmarried child over the age of 18 years of age is no longer incapable of self-support.
- (6) Termination of survivor's benefits because the survivor is over the age of 18 and is no longer incapable of self-support.
- (7) Termination or reduction of a schedule award before its expiration date because:
 - (a) The OWCP miscalculated the award, resulting in a decrease in the amount payable. This kind of error includes, but is not limited to, incorrect determinations of the percentage of impairment, the number of weeks of the award or the expiration date of the award, the application or amount of a cost-of-living increase, or the pay rate.
 - (b) The medical evidence justifies an award of shorter duration than that already granted.

Where the adjustment is made after the original award expired, the CE should prepare an amended award and consider overpayment procedures as applicable. See PM 2-0808.

- (8) Termination of the services of a specific physician the OWCP has paid to treat the claimant's work-related injury, even if written authorization for the services paid was not provided.
 - (9) Termination of a specific service which the claimant has received, or expects to receive, on a fairly regular and recurring basis for 60 days or more, and for which the OWCP has paid or authorized without an end date. In this instance, the OWCP has de facto authorized the service and led the claimant to expect that payment for it will continue.
 - (10) Rescissions issued because the OWCP has accepted a claim and paid benefits, and it is later determined that those benefits (in whole or in part) were accepted or paid in error. See paragraph 19 of this chapter for more detailed information.
- c. If any doubt exists about whether a pre-termination or notice of proposed action is needed, the CE may wish to issue such notice.

5. Decision Format and Content. A formal disallowance should normally be issued by Notice of Decision, but in some circumstances a Letter Decision may be used.

Regardless of the format used, all decisions should contain findings of fact sufficient to identify the benefit being denied and the reason for the disallowance, the name and title of the CE who authored and/or certified the decision, and the appropriate appeal rights.

- a. The decision should be tailored to the specifics of the individual case so that the claimant understands the specific defect in his/her claim for benefits.
- b. Letter Decisions. A Letter Decision should generally only be used when denying less complex issues, such as a specific medical procedure or period of disability, when less discussion of evidence is required.

A Letter Decision does not follow a prescribed format and is written as a continuous narrative. It should provide a background, define the issue, set forth the requirements for entitlement and the decision made in the claim, summarize the evidence evaluated to make that decision, and explain the reason the adverse decision was reached. A thorough discussion of the weight of medical evidence of record to justify the disallowance must be provided, if applicable.

- c. Notices of Decision. Notices of Decision vary in format depending on the complexity of the issue.

(1) Initial denials and recurrence denials are both considered Notices of Decision, but they usually do not require a separate cover letter or memorandum. See FECA PM chapter 2-1401 or 2-1500 for additional information regarding initial denials and recurrence denials, respectively.

(2) A cover letter (Form CA-1042 for disability cases and Form CA-1079 for death cases, or equivalent) must be attached to all Notice of Decision memoranda (see below). The cover letter should explain what is being denied, and what, if any, benefits continue, e.g. compensation benefits are terminated but medical benefits continue.

(3) A Notice of Decision (NOD) memorandum should be used when denying more complex issues, or when a more detailed discussion of the evidence is required, such as proposed and final terminations of benefits. This should not be confused with Memoranda to the Director, which were historically used by the OWCP but are no longer the preferred method for denying benefits.

The NOD memorandum contains six prescribed elements: Issue for Determination; Requirements for Entitlement to Benefits; Background of the Claim; Evidence of Record; Basis for the Decision; and Conclusion.

(a) Issue. The issue for determination identifies the specific benefit to be denied. In one or two sentences, the CE should include all aspects of the benefits which are being denied and for what reason. If applicable, the CE should clearly state the period of time covered by the disallowance.

(b) Requirements for Entitlement. The requirements section outlines the criteria the claim must meet to establish entitlement to the benefit stated in the issue for determination. The CE may use standard language to describe these criteria, but must provide an adequate description of the kind of evidence needed so that the reader has a clear picture of the requirement.

(c) Background. The background includes the history of the claim relevant to the benefit being denied. A background should usually include the following elements, though the information may vary based on the type of denial: the claimant's occupation and name and location of employer; the date of the initial injury/exposure; the mechanism of the initial injury/exposure accepted by the OWCP; the medical diagnoses for which the initial claim was accepted; when the claim for the benefit at issue was filed, and, if previously accepted, the period of time allowable. The background may also discuss prior periods of compensable wage loss or medical benefits and/or second opinion or referee evaluations the claimant attended as relevant to the issue at hand.

In final decisions, the CE should identify when and how the OWCP notified the claimant of the deficiencies in the benefit being claimed and the evidence needed to correct those deficiencies.

(d) Discussion of Evidence. The evidence of record section should provide a summary of the relevant evidence which pertains to the benefit issue at hand, including evidence received and/or requested. The CE should discuss evidence germane to the issue from the beginning of the development process for the particular benefit at issue. Specific dates and authors of the relevant evidence (medical reports, statements, etc.) should be stated. The CE should discuss key parts of the evidence received and requested in support of the benefit at issue, such as the claimant's description of what occurred in his/her statement, or the findings upon examination and the physician's conclusions in a pertinent medical report. Any discrepancies in the evidence should be discussed in detail. Any repetitive or irrelevant material should be identified as such, and detailed discussion regarding such evidence should be avoided.

(e) Basis for Decision. This section identifies the deficiencies in the claim and provides the reason for the adverse decision. The CE should discuss the totality of the evidence in this section and provide his/her reasoning concerning the conclusion reached. The CE's evaluation of the evidence should be clear and detailed so that the reader understands the reason for the disallowance of the benefit and the evidence necessary to overcome the defect of the claim.

As most decisions are determined by medical evidence, the CE should summarize the evidence bearing on the issue for determination and, if applicable, explain why one medical opinion outweighs another. If more than one medical opinion is present, the CE should carefully discuss the weight of such evidence, including the following: the physician's specialty; objective findings found upon physical examination and relevance of those findings; and the definitiveness of the physician's opinion and whether it was well-rationalized. See PM 2-0810 for a more detailed discussion of evaluating medical evidence.

A thorough discussion of the weight of medical evidence should provide the reader with the following:

(i) Summary of the examination findings of the treating physician and the second opinion and referee examiners, when applicable, as well as a discussion of each of their conclusions.

(ii) Explanation as to why the case was referred for second opinion and referee evaluation, if applicable, including a description of the existing conflict.

(iii) Discussion as to why the second opinion examiner was granted weight over the treating physician, or if there is a conflict, an explanation as to why the referee examiner was afforded special weight, if applicable.

The Basis for the Decision section may include citations from ECAB decisions, the FECA, and/or the Regulations that support the decision. However, a sample ECAB quotation regarding weight of medical evidence does not satisfy the intent of this section of the decision. Rather, a thorough explanation as to the reasons for the disallowance should be provided, as well as the reasoning for assigning the weight of medical evidence when conflicting medical reports/opinions are in file. Additionally, if an ECAB citation is used, the CE should be careful to choose one that is relevant to the specific issue of the disallowance.

(f) Conclusion. This section states the final conclusion reached and the action taken. It should usually not exceed one or two sentences, and the scope of the statement should reflect that given under the Issue for Determination. That is, each issue identified at the beginning of the decision should be addressed at the end.

6. Writing the Decision. The disallowance decision is a legal document which serves as the basis for further actions in the claim, including appeals. The CE should, therefore, write a clear, understandable decision that keeps the reader in mind, as the explanation of benefits will be read by those who are not experts in workers' compensation matters.

If discussions are lengthy, the CE should divide them into shorter paragraphs so that the content is easier to read and better understood by all audiences.

a. Basic Language. A Notice of Decision should be written in the first person (using "you") and use basic language where possible.

So that the meaning of the disallowance is clearly conveyed to his/her audience, the CE should usually use the active rather than the passive voice, and avoid using technical terms and OWCP jargon.

The CE should also explain any abbreviations used in the text to assist readers at every level of education and knowledge about workers' compensation claims.

Example:

The CE should not write, "Causal relationship (OWCP jargon) was not established by your T/P (abbreviation and passive voice)" without defining T/P and causal relationship and using an active versus a passive voice.

Instead, the CE should write, "Your treating physician (no abbreviation and active voice) failed to provide medical evidence to establish causal relationship - a determination that your diagnosed condition is due to your work injury (OWCP terminology is defined)."

b. Specific References. In the formal disallowance, the CE should specifically reference the sources, documents, and dates used in drawing his/her conclusion.

Example:

The CE should not write, "The employee was requested to submit additional medical evidence but failed to do so."

Instead, the CE should state, "By letter dated January 15, 2013, you were advised of the deficiencies in your claim and provided 30 days to submit a rationalized medical opinion on the relationship between your knee condition and the work injury of May 15, 2012. We did not receive any evidence in response to that request."

c. Findings of Fact. A finding that the claimant failed to meet the burden of proof is properly made from the evidence, or lack thereof, and not simply because the claimant did not respond to a request for information from the OWCP. The findings of fact are the conclusions drawn from the evidence, not a recitation of that evidence.

Example:

The CE should not state, "The medical report shows that the claimant's injury caused no disability for work."

Instead, the CE should state the conclusions he/she drew from the medical report, "Based on Dr. Smith's October 10, 2012 report, you are not disabled from work as a result of the injury."

d. State the findings chronologically. The CE should write the disallowance chronologically so that the basis for the decision flows logically from the facts.

Example:

When discussing medical evidence leading to a termination of benefits, the CE should address the evidence presented by the attending physician, the second opinion physician, and the referee physician, in that order. It may then be necessary to discuss clarifying opinions or subsequent reports, but the basic findings and opinions of the three physicians should be clearly set forth, affording a firm basis for further discussion.

e. State the findings clearly. The CE should phrase the findings so that the reader can interpret them in only one way.

Example:

The finding that "you did not sustain a personal injury while in the performance of duty" could mean either that he did not sustain a personal injury, OR that he was not in the performance of duty at the time of the injury. Thus, the statement is not clear to the reader.

Rather, it is clearer to say, "Although it has been determined that you sustained an injury, the injury was not within the performance of your duties."

f. Evaluating the Evidence. When evaluating the relevant findings, the CE should focus on the issue(s) which need resolution and consider ALL of the evidence which bears on the issue at hand. The CE should acknowledge the existence of evidence which lacks probative value, and explain why it lacks such value and is being omitted from the discussion. The CE should also

avoid lengthy discussions of evidence not pertinent to the issue and any evidence which has been correctly summarized previously.

Example:

If the issue is continuing disability during a specific period of time, it is not necessary to address medical evidence which pertains to other time periods.

7. Pre-Termination Notices. If the weight of medical evidence of file establishes that the claimant is no longer entitled to benefits previously authorized, the CE must determine whether a pre-termination is necessary or whether the benefit can be disallowed without notice. See paragraph 4 above. If the benefit requires pre-termination notice, one should be issued using a NOD memorandum, and the claimant afforded 30 days to submit additional evidence to maintain the benefits he/she has been receiving.

a. Evaluating Evidence. Before making the determination that the claimant is no longer entitled to the current level of benefits, the CE must carefully review the evidence of file and ensure that the weight of evidence fully supports the conclusion.

If all medical benefits are being terminated, the CE must ensure that all accepted conditions in the claim, including authorized surgeries, consequential injuries, etc., were fully addressed by the physician who carries the weight of medical evidence of file. If not, the CE should further develop the issue(s) until a solid conclusion on all previously accepted or authorized conditions can be reached. See PM chapter 2-810 for additional discussion of developing medical evidence. The medical report used to establish the weight of medical evidence should be fully rationalized.

b. Payment Status. A pre-termination notice does not constitute a formal decision sufficient to terminate benefits, and no appeal rights are afforded at the pre-termination phase. Payment of compensation and medical benefits will continue until any evidence or argument submitted has been reviewed and an appropriate decision has been issued. See 20 C.F.R. § 10.540 (b).

c. Follow up to the pre-termination notice. The CE should follow up promptly after the 30-day period has expired. After 30 days have passed, the CE should review any additional information received and take the next appropriate action.

d. Interim Reply. A claimant may state that he or she intends to submit additional evidence but cannot do so within the 30-day period. Absent extraordinary circumstances, the OWCP will not grant any request for an extension of this 30-day period. See 20 C.F.R. § 10.541 (a). The CE should, therefore, advise the claimant that the OWCP will issue a decision at the end of the 30-day period and that the claimant may submit the evidence later, in support of a request for reconsideration or hearing on the final decision. If the evidence reaches the file before the final decision is released, however, the CE must consider and act upon it accordingly.

e. Responses and outcomes to the pre-termination notice. If additional evidence or argument is received in response to the pre-termination notice, the CE must evaluate it per 20 C.F.R. § 10.541.

(1) No Reply. If the claimant does not respond to the pre-termination notice, the CE should proceed with the final termination decision.

(2) If the evidence is repetitious, cumulative, or irrelevant to the issue at hand, further development is not necessary and the CE can proceed with a final termination decision. However, the evidence should be described and summarized within the content of the final NOD memorandum, and an explanation should be provided as to why the evidence is considered to be repetitious, cumulative, or irrelevant.

(3) If the evidence is relevant to the issue at hand but does not present a conflict to the evidence used to propose termination, there is no need for further development. The CE should proceed with a final termination decision. A detailed discussion of the evidence should be provided in the final NOD memorandum, and an explanation provided as to why the evidence does not change the course of the termination.

(4) If the evidence requires the CE to develop it further (e.g. it creates a conflict of medical opinion which must be resolved by referral to a referee), the CE should take prompt action towards resolution. The CE should write a letter to the claimant advising what development action is being taken. An explanation should be provided that development may result in final termination of benefits with no second notice of proposed action. See 20 C.F.R. § 10.541 (b).

The CE should actively pursue the issue until it is resolved, resulting in either a continuation of benefits or a termination of benefits.

(5) If the evidence submitted is sufficient to refute the proposed termination, the CE should continue benefits. A letter should be issued to the claimant explaining that benefits will continue.

8. Termination Decisions. Once it has been determined that the weight of medical evidence supports termination of benefits, a final termination should be issued using a NOD memorandum.

a. Decision Content. The entirety of the contents of the pre-termination notice does not need to be included in the final decision, but key points should be summarized.

(1) The issue for determination should not simply be stated as "whether the proposed decision should be made final." Rather, the benefit under consideration should be specifically stated, as in the proposed notice. For example, "The issue for determination is whether the weight of medical evidence of record establishes that there are residuals of the accepted work-related conditions that entitle you to ongoing medical and compensation benefits."

(2) The pre-termination notice should then be acknowledged in the background section of the decision as an action recently taken.

(3) All evidence received in response to the pre-termination notice should be discussed, with an explanation as to why that evidence is insufficient to alter the decision to terminate benefits.

(4) All evidence upon which the final termination is based should be discussed and summarized, as well as any follow-up development actions that were taken (e.g. a referee evaluation). If the final termination is based upon further development actions that led to upholding the proposed termination, those actions should be discussed thoroughly.

(5) Appropriate appeal rights must accompany the decision and be placed into the case file.

Note: If employment-related disability has ceased but residuals of the injury persist, entitlement to medical benefits must be addressed.

b. A cover letter, Form CA-1042 or equivalent, must be attached to the final termination decision (NOD memorandum). If compensation for wage loss is being terminated, and the claimant remains out of work, the cover letter should advise the claimant to contact his/her employing agency or local Office of Personnel (OPM) area office concerning restoration rights and advice for continuing health and/or life insurance benefits.

c. System Coding. The Case Management system needs to reflect when a claim is terminated for all medical or compensation benefits, and Disability Management-DM Tracking should also be updated to reflect the appropriate resolution code. The termination should also be updated in the Decision Registry (Continuing Injury-Related Disability or Causal Relationship/No Residuals). See PM 2-0401 for a detailed list of pay status and adjudication codes, and PM 2-0601 for a detailed list of disability management codes.

9. Claims for Compensation. A claimant may file a CA-7 form claiming compensation for leave without pay, leave buy back, or other wage loss such as premium pay, as a result of the work-related injury/illness. The claim for wage loss may be for full-time, part-time, or intermittent hours. After appropriate development, if it is determined that compensation is not payable, a formal disallowance with appeal rights should be issued (for which a Letter Decision is usually sufficient). (However more complex claims for compensation spanning long periods or involving varying intermittent losses may require a NOD memorandum). See FECA PM 2-0901 for more information on the development and payment of compensation claims.

Formal disallowances can also be issued for schedule award claims. See PM 2-0808 for further information on the development, payment and denial of schedule awards.

a. Responsibilities.

(1) If after appropriate development the evidence is insufficient to support payment for the full period claimed, or any part of the period claimed, the CE must formally deny the compensation being claimed or the portion of compensation that is not payable.

(2) The claimant should not be penalized for the employing agency's failure to provide pay information for processing compensation, and a formal denial of compensation should not be issued when the deficiency is the sole result of the employing agency's failure to provide necessary information in response to a request from the OWCP.

b. System Coding. The denial of the claim for compensation should be coded in the Case Management system, and Decision Registry (Wage Loss) should also be updated to record the formal denial.

10. Medical Authorization Requests. 5 U.S.C. § 8103 stipulates that, "The United States shall furnish to an employee who is injured while in the performance of duty, the services, appliances, and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of the monthly compensation."

If the medical evidence of record establishes that a medical request does not benefit the work-related condition, decrease disability or compensation benefits, and/or is unnecessary or unreasonable, a formal disallowance may be issued. (Requests for housing and vehicle modifications are addressed in PM 2-1800.)

a. Initial Processing. When a medical request is received by the Central Bill Payment Unit, it is processed based on review of the submitted procedure code and its relationship to the accepted conditions in the case. If the procedure code requested is typically prescribed for the accepted condition, the medical request is authorized. If the procedure code requested is not typically prescribed for the accepted condition, the medical request is routed to the CE for further review. If the CE determines that the request is not medically indicated for the effects of the work-related injury, the CE should take appropriate action as needed based on the specific request.

b. Responsibilities. If, after any necessary development, the weight of medical evidence does not support authorization for the medical request, the CE can issue a formal decision with appeal rights. A Letter Decision will normally suffice in this instance. Guidelines for development according to the type of medical request are further detailed in PM 2-0810 and PM 3-0300.

Denials may occur for, but are not limited to, any of the following reasons:

(1) No explanation from the treating physician as to how authorization is expected to be effective in treating the accepted condition.

(2) The request is unnecessary to treat the work-related condition.

(3) The claimant wants an elaborate or specialized item/service when a more basic one is sufficient.

(4) The use of the medical item requested is not commensurate with the claimant's physical restrictions.

c. Decision. A pre-termination notice is not required if the claimant was notified of a specific period of authorization and any specific period of extension. In this circumstance, the OWCP has not led the claimant to expect that the benefit/payment will continue beyond the authorized period. A pre-termination notice is needed, followed by a formal denial, if an indefinite authorization was provided.

(1) If the medical request cannot be authorized for obvious reasons, or the medical evidence indicates that the request is completely unrelated to the work injury, a letter explaining why the request cannot be authorized may be sufficient, rather than a formal denial. Following the issuance of this letter, should the claimant and/or the authorized representative request a formal decision with appeal rights, however, one should be provided.

(2) When development has occurred, and the medical request cannot be authorized, a formal denial should be issued.

d. System Coding. A formal medical request denial should be coded in Decision Registry (Medical Treatment/Surgery); however, a denial of a medical request alone would not change the adjudication or case status codes for the case; therefore, no other update is typically required.

11. Additional Diagnoses and Consequential Injuries. After an initial claim is accepted, the claimant or the medical provider may request that an additional diagnosis be accepted as work-related, or claim that weakness or impairment caused by a work-related injury led to a consequential injury. This may affect the same part of the body as the original injury/illness or a different area altogether, and could be for a physical or psychological condition. See PM 2-0805 for a discussion of causal relationship and consequential injuries.

If the medical evidence establishes that the additional diagnosis or consequential injury is not a result of the original injury/illness, a formal disallowance is needed, and usually a Letter Decision is sufficient.

a. Responsibilities. Upon receipt of a request to amend the claim to include an additional diagnosis or consequential injury, the CE is responsible for reviewing the evidence of record and determining if sufficient documentation exists to support acceptance. If, after any necessary development, the weight of medical evidence does not support the additional diagnosis or consequential injury, the CE is responsible for issuing a formal decision with appeal rights.

b. System Coding. A formal denial for an additional diagnosis or consequential injury should be coded in Decision Registry (Other); however, as denial of the additional diagnosis or consequential injury alone would not change the adjudication or case status codes of the case, typically no further updates are needed.

12. Recurrences. After the initial acceptance of a claim, the claimant may claim a recurrence of medical condition or a recurrence of disability. A recurrence of a medical condition is defined as the documented need for further medical treatment after prior release from medical treatment for the accepted condition when there is no work stoppage. 20 C.F.R. § 10.5 (y). A recurrence of disability is a work stoppage due to: a spontaneous, material change in the accepted condition without intervening injury or illness; an increase of disability resulting from the accepted condition or consequential injury/illness; or withdrawal of a light duty assignment which accommodated the claimant's condition(s) due to the initial work-related injury/illness. 20 C.F.R. § 10.5 (x).

See FECA PM 2-1500 for a complete discussion of recurrences. Note - If a formal loss of wage-earning capacity (LWEC) decision has been issued, and the claim is for recurrent disability, it should be processed in accordance with procedures for modifying a formal LWEC.

a. Responsibilities. Upon receipt of a claim for recurrence, the CE is responsible for reviewing the evidence of record and determining if sufficient documentation exists to support acceptance. If, after any necessary development, the weight of medical evidence does not support the recurrence, the CE is responsible for issuing a formal decision with appeal rights.

b. System Coding. The recurrence denial should be reflected in the Case Management system and coded in Decision Registry as Recurrence, with the appropriate type: Consequential, Lost Time or Medical. The case status may also need to be updated to reflect the correct pay and status codes.

13. Reductions/ Loss Of Wage-Earning Capacity. When the disability for work is partial, the FECA provides for a reduction in compensation to reflect the claimant's wage-earning capacity (WEC). The employee's actual earnings are used to calculate lost wages if the earnings fairly and reasonably reflect his/her earning capacity. See 5 U.S.C. § 8115; 20 C.F.R. § 10.403.

In some situations, if the actual earnings of the employee do not fairly and reasonably represent his wage-earning capacity or if the employee has no actual earnings, his wage-earning capacity must be determined on the basis of a position deemed suitable but not actually held. Proposed and final reduction decisions should be written using a NOD memorandum because they are generally more complex in nature. The same principles discussed for proposed and final termination decisions also apply to reduction decisions.

If a WEC decision is issued based on actual earnings, a proposed and final reduction decision is not required.

a. Responsibilities. The CE is responsible for reviewing the evidence of record and determining if sufficient documentation exists to issue a formal WEC decision, even if the claimant is not currently employed. If so, the CE is responsible for issuing a formal decision with appeal rights (after a proposed reduction decision if necessary).

b. System Coding. The Case Management system should reflect when a WEC determination is made. The CE should update the case status to reflect payment of partial wage loss, if applicable. The WEC decision should also be updated in the Decision Registry-LWEC (Constructed, 0% and Actual Earnings). Disability Management-DM Tracking should also be updated to reflect the appropriate resolution code. See PM 2-0401 for a detailed list of pay status and adjudication codes and PM 2-0601 for a detailed list of disability management codes.

14. Sanctions for Failure to Accept Suitable Work. 5 U.S.C. § 8106(c) provides a severe penalty against workers who refuse offers of suitable work, or who abandon suitable work without good cause. After appropriate warning letters have been provided to the claimant, if the refusal of suitable work continues, the CE should prepare a formal decision which provides full

findings of facts as to why the claimant's reasons for refusing the job are deemed unacceptable and terminate compensation. The formal decision should use the NOD memorandum format. See PM 2-0814 for additional information on the refusal of suitable work.

a. Responsibilities. Upon receipt of evidence that the claimant has refused or abandoned suitable work, the CE is responsible for reviewing the evidence of record and determining if sufficient documentation exists to proceed with a sanction decision. If, after any necessary development and appropriate warning letters, the evidence establishes that the claimant refused or abandoned suitable work, the CE is responsible for issuing a formal sanction decision with appeal rights.

b. System Coding. The CE should update Decision Registry (Failure to Accept Permanent Suitable Work or Job Abandonment (8106)) and update the case status codes in the Case Management system, as well as Disability Management-DM Tracking. See PM 2-0401 for a detailed list of pay status and adjudication codes, and PM 2-0601 for a detailed list of disability management codes.

15. Forfeiture. Section 8106(b) of the FECA provides that the Secretary of Labor may require a partially disabled employee to report his earnings from employment or self-employment, by affidavit or otherwise, in the manner and at the times the Secretary specifies. The employee shall include in the affidavit or report the value of housing, board, lodging, and other advantages which are part of his earnings in employment or self-employment and which can be estimated in money. An employee who (1) fails to make an affidavit or report when required, or (2) knowingly omits or understates any part of his earnings, forfeits his right to compensation with respect to any period for which the affidavit or report was required. When a finding is made that compensation was forfeited, a formal decision should be issued using a NOD memorandum because they are generally more complex in nature. See PM 2-1402 for a complete discussion regarding forfeitures.

a. Responsibilities. Upon receipt of unreported earnings or activities, the CE is responsible for reviewing the evidence of record and determining if sufficient documentation exists to forfeit compensation. If, after any necessary development, the evidence establishes that the claimant willingly and knowingly omitted required earnings information, the CE is responsible for issuing a formal decision with appeal rights.

b. System Coding. A forfeiture decision should be coded in Decision Registry (Forfeiture). As forfeiture of compensation usually relates to a closed period during which compensation was previously paid, the adjudication or case status codes of the case would not normally change; therefore, no further updates are typically required as a result of this decision.

16. Suspensions. When a claimant fails to cooperate with the OWCP's direction, benefits can be suspended and a Letter Decision will normally suffice in this instance. Although a formal proposed notice of suspension is not needed before suspending benefits, the CE must notify the claimant of the legal basis for the suspension action and the consequences for failure to comply with the OWCP's instructions. When issuing a suspension decision, the CE should ensure that all salient points are covered in the decision so that the claimant has a clear understanding of the reason for the suspension and what actions are needed to resume compensation payments.

a. Suspensions may occur for the following reasons:

(1) Failure to Appear for Medical Appointment. The legal authority is found at 5 U.S.C. § 8123(d), 20 C.F.R. § 10.323. See PM 2-0810.

(2) Failure to Submit Reports of Earnings. The legal authority is found at 20 C.F.R. § 10.528. See FECA 2-0812.

(3) Failure to Cooperate with Vocational Rehabilitation Efforts. The legal authority is found at 5 U.S.C. § 8113(b), 20 C.F.R. § 10.519. See PM 2-0813.

b. Responsibilities. Upon notification of a claimant's failure to comply with any of the above statutory or regulatory requirements, the CE is responsible for reviewing the evidence of record and determining if sufficient documentation exists to support such non-compliance. If, after any necessary development, the weight of evidence establishes that the claimant has not taken action as directed, the CE is responsible for issuing a formal decision with appeal rights.

c. System Coding. The Case Management system needs to reflect a formal suspension of benefits and the proper status codes. The suspension decision should also be updated in the Decision Registry as Suspension (options are Failure to Submit CA-1032, Non-Cooperation with Rehab or Refusal-Obstruction Medical Exam). Disability Management-DM Tracking should also be updated to reflect the appropriate code. See PM 2-0401 for a detailed list of pay status and adjudication codes, and PM 2-0601 for a detailed list of disability management codes.

17. Convictions for FECA Fraud. If the evidence substantiates that the claimant committed fraud in connection with a claim for FECA benefits, the U.S. Department of Justice may choose to prosecute the individual. When a claimant is convicted of defrauding the FECA in the application for or receipt of benefits, he/she forfeits entitlement to any future medical and compensation benefits (including schedule award) for any injury on or before the date of the conviction. Termination of entitlement under this section is not affected by any subsequent change in, or recurrence of, the beneficiary's medical condition.

a. Legal Authority. Public Law 103-112, enacted on October 21, 1993, prohibits individuals convicted of fraud related to claims under the FECA from receiving benefits under the Act. Public Law 103-333, enacted on September 30, 1994, amended the FECA by adding a new section, 5 U.S.C. § 8148, which provides for (a) the termination of benefits payable to beneficiaries who have been convicted of defrauding the program.

5 U.S.C. § 8148 (a) states: Any individual convicted of a violation of section 1920 of title 18, or any other Federal or State criminal statute relating to fraud in the application for or receipt of any benefit under this subchapter or subchapter III of this chapter, shall forfeit (as of the date of such conviction) any entitlement to any benefit such individual would otherwise be entitled to under this subchapter or subchapter III for any injury occurring on or before the date of such conviction. Such forfeiture shall be in addition to any action the Secretary may take under section 8106 or 8129.

b. Responsibilities. When the CE (or designated Office employee) learns that legal action is underway and a conviction may result, he/she should closely monitor the proceedings so that benefits can be promptly terminated if a conviction occurs or a plea agreement is accepted. Where a conviction is imminent, the CE may terminate periodic roll benefits and pay compensation on the daily roll to help minimize or avoid overpayments.

When the claimant is convicted of defrauding the FECA (misdemeanor or felony), or pleads guilty, the CE is responsible for ensuring the case file contains proper documentation of the offense. The CE must also terminate compensation payments and prepare a formal decision for the District Director's signature in accordance with 5 U.S.C. § 8148, explaining that benefits are terminated based on FECA fraud. This Letter Decision is issued in addition to any forfeiture of benefits decision under §8106 (see PM 2-1402), and any resulting overpayment decision under §8129 (see PM 6-0300-18).

c. Obtaining Evidence.

(1) FECA Office staff may be advised by the Department of Labor's (DOL) Office of Inspector General (OIG), the United States Attorneys' offices, the investigative branch of an Employing Agency, or other persons that a claimant receiving or claiming benefits under the FECA has been convicted of filing a false claim or making a false statement (e.g. submitting a false Form CA-1032) or otherwise defrauding the FECA program.

(2) Prior to termination of benefits, the CE must ensure the record contains evidence establishing that the person was convicted of fraud and the conviction was related to the claim for, or receipt of, benefits under the FECA. The DOL-OIG and the Solicitor's Office may be able to help obtain necessary documents. The case file should be documented with:

(a) A copy of the indictment, or formal accusation that the person has committed the crime, and

(b) A copy of the plea agreement with an indication that it was accepted by the court (e.g. the court stamp, judge's signature, etc.), or

(c) A copy of the guilty verdict.

(3) A pre-trial diversion agreement is NOT sufficient for termination under 5 U.S.C. § 8148(a).

d. Effective date. Compensation should be terminated effective the date of the conviction, which is the date of the verdict, or, in the case of a plea agreement, the date the claimant made the plea in open court (the date the judge accepted the plea in court). This date should not be confused with the date of the indictment, the date the court papers are prepared, or the date the defendant signed the plea. See 20 C.F.R. § 10.17. If the documentation is unclear, the OIG and/or the Solicitor's Office should be consulted to help determine the date of the conviction.

e. Decision Format and Content. A FECA fraud decision should be issued using the Letter Decision format, and a pre-termination notice is not required. The decision should:

- (1) Advise the claimant that he/she was found guilty of fraud, explain the reason for the fraud conviction, and provide the date of the conviction (or plea agreement).
- (2) Reference 5 U.S.C. § 8148, which provides for termination of compensation due to FECA fraud.
- (3) Explain that medical bills will be paid for authorized medical treatment received prior to the date of the decision, but no further medical treatment will be paid for.
- (4) Advise that compensation benefits are terminated effective the date of the conviction.

f. System Coding. The CE should update the Case Management system with the appropriate denial code, D5/C3. The effective date for this code will be the date of the fraud denial. The termination should also be updated in the Decision Registry (Fraud Denial (8148)), and Disability Management-DM Tracking should be updated with the appropriate resolution code. See PM 2-0601 for a detailed list of disability management codes.

18. Imprisonment for Felonies Other than Fraud. When a claimant in receipt of benefits under the FECA is convicted and imprisoned due to a felony (for any offense other than FECA fraud), entitlement to all medical and compensation benefits (including schedule award) is suspended during the period of imprisonment. However, the claimant's dependents remain entitled to reduced benefits during the period of imprisonment.

No action can be taken for any time spent incarcerated due to a non-felony or misdemeanor conviction, or for time imprisoned while awaiting trial. Similarly, if bail is continued following a felony conviction while the claimant awaits sentencing, no action should be taken to suspend compensation until the date of incarceration.

a. Legal Authority. Public Law 103-333, enacted on September 30, 1994, amended the FECA by adding a new section, 5 U.S.C. § 8148, which provides for (b) the suspension of benefits payable to beneficiaries imprisoned as a result of felony conviction.

5 U.S.C. § 8148 (b) states:

- (1) Notwithstanding any other provision of this chapter (except as provided under paragraph (3)), no benefits under this subchapter or subchapter III of this chapter shall be paid or provided to any individual during any period during which such individual is confined in a jail, prison, or other penal institution or correctional facility, pursuant to that individual's conviction of an offense that constituted a felony under applicable law.
- (2) Such individual shall not be entitled to receive the benefits forfeited during the period of incarceration under paragraph (1), after such period of incarceration ends.
- (3) If an individual has one or more dependents as defined under section 8110(a), the Secretary of Labor may, during the period of incarceration, pay to such dependents a percentage of the

benefits that would have been payable to such individual computed according to the percentages set forth in section 8133(a)(1) through (5).

b. Responsibilities. When notification has been received that a claimant has been convicted of a felony other than FECA fraud, the CE is responsible for ensuring that the case file contains proper documentation of the offense and incarceration. The CE must also terminate or adjust compensation payments if the claimant has dependents, and issue a formal decision suspending benefits effective the date of the post-conviction incarceration.

c. Obtaining Evidence.

(1) A claimant has an affirmative duty to provide notice of any conviction and imprisonment. The employing agency is also expected to provide the OWCP any information or documentation it may have concerning such matters. See 20 C.F.R. § 10.18.

(2) The CE should closely monitor a case for receipt of an Investigative Memorandum, signed Form CA-7 or Form CA-1032, or other information that indicates the claimant has been convicted of, and has been incarcerated for, a felony offense, other than fraud. The Solicitor's Office may be able to assist with gathering additional documentation.

(3) Prior to suspension of benefits, the CE must ensure the record contains evidence establishing that the person was convicted of a felony. The case file should also contain documentation from a court or penal institution verifying the first date of incarceration due to such conviction.

d. Effective Date. Compensation should be terminated/adjusted effective the first date the claimant is incarcerated after conviction.

e. Payments during Felony Imprisonment.

(1) If the claimant has eligible dependents, the CE should calculate compensation by applying the percentages outlined in 5 U.S.C. § 8133(a)(1) through (5) to the claimant's gross current entitlement, i.e. 50% of gross current entitlement to the spouse if there is no child, or 45% to the spouse if there is a child (children), with 15% to each child, not to exceed 75% of gross current entitlement.

(a) The percentages outlined in 5 U.S.C. § 8133(a)(1) through (5) should be applied to the beneficiary's gross current entitlement, not the claimant's monthly pay. See 20 C.F.R. § 10.18 (b).

(b) Payments to dependents should be set using the "gross override" function in the Compensation Management system, with appropriate deductions for health and life insurance benefits.

(c) In the case of a minor dependent, payment should be made payable to the beneficiary or guardian.

(2) If a decision concerning entitlement is pending when the claimant is convicted and sent to prison, and compensation is due for a period of time prior to imprisonment, payment for that period may not be made until the claimant's release.

(3) When the claimant is released from prison, benefits should resume at the usual rate, i.e. 75% of the pay rate, assuming at least one eligible dependent remains. Should this change be delayed, the CE should calculate compensation retroactively due the claimant, including dependents from the date of prison release, less compensation paid to dependents only from the date of prison release, and pay the claimant the difference.

f. Decision Format and Content. A suspension of benefits for felony imprisonment should be issued using the Letter Decision format (however, more complex claims involving various dependents may require a NOD memorandum). No pre-termination notice is needed. The decision should:

(1) Advise the claimant that benefits are being suspended because he/she was convicted of a felony, and provide the date of the conviction.

(2) Reference 5 U.S.C. § 8148, which explains why the claimant is not entitled to any medical or compensation benefits during the period of incarceration.

(3) Advise that benefits are suspended from the date of incarceration after conviction through the date of release.

(4) Outline any compensation payable to the claimant's dependents during the period of incarceration, if applicable.

g. System Coding.

(1) If dependents remain entitled to benefits while the claimant is imprisoned, the pay status and adjudication status codes will have to remain active (PR/AP).

(2) If there are no dependents, the CE should code the Case Management system with the case status C5 (Closed, previously accepted for benefits) and D0 (Disallowed). The effective date for this code will be the date of the suspension decision. See PM 2-0401.

(3) The CE should update Disability Management-DM Tracking with the appropriate resolution code, and update Decision Registry with the decision type - Other.

19. Rescissions. When the OWCP has accepted a claim and paid benefits, and it is later determined that those benefits were accepted or paid in error, the OWCP has the burden of proof to rescind the entitlement.

a. Legal Authority. Section 5 U.S.C. § 8128 (a) states:

The Secretary of Labor may review an award for or against payment of compensation at any time on his own motion or on application. The Secretary, in accordance with the facts found on review, may—

- (1) end, decrease, or increase the compensation previously awarded; or
- (2) award compensation previously refused or discontinued.

This authority includes rescission of claims as a whole, or of specific entitlements.

b. Responsibilities. When it has been determined that the original decision may have been issued in error, the CE is responsible for performing any necessary case development to fully resolve the issue. If, after proper development, it is established that the original decision was issued in error, the CE is responsible for issuing a proposed and final decision rescinding the original finding.

c. Obtaining Evidence. When considering rescission, the CE is responsible for carefully and thoroughly evaluating and developing, if necessary, all the evidence in the context of the OWCP's burden of proof. This may entail asking factual questions of the claimant and/or the employing agency. It may also entail preparing a Statement of Accepted Facts and requesting a medical report from the claimant's treating physician, and/or requesting DMA review or scheduling a second opinion evaluation. If a conflict of medical opinion ensues, a referee evaluation may be appropriate.

d. Decision Format and Content. As rescission of a claim or a portion of a claim is often complex, the NOD memorandum should be used.

A rescission decision should contain a brief background of the claim, discuss the evidence on which the original decision was based, and explain why the Office finds that the decision should be rescinded. The evidence used to rescind the claim should be thoroughly discussed so that it is clear to the reader how the case was incorrectly adjudicated, and why the original decision is now being invalidated.

See M.G., Docket No. 10-818 (issued March 21, 2011) (the OWCP needs clear explanation of rationale for rescinding acceptance of surgery and accompanying disability).

e. New Decision. After issuing a rescission decision, it may be necessary for the CE to issue a new decision depending on the circumstances of the case and whether the claim was rescinded in whole or in part.

f. System Coding. The CE should update the Case Management system with new case status codes, if needed. The status will vary depending on the specific issue overturned by the rescission. For example, if the rescission decision now accepts a case previously denied, the pay and adjudication status codes need to reflect an open and accepted claim.

The CE should also update Decision Registry (Rescission). And if compensation is terminated as a result of the rescission, Disability Management-DM Tracking may also need to be updated to

reflect the appropriate code. See PM 2-0401 for a detailed list of pay status and adjudication codes, and PM 2-0601 for a detailed list of disability management codes.

Exhibit 1: Signature Authority

GENERAL GS-12 CLAIMS EXAMINERS

- *Traumatic Injury Claims
- *Occupational Disease Claims
- *Death Claims (except suicide)
- *Denials of consequential or additional medical conditions
- *Medical Treatment, Equipment, Supplies
- *Surgery Requests
- *Recurrences
- *Continuation of Pay (COP)
- *Wage Loss Denials (stemming from CA-7 forms)
- *0% Loss of Wage-Earning Capacity (LWEC) Decisions
- *Suspension for Failure to Attend a Medical Appointment
- *Suspension for Failure to Return Form CA-1032
- *Schedule Award Decisions
- *Schedule Award Denials
- *Warning & Final Reduction to zero under 8113(b) for non-cooperation with VR

QUALITY ASSURANCE AND MENTORING EXAMINERS (QAM), SUPERVISORY CLAIMS EXAMINERS, TECHNICAL ASSISTANTS AND SPECIAL EXAMINERS

- *All items listed under General GS-12 CE
- *Proposed Terminations & Final Terminations (except FECA fraud)
- *Proposed Reductions & Final Reductions
- *LWEC Modifications
- *§8106c Suitable Work Decisions
- *Forfeiture of Benefits
- *Rescissions
- *Reconsiderations
- *Warning & Final Reduction (non-zero) under 8113(b) for non-cooperation with VR

OFFICE DIRECTORS DIRECTORS AND BRANCH CHIEFS

- *All death claim decisions due to suicide (acceptances and denials)
- *Termination for FECA Fraud

Note – A Supervisory Claims Examiner or higher may individually grant signature authority to a non-GS-12 Claims Examiner, Workers' Compensation Assistant (WCA) or Customer Service Representative (CSR) for the items listed under the "General GS-12 Claims Examiner".

Chapter 2-1401, Initial Denials

1. Purpose and Scope. This chapter describes the steps involved in processing an initial case denial if any one of the five basic requirements has not been established. Along with Federal Employees' Compensation Act (FECA) Procedure Manual (PM) 2-0801 through 2-0805, it covers the factors that should be addressed when denying an initial claim and preparing the formal Notice of Decision.

A formal decision is required in any case where the Office of Workers' Compensation Programs (OWCP) has received a Form CA-1, CA-2, CA-5, or CA-5b and, after appropriate development, one or more of the five basic requirements of the claim has not been met.

See FECA PM 2-1400 for more information on disallowances and signature authority.

2. Statutory and Regulatory Requirements.

a. Section 5 U.S.C. 8124(a) of the Federal Employees' Compensation Act (FECA) requires the OWCP to make findings of fact with respect to each claim filed after considering the claim and information from the employing agency, and after such investigation as considered necessary, and then to make an award for or against the payment of compensation.

b. 20 C.F.R. §10.115 outlines the basic evidence that is required to establish a claim, and stipulates that evidence must be reliable, probative and substantial. This section also outlines that the evidence should be submitted in writing, and that it is the claimant's burden of proof to establish the claim.

c. 20 C.F.R. §10.121 outlines that if the claimant submits factual and/or medical evidence, but the OWCP determines that this evidence is not sufficient to meet the burden of proof, the OWCP will inform the claimant of the additional evidence needed. The claimant will be allowed at least 60 days to submit the evidence required. The OWCP is not required to notify the claimant a second time if the evidence submitted in response to its first request is not sufficient to meet the burden of proof.

3. Burden of Proof. This paragraph describes the claimant's burden of proof for establishing a claim and the necessary steps the Claims Examiner (CE) should take before an initial claim may be formally denied.

Before preparing an initial case denial, the CE should adequately develop the claim and advise the claimant in writing of his or her burden of proof in establishing entitlement to benefits. After all appropriate development (see FECA PM 2-0800), if one of the five basic requirements has not been met, the case should be denied. A formal decision with appeal rights is required.

a. Burden of Proof. Under the FECA, a claimant has the "burden of proof" for submitting the evidence to establish that a claim meets all five basic requirements. The claimant must always be provided an opportunity to perfect his or her claim and should be informed of the following:

(1) The deficiencies in the evidence submitted and the information necessary to correct them.

(2) The deadline for submitting the evidence and the consequences for failing to do so.

b. Timely Decisions. It is the OWCP's obligation to render a decision on each case as promptly as possible. The Office must notify both the claimant and any authorized representative of its decision in all cases. The employing agency should also be provided with a copy of any formal decision issued.

(1) Timeframe. An initial claim may not be denied until the allotted time given to submit any evidence in support of the claim has passed. The claimant must be allowed at least 60 days to submit the evidence required.

(2) The day the claim is developed is considered day "zero."

Example. If the claim was developed on June 10th, the next day (June 11th) is the beginning of the 60 day period. The claim could not be denied until the 61st day, which would be August 10th.

(3) If the 60th day is a holiday or weekend day, the CE should wait until the next business day (after the claimant has received the full 60 days to submit evidence) to issue the decision.

4. Element for Denial. After the claimant has been provided the opportunity to submit necessary evidence, the CE should review the claim to determine whether the five basic elements have been met. See FECA PM 2-0801 through 2-0805.

The five basic elements should be considered in the order below (a through e). The first element that the claimant fails to establish should be the basis for initial denial. In most cases, however, the decision should also outline the deficiencies in the subsequent elements to ensure that all flaws in the claim are adequately addressed.

a. Time. If statutory time requirements have not been satisfied, the case will be denied as untimely. If this first basic element is not met, the claim does not require further review. See 5 U.S.C. 8122 and FECA PM 2-0801.

b. Civil Employee. If the claim was filed timely, but the injured or deceased party was not a civil employee of the United States within the meaning of 5 U.S.C. 8101(1), the case should be denied on that basis. See FECA PM 2-0802.

c. Fact of Injury (FOI). Once the first two elements are established, it must be determined whether an injury occurred as alleged. See FECA PM 2-0803. This element consists of two components: FOI-Factual and FOI-Medical. Both components must be satisfied before the fourth basic element, performance of duty, may be considered. The CE must decide whether FOI-Factual has been met before addressing FOI-Medical.

(1) To establish FOI, it must be determined whether:

(a) The claimant actually experienced the incident, accident, untoward event, or employment factors alleged to have occurred (factual determination).

(b) A medical condition has been diagnosed by a physician (generally an MD or DO) in connection with the event or employment factor(s) (medical determination). While only a diagnosis associated with the injury is needed to meet this element, a description of symptoms alone does not suffice.

(2) Denial Basis.

(a) If the factual evidence fails to establish that the injury occurred, the claim should be denied on a factual basis. Even if the medical component is established, the case should still be denied on a factual basis, as this is the first component not met.

(b) If both the factual and the medical evidence are deficient, the claim should be denied on a factual basis, but the lack of a medical diagnosis should also be mentioned.

(c) If the factual evidence establishes that an injury occurred, but the medical evidence fails to establish that a medical condition has been diagnosed in connection with the claimed event or work duties, the claim should be denied on a medical basis.

d. Performance of Duty (POD). The claimant must not only show that an injury occurred, but that he or she was performing official duties (or an activity incidental to employment) at the time of injury. For an injury to be compensable, it must have occurred while the employee was in the performance of duty; the injury must arise out of and occur during the course of employment. See FECA PM 2-0804.

Even if the medical evidence establishes a diagnosis in connection with the injury, if the claimant was not injured in the performance of duty, the claim should be denied on that basis.

e. Causal Relationship (CR). Finally, the claimant must show that the injury was causally related to the accepted event or employment factors. This requirement is satisfied on the basis of medical evidence, which is usually supplied by the attending physician. See FECA PM 2-0805.

If all prior basic elements have been met, but the evidence does not support that the claimant's condition is causally related to the accepted employment incident or factors, the claim should be denied on the basis that causal relationship has not been established.

5. Writing the Initial Denial. Once it has been determined which of the five basic elements has not been established, the initial denial should be issued. The initial denial is an explanation of the disallowance of the claim; thus, it is important that it is clearly written so that the claimant has a complete understanding of why the claim was disallowed and the evidence necessary to perfect the claim. The denial decision is a legal document which serves as the basis for further action in the claim, including appeals, so it should be technically accurate.

a. Notice of Decision. The Notice of Decision for an initial denial should: describe the nature of the injury; summarize the evidence initially submitted with the claim and provide an explanation as to why it was deficient; summarize what was requested upon development; describe all evidence received after development; and explain why the evidence is insufficient to support the claim. See FECA PM 2-1400 for more explanation regarding formal disallowances.

(1) Clear explanation. The initial denial should clearly explain which of the five basic elements have been met, the specific element upon which the claim is being denied, and the additional evidence that is lacking. While the decision should make clear which element of the claim has not been met and is the basis for the denial, the decision should briefly address all deficient elements (except when the claim is denied based on Time or Civil Employee).

For example, if a claim is denied on the medical component of the third basic element, Fact of Injury, because no medical diagnosis/evidence has been submitted, it is important for the claimant to understand that:

- (a) The evidence of record established that the claim was timely filed by a Federal civilian employee and supports that the injury occurred as alleged;
- (b) The case is being denied on the third basic element, Fact of Injury, because medical evidence containing a diagnosis in connection with the injury was not submitted; and
- (c) Even if medical evidence containing a diagnosis is submitted (to satisfy Fact of Injury), medical evidence to establish the remaining medical element, Causal Relationship, is still required. If the performance of duty element is deficient, this should be addressed as well.

(2) Clear Language. The CE should use simple words, avoid technical terms, and use the active voice and the second person. See examples in paragraph b. below.

(3) Shell decisions. Correspondence Library contains shell decisions for each of the five basic elements to serve as a guide in writing the initial denial. Any shell used should be tailored to the

specifics of the individual case. All of the necessary information and an appropriate discussion and analysis of the evidence should be included in the decision.

b. Elements of the Initial Denial. Initial denials are usually written as letter decisions. Regardless of the format, however, each initial denial should contain the following elements:

(1) Complete Background. The decision should provide an explanation regarding what was claimed; explain the evidence that was submitted with the initial filing of the claim; and describe what specific evidence was requested upon development.

Example: On 02/02/12, you filed a claim for a traumatic injury, indicating you sustained an injury or medical condition on 02/01/12 as a result of your employment as a Nurse with the Department of Veterans' Affairs in Anywhere, USA. Specifically, you stated that the injury or condition occurred when you slipped on a wet floor by the nurses' station and hurt your back. In addition to your claim, you submitted your factual statement dated 02/02/12 describing your injury, and a statement from a co-worker who witnessed your fall. No other evidence was submitted with your claim.

On 02/10/12 this office advised you of the deficiencies in your claim and provided you the opportunity to submit additional evidence. Specifically, you were asked to submit a medical report from a qualified physician that included a diagnosis in connection with your injury, and the physician's opinion as to how the diagnosed condition is causally related to the fall at work. You were provided 60 days to submit the requested information.

(2) Discussion of Evidence. All evidence submitted should be reviewed and discussed in the decision. Evidence received following development that lacks probative value should also be acknowledged. Whenever possible, reference the evidence by author and date.

Example: In response to our development letter, we received the following evidence: a disability slip dated 02/02/12 from Dr. John Smith placing you off work for a week due to "pain" in your back; and a 02/14/12 statement from your supervisor, Jane Doe, indicating that she did not witness the injury.

(3) Requirements for Entitlement. An initial denial should contain standard language outlining the requirements for acceptance of a case.

Example: In order for a claim to be accepted under the Federal Employees' Compensation Act (FECA), the claim must meet 5 basic elements. The claim must: 1) Be Timely Filed; 2) Be made by a Federal Civil Employee; 3) Establish Fact of Injury, which has both a factual and medical component. Factually, the injury, accident or employment factor alleged must have actually occurred. Medically, a medical condition must be diagnosed in connection with the injury or event; 4) Establish Performance of Duty. The injury and/or medical condition must have arisen during the course of your employment and within the scope of compensable work factors; 5) Establish Causal Relationship, which means the medical evidence establishes that the diagnosed condition is causally related to the injury or event.

(4) Issue. The CE should identify the specific element of the five basic elements that has not been met.

Example: You have established that you are a Federal civilian employee who filed a timely claim; however, after a thorough review of all evidence, your claim is denied because the medical component of the third basic element, Fact of Injury, has not been met.

(5) Basis for Denial. The decision should provide a thorough explanation and analysis as to why the evidence submitted was insufficient to substantiate the claim, and the decision should be clear with regard to what specific element has not been met.

The claimant should also understand what other evidence would be needed to perfect the claim, e.g. if FOI-Medical has not been met, also alert the claimant that medical evidence establishing Causal Relationship would be needed prior to acceptance of the claim. This allows the claimant the opportunity to submit all necessary evidence if he or she chooses to pursue an appellate option that allows submission of new evidence.

Example: Specifically, your case is denied because you did not submit any medical evidence containing a medical diagnosis in connection with the injury and/or event. The medical evidence in your case only contains a diagnosis of "pain." Pain is a symptom and is not a diagnosis of a medical condition.

Medical evidence is required that not only contains a diagnosis but also establishes that a diagnosed medical condition is causally related to the work injury or event. Therefore, even if you submit medical evidence containing a diagnosis, you must also submit evidence that establishes the remaining medical element, Causal Relationship, as described above.

(6) Appeal Rights. Appeal rights must be included with all initial claim denials, and should correctly advise the claimant of his or her rights of appeal. The courses of action include:

(1) Hearing. The claimant may request a hearing if the injury or death occurred after July 4, 1986. Section 5 U.S.C. 8124 provides, however, that a claimant is only entitled to a hearing as a matter of right if the request is made within 30 days of the Office's initial decision and before any reconsideration is undertaken. The claimant may (but is not required to) submit new evidence in connection with a hearing. See PM 2-1601.

(2) Reconsideration. To support a request for reconsideration, the claimant must submit relevant new evidence or legal argument not previously made. Effective August 29, 2011, an application for reconsideration must be received by the OWCP within one year of the date of the OWCP decision for which review is sought. See 20 C.F.R. §10.605 – 10.609. See also PM 2-1602.

(3) Employees' Compensation Appeals Board (ECAB). The ECAB will not consider new evidence. Therefore, any appeal to the Board must proceed on the basis of the record as it stands at the time of the OWCP's decision. See PM 2-1603. See also 20 C.F.R. §501.2(c).

6. Emotional Condition Denials. To deny an initial claim for an emotional condition, the CE should similarly prepare a Notice of Decision including appeal rights (as described in Paragraph 5 above). However, it is especially important in these cases to identify and discuss all evidence that pertains to the issue at hand, including any unsuccessful attempts to obtain significant evidence.

The CE must first determine whether the situations alleged actually existed or occurred. The CE will then need to distinguish between those workplace activities and circumstances which are factors of employment and those which are outside the scope of employment for purposes of compensation.

a. The CE should outline work-related and non work-related elements into three parts, labeled as follows:

(1) Accepted Events that are Factors of Employment

(2) Accepted Events that are Not Factors of Employment

(3) Incidents Alleged which the Office Finds Did Not Occur

b. Factual Evidence

(1) The CE should summarize each allegation made by the claimant and the employer's response as it pertains to each allegation.

(2) All evidence submitted from the claimant and/or the employer in reference to each allegation should be summarized.

c. Medical Evidence. All pertinent medical evidence submitted and its content should be summarized to the extent that it pertains to the basis for the denial of the claim (as described in Paragraph 5 above).

d. Element for Denial. As described in Paragraph 4 above, after the claimant has had an opportunity to submit necessary evidence, the CE should consider the five basic elements in a hierarchical manner and determine which of the five basic elements has not been established after review of all evidence in the case record. The elements of Time and Civil Employee are determined similarly for all case types; however, there are specific criteria to consider in emotional condition cases when reviewing the remaining three basic elements.

(1) Fact of Injury-Factual. Each distinct allegation should be addressed separately as to whether or not it occurred. An explanation should be provided for each allegation that has/has not been accepted to have occurred.

If it cannot be established that any of the allegations/incidents claimed actually occurred, the claim should be denied on FOI-Factual.

(2) Fact of Injury-Medical. If the claimant has met the factual portion of FOI and substantiated at least one allegation/incident but failed to submit any medical evidence in connection to that allegation/incident, the claim should be denied on the basis of FOI-Medical.

A clear discussion should be provided that advises the claimant that no medical evidence has been received with a diagnosis in connection to any of the accepted events.

Each allegation made by the claimant should be identified, and the CE should provide a final assessment of the accepted events that are factors of employment, those that are not factors of employment, as well as any incidents alleged that the Office finds did not occur.

If there are accepted events that are not found to be compensable factors of employment, the CE should advise the claimant that even if medical evidence is submitted containing a diagnosis, there is no evidence substantiating causal relationship to an accepted factor of employment.

(3) Performance of Duty (POD). Even if only one allegation is determined to be factually accurate and FOI-Medical is established, the CE must consider the next basic element, POD. If it is determined that none of the accepted events are considered to be compensable factors of employment, then the case should be denied on the basis that the injury did not occur in the performance of the claimant's duties.

A denial on POD requires that the CE identify the "Accepted Event(s) that are Not Factors of Employment" and "Incidents Alleged which the Office Finds Did Not Occur." The claimant should be advised that none of the Accepted Events are considered Factors of Employment.

Each accepted event that is not found to be a factor of employment should be discussed separately, with an explanation as to why it is not considered to have arisen out of or occurring during the course of the claimant's employment. ECAB citations where the Board has previously addressed similar circumstances may be used to support the CE's finding.

(4) Causal Relationship (CR). After completion of the above review, if a factor of employment is established as occurring in POD, the CE must consider if the diagnosed condition is causally related to the accepted factor(s), and deny on CR if it is not. See PM 2-800-9(a)(2).

A claim should be denied as not causally related if the medical evidence after initial development is:

- (a) insufficient to support CR on even a *prima facie* basis;
- (b) the second opinion or attending physician's report negates CR, or causally relates the emotional condition to an event that is not a compensable factor of employment; or
- (c) after additional development has been undertaken (clarification of the attending psychiatrist/psychologist's initial report or second opinion examination), a report is not received or is insufficient.

An initial emotional condition denial on CR is similar to a denial on POD in that the three types of factors are delineated, but the CR decision additionally discusses the medical evidence and why it is insufficient to support the relationship of the emotional condition to the accepted factor(s) of employment.

7. iFECS Coding. Once a case is denied, the CE must appropriately code the denial in iFECS. Assignment of the following codes should correlate with the date of the decision. Any denial code prevents the payment of bills and compensation as of that date.

The following adjudication and pay status codes are assigned with initial denial decisions:

- a. D1/C3 The claim was not Timely filed.
- b. D2/C3 The claimant is not a Civil Employee.
- c. D3/C3 Fact of Injury is not established.
- d. D4/C3 Performance of Duty is not established.
- e. D5/C3 Causal Relationship is not established.

Chapter 2-1402, Forfeiture

1. Purpose and Scope. This chapter discusses procedures for determining whether forfeiture of compensation is appropriate for failure to report earnings and employment activity. Review of Periodic Roll cases and the development of possible earnings are discussed in detail in FECA PM 2-0812.

2. Statutory Provisions.

- a. Section 8106(b) of the Federal Employees' Compensation Act (FECA) provides that,

The Secretary of Labor may require a partially disabled employee to report his earnings from employment or self-employment, by affidavit or otherwise, in the manner and at the times the Secretary specifies. The employee shall include in the affidavit or report the value of housing, board, lodging, and other advantages which are part of his earnings in employment or self-employment and which can be estimated in money. An employee who--

- (1) fails to make an affidavit or report when required; or
- (2) knowingly omits or understates any part of his earnings

forfeits his right to compensation with respect to any period for which the affidavit or report was required. Compensation forfeited under this subsection, if already paid, shall be recovered by a

deduction from the compensation payable to the employee or otherwise recovered under section 8129 of this title, unless recovery is waived under that section.

b. Although section 8106 refers to "partially disabled" claimants, the Employees' Compensation Appeals Board (ECAB) has held that the forfeiture provision also applies to claimants receiving compensation for total disability. See Joseph M. Popp, 48 ECAB 624 (1997). See also Ronald H. Ripple, 24 ECAB 254, 260 (1973).

c. The statutory authority for forfeiture applies to the omission or understatement of earnings and work activity; it does not apply to similar misrepresentations of dependent status, receipt of dual benefits, etc. While omission or misrepresentation of these other factual elements may lead to an adjustment and overpayment of compensation, the forfeiture provision may not be applied. See Lucille A. Pettaway, 55 ECAB 228 (2004) (ECAB stated that the penalty provision only applies to reports of earnings from employment or self-employment; therefore, forfeiture under section 8106(b) may not be declared for failure, knowingly or otherwise, to report one's imprisonment for a felony).

3. Periodic Roll Review. All cases on the periodic roll require completion of Form EN-1032 on a yearly basis; Form CA-1032 is the cover letter for this form. The office generates and mails Form CA-1032 (with attached EN-1032) to claimants. The Claims Examiner (CE) should review each case after 30 days has elapsed. If there is any evidence on Form EN-1032 that the claimant has any type of employment or earnings, further action is warranted. The CE should pursue clarification and obtain further information from the claimant, the Social Security Administration, or the new employer. The CE may also consider referral to the Office of Inspector General if sufficient information regarding the employment is not received from the claimant or other sources. See FECA PM 2-0812 for a more detailed discussion of the review of cases on the periodic roll.

4. CA-1032 Reporting Requirements. The EN-1032 covers the 15-month period prior to the date of the claimant's signature. This form specifically instructs the claimant to report all work and volunteer activity, other than ownership or passive investment in a publicly traded business. The claimant is specifically instructed to:

a. Report all employment for which a salary, wages, income, sales commissions, piecework, or payment of any kind is received (including service with the military forces of the United States, the National Guard, a Reserve component, or other affiliates), even for employment held at the time of injury if he/she has worked at that employment during any period covered by the form.

b. Report all self-employment or involvement in business enterprises, even if the activity was part-time or intermittent, or was performed for a family business. Examples are provided: farming; sales work; operating a store or a restaurant; carpentry; mechanical work; painting; contracting; child care; odd jobs, keeping books and records; or managing and/or overseeing a business of any kind.

c. Report the "rate of pay," including the value of such things as housing, meals, clothing, and reimbursed expenses, if they were received as part of the employment.

d. Report any work or ownership interest in any business enterprise, even if the business lost money, or if profits or income were reinvested or paid to others. If the claimant performed any duties in any business enterprise for which no pay was received, he/she is instructed to show as the rate of pay what it would have cost the employer or organization to hire someone to perform the work or duties performed, even if the work was for the claimant or a relative.

e. Report any volunteer work, including volunteer work for which any form of monetary or in-kind compensation was received.

After answering these questions, the claimant is required to certify the responses and sign the affidavit after reading the certification statement, which states that "I know that fraudulently concealing or failing to report income or other information in claiming payment or benefit under FECA may result in the forfeiture of compensation for the period covered by this form and may also result in a civil action against me for damages under the False Claims Act or other applicable laws."

5. Key Elements of a Forfeiture Decision. There are two key requirements for a finding of forfeiture under Section 8106(b)(2): 1) whether the claimant failed to report earnings; and 2) whether he/she did so knowingly. A claimant can only be subjected to the forfeiture provision of section 8106(b)(2) if he or she "knowingly" failed to report employment or earnings. A discussion of earnings can be found in paragraph 6, and guidance for making a determination on the second component, "knowingly," is found in paragraph 7.

If the claimant knowingly omits or understates earnings, compensation will be declared forfeit for the period covered by the requested report. Also, forfeiture may be declared for failure to report self-employment if a value could be placed on the work performed in the open labor market, and the evidence establishes that the claimant was aware or reasonably should have been aware of the requirement to report such employment.

It is not enough to merely establish that there were unreported earnings. The evidence must demonstrate the claimant knowingly failed to report the earnings or activity. Forfeiture is a penalty and, as such, must be narrowly construed.

6. Definition of Earnings. As noted in paragraph 4 of this chapter, Form EN-1032 is explicit in the type of work and volunteer activity that should be reported. The FECA regulations very clearly define earnings and the need to report volunteer activity, even if no pay was received.

a. 20 C.F.R. §10.5(g) defines earnings from employment or self-employment as:

(1) Gross earnings or wages before any deductions, and includes the value of subsistence, quarters, reimbursed expenses and any other goods or services received in kind as remuneration; or

(2) A reasonable estimate of the cost to have someone else perform the duties of an individual who accepts no remuneration. Neither lack of profits, nor the characterization of the duties as a hobby, removes an unremunerated individual's responsibility to report the estimated cost to have someone else perform his or her duties.

b. The reporting requirements for volunteer activity are outlined in 20 C.F.R. §10.526:

An employee who is receiving compensation for partial or total disability is periodically required to report volunteer activity or any other kind of activity which shows that the employee is no longer totally disabled for work. The fact that the employee did not receive any salary for this work is not a basis for failing to report this activity; instead the employee must report the cost if any to have someone else do the work or activity

Claimants are required to report and describe volunteer activity even if no remuneration is received, as reporting these activities and employment is material to a determination of continuing disability. Even if there is no immediate change in monetary compensation, OWCP must evaluate this information in the context of further case action. A claimant who is regularly performing his or her second job or engaged in regular volunteer activity may be sent for a second opinion evaluation or evaluated for vocational rehabilitation.

c. A claimant's failure to report investments does not constitute grounds for forfeiture. Passive investments such as mutual funds, stock ownership, or strictly a financial interest in a business unaccompanied by any active involvement or employment activity in that business is not activity that is required to be reported. See generally Vernon Booth 7 ECAB 209, 211 (1954); Anthony V. Knox, 50 ECAB 402, fn 11 (1999) (While appellant's unreported employment activity with respect to his rental property business subjected him to FECA's forfeiture provisions, the record did not establish he engaged in farm work on the farm he owned.) Farm ownership alone is not subject to the forfeiture provisions of FECA.

7. Definition of Knowingly. The term "knowingly" is defined in 20 C.F.R. §10.5(n) as "with knowledge, consciously, willfully or intentionally." For an omission or understatement to be considered "knowingly" made, the file must contain positive evidence, such as a statement from the claimant that he or she had earnings, or a statement indicating earnings less than the amount actually earned according to other sources. To determine whether the claimant reasonably should have known that the earnings or employment activity should have been reported to the OWCP, the circumstances of the case should be carefully evaluated with respect to the claimant's age, education level, and familiarity with the reporting requirements, as well as the nature of the employment/earnings involved and any other relevant factors.

However, it should be noted that the instructions for filling out the Form EN-1032 are quite specific and require the claimant to report all employment activities, including volunteer work. The ECAB has repeatedly held that the Form EN-1032, as signed and dated by an employee receiving compensation, may constitute substantial evidence as to what the employee "knew" with regard to the requirement to report his or her employment activities to OWCP.

See the following ECAB cases for more guidance in this area:

A.A., Docket No. 07-877 (issued October 17, 2007) (employee knowingly failed to report her employment earnings on the CA-1032 she submitted);

S.R., Docket No. 07-618 (issued July 10, 2007) (employee knowingly failed to report work activities and earnings from an eBay account);

David P. Bjornson, Docket No. 04-1339 (issued March 21, 2005) ("...appellant's signing of certification clauses on the CA-1032 form provides persuasive evidence that he "knowingly" understated his earnings and employment information");

John A. Graham, Docket No. 04-759 (issued September 30, 2004) (failure to fully report his earnings to OWCP was found to be a "knowing omission" by appellant);

Daniel J. Baladez, Docket No. 01-439 (issued June 4, 2003) (employee knowingly failed to report his earnings from his "hobby");

John Lombardo, Docket No. 01-814 (issued July 1, 2002) (employee knowingly failed to provided information on his intermittent work activities);

Francisco Serrano, 40 ECAB 824 (1989) (the employee knowingly failed to provide information on his employment in his brother's company);

Monroe E. Hartzog, 40 ECAB 322 (1988) (the employee knowingly failed to report his employment in a family business selling mobile homes);

Harry S. Renkert, 39 ECAB 1142 (1988) (the employee knowingly failed to report his employment as a fishing guide);

Jesse Meredith, Jr., 38 ECAB 575 (1987) (the employee knowingly failed to report his earnings as a substitute teacher); and

Cheryl Thomas, Docket No. 03-1848, (Issued July 6, 2004), 55 ECAB 610 (Claimant's underreporting of employment constituted grounds for forfeiture)

If it is determined that the omission or failure was not knowingly made, the claimant's compensation entitlement during the period of the employment should be determined on the basis of his or her actual earnings. If the claimant simply fails to submit Form EN-1032, compensation should be suspended. See FECA PM 2-0812.

8. Penalty Decision. 20 C.F.R. §10.529 provides that, "If an employee knowingly omits or understates any earnings or work activity in making a report, he or she shall forfeit the right to compensation with respect to any period for which the report was required. A false or evasive statement, omission, concealment, or misrepresentation with respect to employment activity or earnings in a report may also subject an employee to criminal prosecution."

a. Signature Authority. Only a Quality Assurance and Mentoring Examiner (QAM) or higher authority may issue a forfeiture decision.

b. Advising the Claimant. When the evidence shows that the claimant had earnings and knowingly did not report them on Form EN-1032, the QAM should prepare a formal decision declaring the compensation forfeit. The forfeiture decision must clearly address the period of activity and how the determination was made that the claimant knowingly made an omission or understatement. Note also that when composing the decision, the QAM should not rely solely on investigative summaries; rather, the QAM should cite specific evidence, e.g. witness statements, documentation of earnings, etc.

c. Period of Forfeiture.

(1) If Form CA-1032 was issued, the forfeiture applies to the entire period covered by the form (15 months from the date of the signature). The entire period is forfeit, even if the claimant had unreported earnings for only part of the period.

(2) If Form CA-1032 was not issued for the period during which the claimant worked or had earnings while receiving compensation, the period of forfeiture is limited to the period that the claimant actually worked and did not report earnings. See Curtis D. Humphrey, 47 ECAB 553 (1996).

d. Discussion of Knowingly. The forfeiture decision should specifically discuss the evidence which supports that the claimant knowingly failed to report earnings. This evidence could include documents which inform the claimant of the need to report earnings and the possible consequences of failing to do so, such as the advisory letter issued when the claimant is placed on the periodic compensation roll (i.e. the CA-1049), or the explicit language contained on signed EN-1032 forms.

e. Resulting Overpayment Decision. A preliminary overpayment decision should be released with the forfeiture decision, finding the claimant to be with fault in creating the overpayment, since the claimant failed to furnish information which he or she should have known to be material. After due process has been provided and a final decision has been issued by the Claims Office or by the Branch of Hearings and Review, OWCP should recover the overpayment in the same manner as any other overpayment.

f. Other Entitlement Decisions. If injury-related disability does not continue, a notice of proposed termination should be issued simultaneously with the forfeiture decision. If work-related disability is established, the claimant's wage-earning capacity should be determined based on actual earnings or a constructed loss of wage-earning capacity (LWEC) rating, and benefits should be reduced accordingly.

Generally, a forfeiture decision should not be released until the entitlement issue is fully resolved; however, based on the circumstances in a particular case, proceeding with forfeiture prior to completely resolving entitlement may be appropriate.

g. Schedule Awards. A claimant who forfeits compensation for failing to report earnings or employment also forfeits entitlement to a schedule award thereafter. Garry Don Young, 45 ECAB 621 (1994) (Section 8106(b)(2) of the Act contemplates a schedule award as compensation, for purposes of forfeiture, as monetary compensation payable to an employee under section 8107 is a payment made from the Employees' Compensation Fund).

h. Later Reports of Earnings. Any compensation used to recover an established overpayment is itself subject to forfeiture should the claimant again knowingly fail to report earnings/activity on Form EN-1032.

9. Form CA-7, Claim for Compensation. Forfeiture may also be declared based on an omission or misrepresentation of earnings/work activity on Form CA-7. See C.A., Docket No. 08-1203 (issued April 2, 2009) (ECAB affirmed OWCP's determination that appellant forfeited compensation as appellant "knowingly" omitted her earnings under section 8106(b)(2) of the Act by failing to report her employment activities and earnings on the applicable CA-7 forms.)

a. Reporting Requirements. The CA-7 form asks the claimant to report all earnings from employment (outside of his/her federal job) for the period claimed on the CA-7. The claimant is specifically advised to include all employment for which salary, wages, sales commissions, etc. are received, including any self employment, and that failure to report such may result in forfeiture of compensation or criminal prosecution. By signing the form, the claimant is certifying the accuracy and truthfulness of the information contained on the form.

b. A forfeiture based on Form CA-7 will cover only the period claimed on the CA-7.

c. Any CA-7 form used for forfeiture must be reviewed carefully, as the ECAB has ruled that the language in some earlier versions of the form (prior to June 2005) is not sufficient to reasonably put the claimant on notice that all earnings need to be reported, no matter the source. If the form in question is prior to June 2005, you should not pursue forfeiture and instead should pursue only the overpayment, if appropriate.

Chapter 2-1500, Recurrences

1. Purpose and Scope. This chapter describes policies and procedures for developing and adjudicating claims for recurrent medical conditions and recurrent disability. It also addresses return to work issues related to recurrences.

Modifications of formal wage-earning capacity determinations are discussed in PM 2-1501.

If a denial of a recurrence is issued, a formal decision should be issued in accordance with procedures outlined in PM 2-1400.

2. Regulatory References.

a. 20 C.F.R. §10.5 (y) defines a recurrence of a medical condition as "A documented need for further medical treatment after release from treatment for the accepted condition or injury when there is no accompanying work stoppage. Continuous treatment for the original condition or injury is not considered a 'need for further medical treatment after release from treatment,' nor is an examination without treatment."

b. 20 C.F.R. §10.5 (x) defines a recurrence of disability as "An inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition which had resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness. This term also means an inability to work that takes place when a light-duty assignment made specifically to accommodate an employee's physical limitations due to his or her work-related injury or illness is withdrawn or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations.

A recurrence of disability does not apply when a light-duty assignment is withdrawn for reasons of misconduct, non-performance of job duties or other downsizing or where a loss of wage-earning capacity determination as provided by 5 U.S.C. 8115 is in place."

c. 20 C.F.R. §10.104 provides that:

"(a) A recurrence should be reported on Form CA–2a if that recurrence causes the employee to lose time from work and incur a wage loss, or if the employee experiences a renewed need for treatment after previously being released from care. However, a notice of recurrence should not be filed when a new injury, new occupational disease, or new event contributing to an already existing occupational disease has occurred. In these instances, the employee should file Form CA–1 or CA–2.

(b) The employee has the burden of establishing by the weight of reliable, probative and substantial evidence that the recurrence of disability is causally related to the original injury.

(1) The employee must include a detailed factual statement as described on Form CA–2a. The employer may submit comments concerning the employee's statement.

(2) The employee should arrange for the submittal of a detailed medical report from the attending physician as described on Form CA–2a. The employee should also submit, or arrange for the submittal of, similar medical reports for any examination and/or treatment received after returning to work following the original injury.

(c) A claim for recurrence of disability is not available where OWCP has issued a loss of wage-earning capacity determination pursuant to 5 U.S.C. 8115. Under that circumstance, the only method for claiming additional wage loss compensation is through a request to modify that determination. However, OWCP is not precluded from adjudicating a limited period of disability

following the issuance of a loss of wage-earning capacity decision, such as where an employee has a demonstrated need for surgery." (See PM 2-1501.)

d. 20 C.F.R. §10.509 provides in part 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."

3. Claims for Recurrence. Claims for recurrences are usually received on Form CA-2a (Notice of Recurrence), though at times a CA-7 (Claim for Compensation) may be the first form received for recurrent disability.

a. Claim Form. An employee who requests action from OWCP based on renewed disability for work should be asked to complete Form CA-2a. An employee who is requesting further medical treatment after previously being released from care should also be asked to complete Form CA-2a. (If the claim remains open for medical care, or if the claimant was never released from treatment for the accepted work condition(s), Form CA-2a is not normally required).

The form should be filled out as follows:

(1) A claimant who is still Federally employed should complete Part A and give the form to the employing agency for completion of Part B.

(2) A claimant who is no longer Federally employed should complete Parts A and C. The form need not be forwarded to the former employing agency for completion of Part B.

Note that in some instances sufficient information may be available in the file and the CE may be able to take action on a claim for recurrence of disability without the Form CA-2a, such as when a CA-7 is filed and medical documentation in the file supports recurrent disability. Claims for recurrent medical care may be adjudicated based upon current medical evidence in file. See paragraph 4 below.

b. Prior Decisions. Upon receipt of a recurrence claim, the CE should first review the case file to determine if any formal decisions addressing continuing injury-related residuals or disability for work have been issued. Such decisions may impact the recurrence claim.

(1) If a decision has been issued finding that the claimant no longer suffers any residuals of the work injury, and the alleged recurrence occurred subsequent to the issuance of the decision, the claimant should be referred to the appeal rights accompanying the termination decision. No further action should be taken on the recurrence claim.

(a) The CE should carefully review the recurrence claim to determine if the claimant is requesting reconsideration rather than claiming a recurrence. A reconsideration request should refer explicitly to a prior formal decision and ask that the decision be reevaluated, while a request to reopen the case should address some material change in the employee's medical condition or employment status.

(b) Requests are sometimes unclear, however, and it is possible to have a valid claim for recurrence in a denied case if the denial was limited to a specific period of time or particular medical services, and the claim for recurrence addresses a different time period or a change in job duties.

(2) If a formal loss of wage-earning capacity (LWEC) decision has been issued, and the claim is for recurrent disability, it should generally be processed in accordance with procedures for modifying a formal LWEC. See PM 2-1501.

(3) If a sanction decision has been issued under 8106(c) for failure to accept suitable work, the claim is for recurrent disability, and the alleged recurrence occurred subsequent to the issuance of the decision, the claimant should be referred to the appeal rights accompanying the sanction decision. No further action should be taken on the recurrence claim.

c. Scenarios Not Considered Recurrences of Disability. A recurrence of disability does not include a work stoppage caused by the following factors:

(1) Termination of a temporary appointment, if the claimant was a temporary employee at the time of the injury. See M.S., Docket No. 11-1184 (issued December 12, 2011) (The ECAB affirmed the denial of a recurrence of disability on or after March 13, 2010. On September 26, 2009 appellant sustained a back sprain in the performance of duty. He stopped work and returned to light duty on November 4, 2009. Appellant filed various compensation claims for disability compensation beginning March 13, 2010. The ECAB stated: "The record reflects that appellant was a transitional employee whose term expired on March 8, 2010. The employing establishment stated that appellant's employment was terminated on March 8, 2010 due to the expiration of his non-career appointment. The ECAB held that when a claimant stops work for reasons unrelated to the accepted employment injury, there is not disability within the meaning of FECA. A recurrence of disability also does not include work stoppage caused by the termination of a temporary employment. In this case, both the employing establishment and appellant stated that he was a temporary employee and that his term appointment terminated on March 8, 2010. ECAB found the evidence does not establish that he was off work due to a medical disability.")

(2) Cessation of special funding for a particular position or project (e.g., "pipeline" grants);

(3) True reductions in force (RIFs), where employees performing full duty as well as those performing limited duty are affected;

(4) Closure of a base or other facility; or

(5) A condition which results from a new injury, even if it involves the same part of the body previously injured, or by renewed exposure to the causative agent of a previously suffered occupational disease. If a new work-related injury or exposure occurs, Form CA-1 or CA-2 should be completed accordingly. In some instances, Form CA-2a may be used in place of a CA-1 or CA-2 form to administratively create a new claim. See PM 2-0800.

However, in some occupational disease cases where the diagnosis remains the same but disability increases due to additional exposure to the same work factors, the claimant may submit Form CA-2a rather than filing a new claim. For instance, a claimant with carpal tunnel syndrome who has returned to work but whose repetitive work activities result in the need for surgery, is not required to file a new claim.

Note, however, that in emotional stress and hearing loss cases, a new claim should always be filed.

d. Initial Review. The CE should review the nature of the claimant's request to determine whether the claim is for a recurrence of a medical condition and/or a recurrence of disability. For recurrent disability claims, the CE should note whether the date of recurrence was over 90 days following the previous return to duty.

Claims for recurrence of a medical condition should be developed in accordance with paragraph 4 below. Claims for recurrence of disability should be developed in accordance with paragraph 5 below if recurrent disability occurred within 90 days of return to duty, or in accordance with paragraph 6 below if recurrent disability occurred later than 90 days following return to duty.

e. Determining Whether a Decision is Necessary. Claims for recurrence require adjudication except when noted in paragraph (b) above, or when:

(1) The claimant is still receiving continuation of pay (COP). Claims for recurrence of disability for work during this time almost always occur within 90 days of return to duty, and thus are considered causally related to the initial injury within the COP period, as long as no intervening injury occurred and the medical supports COP. (See paragraph 5 below.)

(2) The recurrence is for medical care only, and there has been no release from care or significant gap in treatment.

(3) Neither wage-loss compensation nor payment for medical expenses is claimed at present.

In these instances, the CE should advise the claimant and employing agency in writing as to why no action is being taken.

f. Advising the Employing Agency. Whether or not the employee is still employed by the Federal agency for which he or she worked at the time of injury, or is carried on its rolls, the CE should provide the agency with copies of any correspondence about the claim for recurrence.

4. Recurrence of Medical Condition/Care. The purpose of this paragraph is to address the evidence needed to adjudicate claims for recurrent medical care if the claimant had previously been released from medical care for the accepted work condition(s).

a. Within 90 Days of Release from Medical Care (as computed from the date of last examination or the physician's instruction to return PRN (as needed)). The claimant is responsible for submitting a statement from the attending physician supporting causal relationship between the

claimant's current condition and the accepted condition. The statement need not contain significant medical rationale, unless:

(1) Clear evidence of an intervening injury appears in the file, in which case factual bridging information should be requested if the necessary information was not submitted with Form CA-2a. (See PM 2-0805 for further discussion of intervening injuries.)

(2) The case was originally accepted for temporary aggravation of a pre-existing condition. In this instance, reasoned opinion supporting causal relationship to the work injury should be required.

(3) The recurrence claim involves a different diagnosis from the accepted condition.

b. After 90 Days of Release from Medical Care (as computed from the date of last examination or the physician's instruction to return PRN). The claimant is responsible for submitting an attending physician's report which contains a description of current objective findings and provides medical rationale for the causal relationship between the claimant's current condition(s) and the accepted condition(s).

(1) The medical evidence needed to establish causal relationship is outlined in FECA PM 2-0805. The medical rationale provided should be as detailed and conclusive as the evidence required to establish the original claim.

(2) The CE must evaluate the medical evidence in light of any intervening injuries or newly acquired medical conditions as described on Form CA-2a. If the information provided with the form is not sufficient to obtain a clear picture of the employee's activities and health during the period since release from medical care, the CE should request clarification or additional information as indicated.

(3) As with recurrences of medical conditions within 90 days of release from care, additional medical explanation will be needed if the original acceptance involved a temporary aggravation of a pre-existing condition, or if the recurrence claim involves a different diagnosis.

c. Recurrence Claims for Injuries in which a Destructive Procedure/Permanent Impairment has been accepted. Certain "destructive" procedures such as chordotomy or neurectomy will not normally be authorized due to resulting nerve damage (see PM 3-400). However, in cases of severe debilitating injury or disease, after all other medical and therapeutic options for relief have been exhausted, such procedures may be authorized. Permanent impairment usually follows such procedures. If a recurrence is claimed following such an approved procedure, the claimant need only submit medical evidence supporting the continued need for treatment of the accepted condition(s) for the CE to accept the recurrence claim.

5. Recurrent Disability for Work within 90 Days of Return to Duty. The purpose of this paragraph is to describe the evidence needed to adjudicate claims for recurrence of disability for work filed shortly after return to full or limited duty. Recurrences claimed due to withdrawal of limited duty are addressed in paragraph 6a below. Where a formal LWEC decision

is in place, the recurrence claim should be handled as a request for modification of the LWEC per PM 2-1501, regardless of the length of time between return to work and work stoppage.

a. Burden of Proof. The claimant is required to produce evidence establishing that the claimed disability is causally related to the accepted condition(s). In cases where recurring disability for work is claimed within 90 days of the first return to duty, the focus is on disability rather than causal relationship of the accepted condition(s) to the work injury.

b. Disability for Work. The CE should ask the claimant to submit a narrative statement from the attending physician which describes the duties which the employee cannot perform, and the demonstrated objective medical findings that form the basis for renewed disability for work.

6. Recurrent Disability for Work after 90 Days from Return to Duty. The purpose of this paragraph is to address the evidence needed to adjudicate a claim for recurrence of disability for work for periods after 90 days from return to duty. This evidence differs according to whether the claimant returned to full or limited duty.

a. Claimants Performing Limited Duty. A claimant working limited duty may file a recurrence of disability as the result of a material change in the accepted condition(s), the withdrawal of a limited duty assignment, or any other issue affecting the suitability of the work being performed.

(1) Burden of Proof. Claimants who are performing limited duty are not considered fully recovered from their work-related injuries, assuming the medical evidence establishes continued causal relationship between work restrictions and the accepted condition(s). This is true whether or not they have been rated for an LWEC; however, see PM 2-1501 for guidance when an LWEC rating is in place. Therefore, the claimant's burden of proof is to establish that any increase in disability for work is due to the accepted injury rather than another cause (Terry L. Hedman, 38 ECAB 222 (1986)).

In Hedman, the ECAB found that when an employee who is disabled from the job he held when injured on account of employment-related residuals returns to a limited duty position, or the medical evidence of record establishes that he can perform the limited duty position, the employee has the burden of establishing by the weight of the reliable, probative and substantial evidence a recurrence of total disability, and to show that he cannot perform such limited duty. As part of his burden, the employee must show a change in the nature and extent of the injury-related condition, or a change in the nature and extent of the limited duty job requirements. However, an increase in pain does not constitute objective evidence of disability. See Sally S. Weinacht, Docket No. 91-1035, issued November 12, 1991; D.C., ECAB Docket No. 08-2185 (Apr. 10, 2009).

(2) Change in Medical Condition. In cases where the claim is for recurrent disability as the result of a material change in the accepted condition(s), the CE should request a narrative medical report which describes the objective medical findings that form the basis of renewed disability for work. The physician should describe the changes in the accepted condition(s) and provide rationalized medical opinion regarding the causal relationship between such changes and the increase in disability. Note again that an increase in pain is not objective evidence of increased

disability. This information should be evaluated in light of any intervening injuries or subsequently acquired medical conditions reported on Form CA-2a.

If the claimant meets his or her burden of proof, the CE should accept the recurrence claim and initiate disability management procedures consistent with PM 2-0600.

(3) Change in Limited Duty Position. If the claim for recurrence of disability for work is based on modification of the claimant's duties or physical requirements of the job, the claimant should be asked to describe such changes, and the employing agency should be asked to comment. If not present in the file, the CE should also request that the claimant provide medical evidence of current work limitations causally related to the accepted condition(s).

If the evidence establishes that the limited duty position has changed such that it no longer accommodates the claimant's work restrictions, the CE should accept the recurrence and initiate disability management procedures consistent with PM 2-0600.

(4) Withdrawal of Limited Duty With No Previous LWEC. If the employing agency has withdrawn a limited duty assignment made specifically to accommodate the claimant's condition due to the work-related injury, and the withdrawal did not occur for cause, RIF, or closure of the facility, the CE need only establish continuing injury-related disability for regular duty to accept the recurrence and begin payment of compensation benefits.

To do so, the CE will need to ensure that the file contains an accurate description of the nature and extent of injury-related disability. It should be clear from the medical evidence of record that the claimant continues to suffer residuals of the work injury that are disabling. If the evidence is insufficient, the CE will need to request this information. While wage-loss compensation should not be paid during the development process, the CE should move expeditiously to develop the recurrence claim.

If the recurrence is established, the CE should accept the recurrence and initiate disability management procedures consistent with PM 2-0600.

(5) Withdrawal of Limited Duty With Existing LWEC Determination. When the employing agency has withdrawn a limited duty position which accommodated the claimant's work restrictions, and a formal LWEC decision has been issued, the LWEC decision will remain in place. Any claim for a recurrence of disability should be treated as a request for a modification of the LWEC, and not as a recurrence of disability. Such cases should be handled consistent with the procedures provided in PM 2-1501.

b. Claimants Performing Full Duty. Where the claimant had returned to full duty for more than 90 days, well-rationalized evidence must show that the recurrence of disability for work is directly related to the original injury. Careful attention should be given as to whether the claim is for a recurrence of the original injury, or if a new injury has occurred. See paragraph 3.c (5) above.

(1) Burden of Proof. It is the claimant's burden to submit factual and medical evidence in support of the claimed recurrence. It is not assumed that any subsequent incapacity involving the injured part of the body is the result of the original injury solely because the original injury was accepted. The totality of the evidence must clearly indicate that the recurrent disability is causally related to a material change in the accepted condition(s) without intervening cause.

(2) Evidence Required.

(a) Factual evidence. The claimant should be asked to provide a description of changes in his or her accepted condition(s), and any changes in duties during the intervening period. A description of any intervening injuries and subsequent medical treatment should also be requested.

(b) Medical evidence. The claimant should be asked to provide a report from his or her treating physician to include: (1) a description of current objective examination and diagnostic findings; (2) current diagnosis; (3) a well-reasoned medical opinion supporting causal relationship between the current findings/diagnosis and the work injury; (4) a discussion of the changes in findings, and how such changes are causally related to the claimed recurrent disability; (5) a discussion of any similar pre-existing or intervening condition(s) affecting the same part of the body; and (6) a description of the work duties the claimant cannot perform as of the date of the recurrence.

7. Terminations of Employment (Including for Cause). The purpose of this paragraph is to describe situations where entitlement for an alleged recurrence of disability may be impacted by a loss of permanent employment not due to downsizing or RIF, which were addressed above in paragraph 3c above.

To be compensable as a recurrence under the FECA and its implementing regulations defining recurrence, "This withdrawal must have occurred for reasons other than misconduct or non-performance of job duties."

The ECAB has held that "when a claimant stops work for reasons unrelated to his accepted employment injury, he has no disability within the meaning of the Federal Employees' Compensation Act." Bruce Johnson, Docket No. 00-145, issued December 22, 2000. Analysis of relevant cases reveal, however, that it is not merely the termination for cause which makes a claimant ineligible for wage-loss compensation. The seminal ECAB case in this area is John W. Normand, 39 ECAB 1378 (1988). In Normand, the claimant was removed from his light-duty position for disciplinary reasons, and the ECAB affirmed the determination that the employee was not entitled to compensation.

A careful analysis of Normand shows that the ECAB pointed to the definition of "disability" in the implementing regulations, and then noted that appellant would be entitled to compensation on the expiration of his schedule award if he was still disabled, i.e., unable to earn the wages that he was receiving on his date of injury. The ECAB reviewed the record and noted that the employing agency had provided light duty for the claimant, and then the claimant was terminated for "menacing behavior" and "unofficial use of government property." The ECAB specifically noted that "employment within appellant's work restrictions would still be available to him if his

attitude toward his fellow employees had been acceptable," and that there was no evidence that the claimant was "terminated due to his physical inability to perform his assigned duties." The ECAB then specifically noted that there was no evidence in the record that "appellant stopped work due to his physical condition. As there is no evidence in the record that appellant was not capable of performing his assigned duties" after the date he stopped work, the ECAB concluded that the claimant had "no disability" within the meaning of the Act.

a. For *Normand* to apply, it is important to note that:

- (1) The employing agency had offered light duty;
- (2) The claimant had been working the light duty position;
- (3) The employing agency noted that light duty would have still been available if the claimant had not been terminated for cause; and
- (4) Most importantly, there was no evidence in the record that the claimant was unable to perform the light duty position.

b. The following cases discuss *Normand* principles:

- Regina C. Burke, 43 ECAB 399 (1992): The ECAB reversed OWCP's termination of appellant's wage-loss compensation. The OWCP had terminated appellant's monetary compensation on the ground that her disability for work after August 31, 1990 was the result of being dismissed for misconduct. The ECAB noted that OWCP had made no finding with respect to whether appellant's disability had ceased, and failed to discuss whether appellant was physically capable of returning to her work to her date-of-injury position.
- Ralph Dennis Flanagan, Docket No. 94-1569, issued May 28, 1996: The ECAB, citing Normand stated, "Where employment is terminated, disability benefits would be payable if the evidence of record established that appellant was terminated due to injury-related physical inability to perform assigned duties, or the medical evidence of record established that appellant was unable to work due to an injury-related disabling condition."
- Janice J. Green, 49 ECAB 307 (1998): The ECAB held that appellant was entitled to partial wage-loss compensation, although she had been terminated for violating the agency's policy against taking gratuities or gifts from patients. Appellant had returned to work for four hours per day. The agency stated that light duty would have remained available. The ECAB noted that there is evidence that she remained partially disabled at the time she was terminated for cause. The ECAB concluded, "[A]ppellant is not entitled to wage-loss compensation for the four hours a day she was capable of working. Nonetheless, this case must be remanded to the Office for a computation of appellant's wage-loss compensation due to her continued partial disability at the time she was terminated for cause."
- V.B., Docket No. 12-114 (issued June 13, 2012): The ECAB held that appellant had not established entitlement to wage-loss compensation for the period November 19, 2006

through November 28, 2009 and continuing causally related to his accepted employment injury. OWCP accepted appellant's claim for right ilioinguinal neuralgia, and thereafter appellant accepted a modified position on September 7, 2006. He stopped work on September 27, 2006 due to an alleged incident that happened on September 26, 2006. On August 3, 2007, the employing establishment terminated appellant's employment as he was AWOL. The ECAB held that for "the period November 19, 2006 through August 2, 2007, there is no medical evidence indicating that appellant was not able to work due to his accepted condition. Moreover, appellant's employer provided work within his medical restrictions and indicated that light duty remained available. While appellant argued that the employing establishment withdrew its offer of limited duty on November 19, 2006, there is no evidence it was withdrawn due to his employment-related injury or that appellant's medical restrictions were disregarded.....Appellant's employment was terminated on August 3, 2007 for reasons not related to his accepted employment condition. For the period August 3, 2007 until November 28, 2009 and continuing, appellant did not work for the employing establishment. When a claimant stops work for reasons unrelated to his accepted employment injury, he has no disability within the meaning of the FECA. Accordingly, there is no basis for entitlement to wage-loss compensation for that period."

8. Compensation for Recurrent Disability. The purpose of this paragraph is to describe the steps needed to pay compensation in a case where a recurrence of disability for work has been accepted. The employee should submit Form CA-7 to claim compensation. The following guidelines should be observed:

a. Use of COP. Where fewer than 45 days of COP were used, the remaining days may be authorized if less than 45 days have elapsed since the date of first return to duty. See 20 C.F.R. 10.207.

b. Pay Rate. The CE should review the file to determine whether the claimant is entitled to a recurrent pay rate in accordance with FECA PM 2-0900.

If the claimant worked for a private employer, the CE will need to obtain confirmation from the employer of the pay rate reported by the employee. However, entitlement to a recurrent pay rate based on return to private employment requires that the employee must have returned to regular full-time Federal employment after the original disability, and six months must have elapsed since that return-to-work date.

c. Certification. The certifier is responsible for ensuring that the record contains sufficient medical evidence to establish entitlement to compensation for the claimed period. The certifier should also verify the appropriateness of a DOR (date of recurrence) pay rate, if applicable.

d. Schedule Awards. A schedule award and compensation for recurrent disability may not be paid concurrently for the same injury. If a recurrence of disability is accepted for a period which overlaps a schedule award, it will be necessary to interrupt the schedule award in order to pay the period of recurrence. If a recurrent pay rate is established, the claimant will be entitled to that

pay rate for the balance of the schedule award after the period of disability attributable to the recurrence has ceased. See PM 2-0808.

9. Disability Management Actions. If a recurrence of disability is accepted, the CE should ascertain the claimant's current work status if it is not clear and documented in the file.

If the claimant is losing time from work, the CE should promptly initiate disability management actions in accordance with FECA PM 2-0600. In addition, if the claimant is working in a limited duty capacity without wage loss because of the accepted work injury, disability management actions may also begin to assist in returning the claimant to full duty. If the work restrictions are stable and well defined, the CE should refer the case for vocational rehabilitation.

Chapter 2-1501, Modification of Loss of Wage Earning Capacity Decisions

1. Purpose and Scope. Once a formal loss of wage-earning capacity (LWEC) decision has been issued, modification of such a determination is not warranted unless one of three criteria is met. This chapter describes the criteria for developing and adjudicating claims for compensation for disability following the issuance of a formal LWEC decision.

If a formal LWEC decision has not been issued, PM Chapter 2-1500, Recurrences, should be consulted. Also, payment of compensation is discussed in detail in PM Chapter 2-901.

NRP (National Reassessment Program) Note: FECA Bulletin 09-05 (United States Postal Service National Reassessment Program Guidance), issued August 18, 2009, should be consulted if the circumstances in the case indicate that the position in question may have been withdrawn (in whole or in part) as a result of the United States Postal Service's National Reassessment Program which ended on January 31, 2011.

2. Regulatory References.

a. 20 CFR §10.5(f) defines disability as "the incapacity, because of an employment injury, to earn the wages the employee was receiving at the time of injury. It may be partial or total."

b. 20 C.F.R. §10.511 provides the following with regard to modifying an existing LWEC decision:

If OWCP issues a formal loss of wage-earning capacity determination, including a finding of no loss of wage-earning capacity, that determination and rate of compensation, if applicable, remains in place until that determination is modified by OWCP. Modification of such a determination is only warranted where the party seeking the modification establishes either that there is 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. However, OWCP is not precluded from adjudicating a limited period of disability following the issuance of a loss of wage-earning capacity decision, such as where an employee has a demonstrated need for surgery.

c. 20 C.F.R. § 10.509 provides the following with regard to a light-duty job that is eliminated due to downsizing:

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. When this occurs, OWCP will determine the employee's wage-earning capacity based on his or her actual earnings in such light-duty position if this determination is appropriate on the basis that such earnings fairly and reasonably represent the employee's wage-earning capacity, and such a determination has not already been made and the employing agency has stated, in writing, that no other employment is available.

3. Criteria for Modification. In order to determine whether a formal LWEC should be modified, the Claims Examiner (CE) should review the file to determine whether one of the three criteria for modification outlined below has been met.

a. One of the following criteria must be established for a formal LWEC decision to be modified (Elmer Strong, 17 ECAB 226 (1965)):

(1) The original rating was in error. Evidence received or already in file substantiates that the LWEC decision was issued in error.

(2) The claimant's medical condition has materially changed. Current medical evidence demonstrates either (a) a worsening of the accepted medical condition with no intervening injury resulting in new or increased work-related disability, or (b) that the work-related condition has improved and disability has decreased.

(3) The claimant has been vocationally rehabilitated. The evidence substantiates that the claimant has been retrained through vocational training or has been self-rehabilitated.

b. If a claimant with a prior formal LWEC rating accepts a position with no wage loss and returns to work, no employment-related disability or wage-loss entitlement continues. The CE should terminate compensation on the basis that there is no disability within the meaning of the Act despite the fact that an LWEC is in place.

(1) As noted above, 20 C.F.R. §10.5(f) defines "disability" as "the incapacity, because of an employment injury, to earn the wages the employee was receiving at the time of injury." Therefore, there is no disability within the meaning of the Act if the claimant returns to work without wage loss, despite the existence of a prior LWEC decision.

In Mary Miklosz, Docket No. 05-1672 (issued June 9, 2006), the Employees' Compensation Appeals Board (ECAB) found that although the Office did not meet its burden of proof to

modify the prior wage-earning capacity determination, this did not mean that the claimant was entitled to continuing wage-loss compensation. Rather, the ECAB found that upon return to work, the Office should apply the Shadrick formula to the wages received for the number of hours worked and stated that, "To the extent that a claimant is earning wages equal to or greater than those received at the time of injury, there is no disability as the term is generally defined under the Act with regard to wage-loss compensation." See also Gregory A. Compton, 45 ECAB 154 (1993).

(2) Because the claimant was previously receiving compensation in accordance with a formal LWEC decision, compensation should be terminated as of the date of the final decision so that no overpayment results.

(3) The prior LWEC should then be reviewed to determine if modification is necessary. See paragraph 5 in this chapter.

(a) If the prior LWEC can be modified because the claimant's medical condition has changed (or the prior decision was issued in error), the CE should issue a proposed notice to modify the underlying LWEC. Then, after the claimant has worked for 60 days (and the 30 days has passed for submission of evidence in response to the proposed decision), a final decision formally modifying the prior LWEC can be issued in conjunction with a new formal LWEC decision based on the new position. See PM 2-815.

(b) If the prior WEC cannot be modified based on a change in the medical condition, the CE should evaluate the circumstances of the case after the claimant has worked the new position for 60 days to determine whether the prior LWEC can be modified because the claimant has been vocationally rehabilitated. If so, the CE should issue a proposed notice to modify the underlying LWEC on this basis. Then, after 30 days has passed for the submission of evidence in response to the proposed decision, a final decision formally modifying the prior LWEC can be issued in conjunction with a new LWEC decision based on the new position. See PM 2-815.

(4) A new LWEC decision should not be issued without also (or first) formally modifying the prior underlying LWEC.

(5) If the job offer is withdrawn or the claimant sustains disability or a recurrence prior to formal modification of the previous LWEC decision, the claimant is entitled to compensation based on the prior LWEC rate.

4. Initial Actions. The party (claimant or OWCP) seeking modification of the LWEC decision has the burden to prove that one of the three criteria outlined above in paragraph 3a has been met.

a. Evaluating the request. If a claim for wage loss is received (Form CA-7 or CA-2a), the CE should review the file to determine whether a formal LWEC is in place, and, if so, the claim should be developed, if necessary, as a request for modification of the LWEC.

Any request for "modification" (especially those without an accompanying claim for compensation) should be reviewed carefully to determine whether the claimant is seeking a reconsideration of a recently issued LWEC decision, as opposed to a modification of the LWEC determination.

b. If the claimant is seeking modification (usually on the basis of an increase in wage loss), he or she must establish that the original LWEC rating was in error, or that the injury-related condition has worsened.

c. If OWCP is seeking modification (usually on the basis of a decrease in wage loss), OWCP must establish that the original LWEC rating was in error, that the injury-related condition has improved, or that the claimant has been vocationally rehabilitated. For instance, OWCP may seek to modify a formal LWEC rating as a result of information received that demonstrates increased earnings.

5. Development. The CE should develop the evidence to determine if modification of the formal LWEC decision is appropriate. If a claim for wage loss is received but development is necessary to determine whether the formal LWEC should be modified, no change should be made to the previously established LWEC during the development process.

a. Original Rating in Error. The CE should review the evidence of record to determine whether the original rating was in error. There is no need to revisit the original determination if there is no probative evidence that suggests it was in error.

An example of a case with error in the original rating would include an instance where evidence is received that shows that the pay rate used to determine a claimant's wage-earning capacity was incorrect, resulting in an incorrect amount of compensation.

(1) If the record reflects error, the CE can proceed with a modification decision following any development necessary. For example, if OWCP discovers that the pay rate used to calculate the prior LWEC decision was not accurate, the CE should ask the employing agency for any necessary information in writing and issue a decision upon receipt.

(2) If the claimant asserts that the rating was incorrect, but there is no probative evidence already of record to support that contention, development should occur and 30 days should be provided for the submission of evidence. For example, if the claimant submits evidence that suggests that the position upon which the decision was issued was not an actual bona fide position, the CE should request the employing agency to address the issue in writing.

b. Material Change in the Medical Condition.

(1) If the claimant asserts that he/she can no longer perform the duties of the position upon which the rating was issued as the result of the accepted condition(s), the CE should review the current evidence of file.

(a) The CE should determine:

(i) Whether the medical evidence supports that the current condition is related to the original work injury;

(ii) Whether there is continued work-related disability; and

(iii) Whether there has been a material worsening in the nature and extent of the injury-related condition with no intervening factors breaking the chain of causation.

(b) If the case lacks current medical evidence that addresses each item above (within approximately the last 6 months), the CE should request that the claimant provide a current narrative medical report which describes the objective medical findings that form the basis of renewed/increased disability for work. The physician should describe the changes in the accepted condition(s) and provide rationalized medical opinion regarding the causal relationship between such changes and the increase in disability. Conclusory statements of increased disability are insufficient to meet the burden of proof. John P. Duncan, ECAB Docket No. 04-668 (Nov. 15, 2005). Also, an increase in pain does not constitute objective evidence of disability. See Sally S. Weinacht, Docket No. 91-1035, issued November 12, 1991; D.C., ECAB Docket No. 08-2185 (Apr. 10, 2009). The claimant should be given 30 days to submit the requested evidence.

(c) The employing agency should also be requested to provide any information it may have on the claimant's current medical condition and intervening activities, employment duties, or injuries.

(2) If OWCP asserts that the LWEC should be modified to reduce or terminate the LWEC based on decreased disability due to a change (improvement) in the medical condition, the CE should review the evidence to determine whether the record sufficiently supports that the claimant's medical condition has improved such that he/she can now work a greater number of hours or perform more strenuous duties. If either of these is applicable, the CE can propose to modify the LWEC on this basis.

(a) If the claimant has not returned to work, AND the CE determines that the LWEC is in posture for modification on the basis of an improved medical condition, AND a suitable job offer has been provided, the CE should prepare a 30-day notice proposing modification of the existing LWEC determination with supporting rationale. This 30-day notice must also contain language which finds the offered job suitable. See PM 2-814.5d.

(b) If the claimant returns to work in a position with increased work hours or more strenuous duties, resulting in reduced or zero wage loss, and the CE determines that the LWEC is in posture for modification on the basis of an improved medical condition, the CE should issue a proposal to modify the existing LWEC on the basis of an improved medical condition.

c. Vocationally Rehabilitated. It may be appropriate to modify the LWEC rating on the grounds that the claimant has been vocationally rehabilitated if the claimant is employed in a new job (a job different from the job for which he or she was rated) obtained with additional training which pays at least 25% more than the current pay of the job for which the claimant was rated.

See W.G., Docket No. 06-367 (issued December 27, 2006). The ECAB held that the psychology technician position was proper for a modification of an existing wage-earning capacity determination, because the appellant was vocationally rehabilitated and employed in a new job earning at least 25% more than the position in which he was rated. However, the ECAB has held that without a showing of additional qualifications obtained by the appellant through retraining, it is improper to make a new loss of wage-earning capacity determination based solely on increased earnings. See Mary Miklosz, Docket No. 05-1672 (issued June 9, 2006).

(1) If there is evidence of increased earnings as outlined above, and these earnings have continued for at least 60 days, the CE should:

- (a) Determine the duration, exact pay, duties and responsibilities of the current job.
- (b) Determine whether the claimant underwent training or vocational preparation to earn the current salary.
- (c) Assess whether the actual job differs significantly in duties, responsibilities, or technical expertise from the job at which the claimant was rated.

(2) If the results of this investigation establish that the claimant is rehabilitated or self-rehabilitated, or if the evidence shows that the claimant was retrained for a different job, compensation may be re-determined using the *Shadrick* formula. Any modification of compensation should be preceded by a 30-day pre-reduction notice and be made prospectively so that no overpayment results.

6. Termination of Employment. The status of an employee with an established wage-earning capacity whose job is eliminated due to a Reduction-in-Force (RIF), facility closure, or some other form of downsizing, does not change with regard to receipt of FECA benefits unless the claimant has demonstrated that one of the three criteria for modification of an LWEC, described in the paragraphs above, exists.

A reemployed claimant may face removal from employment for reasons such as: the closure of an installation; cessation of special ("pipeline") funding; termination of temporary employment; or a RIF. (A true RIF affects full-duty and light-duty workers alike. If it is not clear whether the claimant's situation involves a RIF or the withdrawal of light-duty, the CE should request the personnel document on which the removal was based.) The ECAB has held that OWCP properly denied modification of a claimant's LWEC decision where the evidence was insufficient to show that the claimant could not perform the duties of his light-duty position which was eliminated due to a RIF. See Jack H. Mason, Docket No. 06-243 (issued June 20, 2006).

7. Withdrawal of Light-Duty. When the employing agency has withdrawn a light-duty position which accommodated the claimant's work restrictions and a formal LWEC decision has been issued, the LWEC decision will remain in place. There is no basis for disturbing the formal LWEC unless one of the three criteria for modifying an LWEC applies. The above guidelines in paragraph 3 apply even when a zero LWEC is in place.

The CE should, however, consult FECA Bulletin 09-05 (United States Postal Service National Reassessment Program Guidance), issued August 18, 2009, if the circumstances in the case indicate that the position in question may have been withdrawn (in whole or in part) as a result of the United States Postal Service's National Reassessment Program. The NRP ended on January 31, 2011.

8. Decision. Following proper development, a formal decision should be issued and compensation reduced or terminated as of the date of the final decision. See PM 2-1400 for more details on formal decisions.

a. If the claimant sought modification of the LWEC, and after appropriate development it is determined that the evidence in file does not substantiate one of the three criteria for modification, a decision should be issued denying modification of the LWEC. Appeal rights should accompany that decision.

b. If the claimant sought modification of the LWEC, and after appropriate development it is determined that the evidence in file does substantiate one of the three criteria for modification, a decision should be issued modifying the prior LWEC determination. If the claimant is entitled to compensation as a result of the modification, then payment should be made after submission of Form CA-7.

c. If OWCP sought modification of the LWEC, and after development it is established that the evidence in file substantiates one of the three criteria for modification, compensation may be recomputed using the *Shadrick* formula. A 30-day proposed notice should be issued in this instance before any adjustment is made to the formal LWEC rating. Following 30 days and any additional development necessary, a final decision should be issued and compensation reduced or terminated as of the date of the final decision. A new LWEC rating may then be issued if appropriate. See PM 2-815.

(1) Modification based on decreased disability. If evidence substantiates that the claimant returned to a position increasing his/her work hours or performing more strenuous duties with reduced or zero wage loss, and a proposed decision to modify the LWEC was issued on the basis that the claimant's medical condition has improved, the CE should, after 30 days have passed, review any evidence submitted. If no evidence is submitted to alter that determination, a decision modifying/terminating the prior LWEC should be issued and compensation reduced or terminated as of the date of the final decision so that no overpayment results.

(2) Modification based on vocational rehabilitation. If evidence substantiates that the claimant returned to work for 60 days in a different job paying 25% more than the current pay of the position at which s/he was rated, and for which s/he received additional vocational preparation with reduced or zero wage loss, and a proposed decision to modify the LWEC was issued on the basis that the claimant had been vocationally rehabilitated, the CE should, after 30 days have passed, review any evidence submitted. If no evidence is submitted to alter that determination, a decision modifying/terminating the prior LWEC should be issued and compensation reduced or terminated as of the date of the final decision. Any modification of compensation should be made prospectively so that no overpayment results.

d. Termination for no residuals. If after medical development it is determined that there are no residuals of the work injury, formal modification of the LWEC is not necessary, since medical evidence sufficient to meet the Office's burden of proof to terminate benefits would also be sufficient to modify an LWEC rating on the basis of a material change in the medical condition. The Office's burden to demonstrate no further disability is effectively the same, irrespective of whether there is an existing LWEC determination in place. See P.Y., ECAB Docket No. 09-2293, issued September 10, 2010. A pre-termination notice should be issued, which acknowledges the prior LWEC rating and any development undertaken. Following 30 days and any additional development necessary, a final termination decision should be issued and compensation terminated as of the date of the final decision. See FECA PM 2-1400.

9. Disability Management (DM) Actions. If the LWEC is modified because the work-related condition has materially changed or worsened to the extent that the claimant cannot perform the duties of the position for which he/she was rated, the CE should promptly begin appropriate DM actions. See FECA PM 2-0600 and 2-0601.

a. Nurse Intervention. In some cases, a nurse referral may be useful to clarify work tolerance limitations or some other medical aspect of the case. See FECA PM 2-0811.

b. Vocational Rehabilitation. If the work restrictions are stable and well-defined, the CE should refer the case for vocational rehabilitation services. See FECA PM 2-0813.

If appropriate, the case may be referred for concurrent nurse intervention and vocational rehabilitation services for dual tracking. See FECA PM 2-600-8.

c. CE Management. In some instances following the modification of an LWEC, other actions may be necessary, such as a referral for a second opinion examination (or, if appropriate thereafter, a referee examination).

10. Intermittent Claims for Wage Loss. If a claim is received for a limited period of disability when a formal LWEC is in place, the LWEC should not be modified unless current medical evidence establishes that the work-related condition has materially changed or worsened to the extent that the claimant cannot perform the duties of the position for which he/she was rated indefinitely or for an extended period of time. See T.H., Docket No. 10-2180, issued July 15, 2011.

The Board has held that OWCP may accept a limited period of disability without modifying a standing LWEC determination. This occurs when there is a demonstrated temporary worsening of a medical condition of insufficient duration and severity to warrant modification of an LWEC determination. This narrow exception is only applicable for brief periods of medical disability. It does not apply to situations where there is a LWEC determination in place and the employee claims additional wage-loss compensation due to the withdrawal of light-duty work.

a. Medical appointments. Claims for wage loss due to medical appointments should be paid in accordance with FECA PM 2-0901-19 without modification of the LWEC.

b. Disability is temporary. If the claimant is off work for a brief period due to his/her temporary inability to perform the duties of the rated position, this period of medical disability can be paid without modification of the LWEC, e.g. a brief recovery period after surgery or an injection with a subsequent day of disability. Once the claimant can return (or actually returns) to the rated position, then compensation should be reinstated based upon the established LWEC.

c. Constructed LWEC. If the established LWEC was constructed, compensation should be reinstated based upon the LWEC once the medical evidence establishes that the claimant is capable of working in the position upon which he/she was rated. A new labor market survey is not required.

Chapter 2-1600, Review Process

1. Purpose and Scope. This chapter outlines the appeal rights of claimants who have been issued formal decisions by OWCP. These rights include hearing, reconsideration, and review by the Employees' Compensation Appeals Board (ECAB). This chapter summarizes the authority, responsibilities and definitions which apply generally to hearings, reconsiderations and appeals.

Applications for hearings are processed by the Branch of Hearings and Review within the National Office, and the applicable procedures are discussed in Chapter 2-1601. Applications for reconsideration are handled by Claims Office personnel as outlined in Chapter 2-1602. Applications for review by the ECAB, which is an entirely separate entity from OWCP within the Department of Labor, are discussed in Chapter 2-1603.

2. Authority.

a. Decision. 5 U.S.C. 8124(a) provides that the Director of the OWCP, under delegation from the Secretary of Labor, shall determine and make a finding of facts and make an award for or against payment of compensation after:

(1) Considering the claim presented by the beneficiary and the report submitted by the immediate superior; and

(2) Completing such investigation as is considered necessary. In this connection, see [FECA PM 2-1400](#).

b. Hearing. Section 5 U.S.C. 8124(b) states that a claimant not satisfied with a formal decision is entitled to a hearing by an OWCP representative if the request is made within 30 days of the date of the decision. This provision, which applies to injuries occurring on and after July 4, 1966, includes the stipulation that any such request must be made before reconsideration under Section 5 U.S.C. 8128(a) is undertaken.

Apart from the hearing provided under 5 U.S.C. 8124(b), OWCP also provides the opportunity for an oral pre-recoupment hearing on the issues of fault and waiver, to anyone who is notified of an overpayment of benefits and requests a hearing within 30 days. See FECA PM Part 6.

c. Reconsideration. Section 5 U.S.C. 8128(a) provides that OWCP may review and reconsider an award for or against payment of compensation at any time on the Director's own motion or on application from the claimant and may:

- (1) End, decrease, or increase the compensation previously awarded; or
- (2) Award compensation previously refused or discontinued.

d. Appeal. Effective July 14, 1946, the ECAB was established by Federal Security Order No. 58 and given "all necessary and appropriate powers" to hear and decide appeals taken from determinations made in claims filed under the FECA. The ECAB and its function were transferred to the Department of Labor by Reorganization Plan No. 19 of 1950 (39 Stat. 742). Formal decisions of OWCP, except decisions concerning the amounts payable for medical services and decisions concerning exclusion and reinstatement of medical providers, are subject to review by the ECAB (20 C.F.R. 10.137).

e. Finality of Review. Section 5 U.S.C. 8128 provides that the action of the OWCP in allowing or denying a payment under the FECA is:

- (1) Final and conclusive for all purposes and with respect to questions of law and fact; and
- (2) Not subject to review by another official of the United States or by a court of mandamus or otherwise. (OWCP is required, however, to respond to any writs of mandamus which may be issued. Such writs direct that action be taken within a specified period of time without directing the particular action to be taken.)

3. Definitions.

a. Claimant. This term includes any individual who has applied directly for benefits under the FECA. Attorneys, physicians, and other parties who have provided services or supplies to an individual applying for such benefits are not claimants within the meaning of the FECA.

b. Application. This term includes any written communication from a claimant or representative which requests a hearing, reconsideration or appeal of a formal decision; no special form is necessary.

(1) A claimant who expresses or implies disagreement with a formal decision without requesting a specific action should be advised of the basis of the decision and reminded to exercise rights of appeal if further action is desired.

(2) Any file in which a complaint about a formal decision is received should be reviewed informally to assess whether the action leading to the complaint was correct. The CE should

determine through correspondence with the claimant whether the inquiry in effect constitutes a request for exercise of appeal rights.

c. Formal Decision. Chapter 2-1400 discusses disallowances in detail. To be considered a formal decision, any notice of decision or compensation order must:

- (1) Notify the claimant of the action and the reasons for it;
- (2) Comply with the statutory requirements of 5 U.S.C. 8124(a); and
- (3) Be released at the appropriate level of authority.

All notices of decision, compensation orders, Letters CA-1048, CA-1066, and CA-1050, and Forms CA-180 and CA-181 are considered formal decisions on claims for monetary compensation, and may be appealed. Letters or compensation orders denying review of a prior decision, or denying modification of a prior decision, may be appealed to the Employees' Compensation Appeals Board. The office must notify the claimant in each case of his or her further rights.

4. Order and Number of Appeals. Appeals may be requested in any order, except that a hearing may not be held after the case has been reconsidered. There is no limit to the number of times a claimant may request reconsideration and submit additional evidence.

In providing information to claimants concerning their rights, the CE should refrain from suggesting that one form of appeal is appropriate in a given case, either as part of the decision or in any later conversation or correspondence.

Chapter 2-1601, Hearings and Reviews of the Written Record

1. Purpose and Scope. This chapter describes the processing of requests for hearings. The procedures include review of the case file, arrangements for the hearing, conduct of the hearing, and issuance of the decision. Additionally, procedures are described for handling requests for review of the written record. These functions, along with pre-recoupment hearings in overpayment cases (see FECA PM Part 6), are the responsibility of the Branch of Hearings and Review (H&R) within DFEC's National Office.

2. Policy. This paragraph describes the scope of claimants' entitlement to hearings and reviews of the written record.

a. Right to a Hearing. Where the injury or death occurred on or after July 4, 1966, the claimant is entitled to a hearing before an Office representative after a final decision and before reconsideration under Section 5 U.S.C. 8128. For injuries or diseases prior to that date, the Employees' Compensation Appeals Board (ECAB) has ruled that claimants are not entitled to a hearing as a matter of right but that the OWCP has the discretionary authority to grant a claimant's request for a hearing regardless of the date of injury or death (See R.L., Docket No. 15-1481 (2015)). A claimant is also entitled to a pre-recoupment hearing following a preliminary determination that an overpayment of compensation has occurred. However, the claimant is not entitled to a hearing under 5 U.S.C. 8124(b) after a final decision concerning an overpayment is issued.

b. Right to a Review of the Written Record. In place of an oral hearing, a claimant is entitled to a review of the written record (subsequently referred to as "review") by an Office representative. Such review will not involve oral testimony or attendance by the claimant, but the claimant may submit any written evidence or argument deemed relevant.

c. Issues for Consideration. The hearing or review will usually be limited to those issues which were addressed by the claims office (Office) in the contested decision. Other issues may be addressed at the discretion of the Office representative.

3. Applications. Requests for hearings and reviews should be mailed directly to the appropriate address clearly outlined in the appeal rights provided to claimants. Claimants may also electronically file their hearing request via ECOMP, an OWCP-hosted free web-based application.

While all requests should be directed to H&R, some improperly indexed may be received in the case file. They should be handled as follows:

a. Central Mail Room (CMR). When the request for a hearing or review is sent to CMR, the envelope and request will be scanned into the case file.

b. Claims File and/or ECOMP. If a request is received in the case file and was not properly indexed as a request for hearing or review, H&R shall be notified as soon as possible so that an H&R record can be created and the request can be tracked. The Office should notify H&R by advising the Branch Chief and Assistant Chief via e-mail of the untracked hearing request.

c. Acknowledgment. H&R will acknowledge receipt of the request by computer-generated letter, providing the claimant and representative of general information about the hearing process.

d. Assignments. The Branch will assign multiple pending appeals on the same case to the same Hearing Representative for efficiency and consistency in handling.

4. Initial Review of the Case. Upon receipt of the hearing or review request, H&R staff will review it to determine whether a reconsideration preceded the request for a hearing or

review, whether the request is timely, whether all necessary evidence is on record, and, if so, whether it supports the decision of the Office.

a. Timeliness. The request is timely if it was mailed (as determined by the postmark or other carrier's date marking) or received in ECOMP within 30 days of the date of the office's decision. 20 C.F.R. § 10.616. If the postmark is not legible, the request will be deemed timely unless the Office has kept evidence of date of delivery on the record reflecting that the request is untimely. In cases where the instructions on the appeal rights that accompanied the decision were not followed and the hearing request was received by ECAB and then forwarded to H&R, H&R will review the available evidence and determine the timeliness of the request.

b. Simultaneous ECAB Appeal. Only one avenue of appeal per decision on a particular issue can be pursued at one time. See *S.K.*, Docket No. 20-1049 (2021). In instances where a claimant requests a hearing or review through H&R and the ECAB on the same issue simultaneously, the Board will take precedence and have jurisdiction over the issue. In these cases, the Hearing Representative will contact the claimant and inform them (and authorized representative, if applicable) that H&R is precluded from reviewing the issue currently before the Board. If the claimant wishes to proceed through H&R, they will have to contact the Board and request to withdraw the appeal. Once the Board has accepted the withdrawal request and dismissed the appeal, H&R will proceed with the review or the hearing. The Hearing Representative will document all communications relating to these instances in the record.

c. Entitlement.

(1) Hearing. If preliminary study shows that the decision was reached in accordance with established policies and is supported by the evidence of record, the case will be scheduled for a hearing as described in paragraph 6 below. If a review has been requested, the procedures described in paragraph 5 below will be followed.

Note on Claimants Requiring Reasonable Accommodations: In the event that the case record contains a purple border, the Branch will arrange for the documented communication assistance. In some instances the communication assistance provided by the Office (such as email) before the hearing may not be effective in terms of claimant/other participation in the hearing; it may then be necessary to consult with the claimant prior to the hearing to arrive at an effective communication aid or service/accommodation for the hearing. In the event a qualified sign language interpreter is documented in the file as the requested communication assistance, the Branch will arrange for that assistance when scheduling the hearing. No additional request is necessary.

(2) Remand. If the decision is not supported by the evidence of record, or if new evidence warrants it, H&R will prepare a remand order setting the office decision aside. This order will include the reasons for the decision to remand and will outline the further action needed. A formal decision vacating the contested decision and a cover letter will also be prepared.

(3) Reverse. If the decision is not supported by the evidence of record, or if new evidence warrants it, H&R will prepare a reversal order setting aside the office decision. This order will include the reasons for the decision to reverse and will outline the further action needed. A formal decision reversing the contested decision and a cover letter will also be prepared.

(4) Remands/Reversals Before Hearing. Examples of issues that may be in posture for remand/reversal before hearing include:

- a. Primary Adjudication cases denied on Fact of Injury Medical or Causal Relationship, and sufficient medical documentation is presented upon initial review of the file or the Office's decision was clearly incorrect.
- b. Schedule Award denials for no evidence of impairment, and an impairment rating is presented upon initial review of the file or the Office's decision was clearly incorrect.
- c. Wage loss denials, and sufficient medical documentation is presented upon initial review of the file or the Office's decision was clearly incorrect.
- d. Termination decisions, and sufficient medical documentation is presented upon initial review of the file or the Office's decision was clearly incorrect.
- e. Expansion/Consequential Claim denials, and sufficient medical documentation is presented upon initial review of the file or the Office's decision was clearly incorrect.

(5) Upon initial review of the file and hearing request, if the evidence needed to reverse or remand a claim can be obtained through telephonic communication, the Hearing Representative may attempt to contact the claimant, employing agency, and/or authorized representative by telephone conference to obtain the documentation needed. This record of the telephone call and information discussed should be documented in the case file via CA-110.

(6) Examples of cases where proactive telephone contact is appropriate include:

- a. Fact of Injury (Factual) issues where the description of injury is vague or general, or there is a minor discrepancy between the date of injury annotated on the form and the date referenced in the medical evidence, and there is no dispute or challenge from the employing agency.
- b. Clear-cut traumatic injury claims where an affirmative statement on causal relationship is lacking.
- c. Performance of Duty denials where a simple supplemental statement may clarify the issue.

d. Any decision where medical documentation is not countersigned by a licensed physician.

(7) If the evidence needed to reverse the case is in the file after the initial review but prior to the scheduled hearing, the Hearing Representative will follow the Summary Decision procedures in paragraph 7(f) below.

5. Review of the Written Record. This paragraph discusses the steps involved in processing requests for review of the written record. Initial review of the request will follow the procedures described in paragraph 4(a)(b) above.

a. Entitlement.

(1) Formal Review. If preliminary study shows that the decision was reached in accordance with established policies and is supported by the evidence of record, the case will proceed to a formal review. H&R will furnish the employing agency with a copy of the claimant's request for review of the written record, together with any pertinent factual documentation submitted. (Medical evidence is not considered "pertinent" for review and comment by the agency and will therefore not be furnished to the agency. The OWCP has sole responsibility for evaluating medical evidence.)

a. The agency will be allowed 20 days to submit any comments and/or documents believed relevant and material to the issue in question. H&R will furnish any comments or documents submitted by the agency to the claimant and allow 20 days for review and comment by the claimant. 20 C.F.R. § 10.618(b).

b. Following a review of the record and any evidence submitted, the Hearing Representative and/or Special Claims Examiner shall decide the claim and inform the claimant, the claimant's representative, and the employing agency of the decision. Appeal rights will be attached to any adverse decision.

(2) Remand. If the decision is not supported by the evidence of record, or if new evidence warrants it, H&R will prepare a remand order setting the office decision aside. This order will include the reasons for the decision to remand and will outline the further action needed. A formal decision vacating the contested decision and a cover letter will also be prepared.

(3) Reverse. If the decision is not supported by the evidence of record, or if new evidence warrants it, H&R will prepare a reversal order setting the office decision aside. This order will include the reasons for the decision to reverse and will outline the further action needed. A formal decision reversing the contested decision and a cover letter will also be prepared.

(4) Remands/Reversals Before Formal Review. Issues that may be in posture for remand/reversal before a formal review is conducted are similar to the examples outlined in paragraph 4(c)(4) above.

(5) Upon initial review of the file and hearing request, if the evidence needed to reverse or remand a claim can be obtained through telephonic communication, the Hearing Representative may attempt to contact the claimant, employing agency and/or authorized representative by telephone conference to obtain the documentation needed. This record of the telephone call and information discussed should be documented in the case file via CA-110.

(6) Examples of cases where proactive telephone contact is appropriate are outlined in paragraph 4c(6) above.

6. Arranging for Hearings. This paragraph addresses the steps involved in arranging for a hearing and discusses some of the issues which may arise in obtaining evidence.

a. OWCP Discretion. For timeliness and efficiency, all hearings will be scheduled by teleconference by default unless it is determined that it is necessary that a hearing be conducted in person or via videoconference (or other electronic means). Reasons that would necessitate scheduling a hearing by means other than a teleconference include:

(1) A reasonable accommodation request for which an in-person or videoconference hearing is required.

(2) A request by the claimant or authorized representative, including evidence and/or argument that supports that an in-person or videoconference hearing is critical to ascertain the facts of the case and supporting why a teleconference would not serve the interests of justice.

(3) If the hearing representative determines that an in person or videoconference would allow the hearing representative to better assess the merits of the claim including the credibility of witnesses.

If a hearing will not be conducted telephonically, the hearing representative will mail a notice that reflects the format of the hearing.

b. Scheduling. A written notice specifying the exact date, time, format, and place for the hearing will be mailed at least 30 days prior to the scheduled hearing. The claimant, the claimant's authorized representative, and the employing agency will be provided with such written notice.

In instances where a claimant requests an appeal through H&R and the ECAB simultaneously, the Hearing Representative will advise all parties that although a hearing will be scheduled, if the Board does not release the case prior to the hearing date, said hearing will be cancelled and rescheduled once the Board releases the record.

c. Employing Agency Participation. When the hearing is scheduled, the employing agency will be advised that its representative may be present at the proceedings and/or receive a copy of the hearing transcript. The agency may, in the discretion of the Hearing Representative,

send more than one representative. 20 C.F.R. § 10.621(a). Agency representatives attend primarily as observers and may not participate in the hearing unless the claimant or the Hearing Representative specifically requests them to do so. A notice to the employing agency will accompany the agency's copy of the letter to the claimant scheduling the hearing.

d. Record of the Hearing. H&R will arrange to record the testimony provided at the hearing, and it will then be transcribed. The transcript of the hearing is the official record of the hearing. (20 C.F.R. § 10.616(d)). Audiovisual coverage of hearings is not permitted, and claimants may not use their own recording equipment.

e. Withdrawal of Hearing Requests. The claimant may withdraw the request for hearing at any time by written notice, or on the record at the hearing. If the request is withdrawn, no further requests for a hearing on the decision at issue will be considered.

f. Postponement of Hearing Requests. Once an oral hearing is scheduled and H&R has mailed appropriate written notice to the claimant and representative, H&R will, upon submission of proper written documentation of unavoidable serious scheduling conflicts (such as court-ordered appearances/trials, jury duty, or previously scheduled outpatient procedures), entertain requests from a claimant or his representative for rescheduling as long as the hearing can be rescheduled on the same monthly docket, generally no more than 7 days after the originally scheduled time. In these instances, rescheduled hearings will usually be held via teleconference, and the Hearing Representative will ensure that the file accurately reflects any action taken to reschedule the hearing. When a request to postpone a scheduled hearing cannot be accommodated on the docket, no further opportunity for an oral hearing will be provided. Instead, the hearing will take the form of a review of the written record and a decision issued accordingly. 20 C.F.R. §10.622(c).

Where the claimant or representative is hospitalized for a non-elective reason, or where the death of the claimant's or representative's parent, spouse, child, or other immediate family member prevents attendance at the hearing, the OWCP will, upon submission of proper documentation, grant a postponement beyond one monthly docket. 20 C.F.R. § 10.622(d)

All decisions regarding rescheduling of hearings as described under Section 10.622 of the CFR, subsections (b) through (d), are within H&R's sole discretion.

g. Abandonment of Hearing Requests. A claimant who fails to appear at a scheduled hearing may request in writing within 10 days after the date set for the hearing that another hearing be scheduled. Where good cause for failure to appear is shown, another hearing will be scheduled and conducted by teleconference. The second hearing will be scheduled as soon as possible but usually no later than 35 days from the date it is requested unless good cause is shown to reschedule at a later date.

The failure of the claimant to request another hearing within 10 days, or the failure of the claimant to appear at the second scheduled hearing without good cause shown, shall constitute abandonment of the request for a hearing.

Where good cause is shown for failure to appear at the second scheduled hearing, review of the matter will proceed as a review of the written record. Hearing Representatives will ensure that the record is properly documented to reflect all changes made concerning rescheduling and changes in format.

Where it has been determined that a claimant has abandoned his/her right to a hearing, H&R will issue a formal decision finding that the claimant has abandoned his or her request for a hearing. In cases involving pre-recoupment hearings, H&R will issue a final decision on the overpayment based on the available evidence before returning the case to the Office. 20 C.F.R. §10.622(f).

h. Subpoenas. A claimant may request a subpoena for documents and/or the attendance and testimony of a witness; however, the decision to grant or deny such a request is within the discretion of the hearing representative. See 20 C.F.R. §10.619.

(1) Subpoenas for documents are issued only if such evidence is relevant and cannot be obtained by other means (e.g. where the agency has factual evidence necessary for the adjudication of the claim that it has not disclosed). Subpoenas for the attendance and testimony of a witness are issued only where oral testimony is the best way to ascertain the facts.

(2) A subpoena request must be made in writing no later than 60 days (as evidenced by postmark, electronic marker, or other objective date marker) after the original hearing request.

(3) The subpoena request must designate the witness or documents to be produced, and clearly describe the address and location of the witness or documents to be subpoenaed. The request must also explain why the testimony or evidence is directly relevant to the issues at hand, and must demonstrate that a subpoena is the best and only method or opportunity to obtain such evidence. The Hearing Representative has the discretion to decide that such facts could be established by other evidence without the issuance of a subpoena.

(4) If H&R determines that issuance of a subpoena is reasonably necessary for the full presentation of the case, a subpoena will be issued in the name of the Hearing Representative which compels the attendance of witnesses.

(5) The OWCP shall pay fees requested by witnesses who have submitted evidence into the case record at the request of the Office. The claimant shall pay fees requested by witnesses who have submitted evidence into the case record at the request of the claimant. In order to reduce reimbursement costs to either party, H&R will, at its discretion, change the hearing format so that witnesses whose attendance is compelled by subpoena can participate by telephone.

(6) If H&R determines that issuance of a subpoena is not reasonably necessary to present the case fully, a formal denial of the request for subpoena, with an explanation for such

denial, will be included with the final decision (see paragraph 8d below). The decision must explain to the claimant the other available means which are reasonably likely to allow discovery of the information or why the information requested is not necessary for the adjudication of the claim.

7. Conduct of Hearings. This paragraph describes the steps involved in the hearing itself.

a. Nature of Proceedings. Hearings will be open to claimants, their representatives, witnesses, designated agency officials, and any other persons whose presence the Hearing Representative deems necessary. The proceedings are informal and are not limited by legal rules of evidence or procedures. The proceedings are limited to one hour; however, this limitation may be extended in the discretion of the Hearing Representative. The testimony will be taken under oath and recorded verbatim.

b. Preliminary Matters. Before opening the proceedings, the Hearing Representative will explain to all parties present that hearings are non-adversarial in nature and that the claimant will have the opportunity to present any written or verbal evidence desired. In the event that communication assistance (such as a qualified sign language interpreter) is utilized at the hearing, the hearing representative will confirm that the requested assistance is available and working effectively prior to starting the hearing. In addition, the hearing representative will permit the hearing to proceed more slowly, or take into account any other needs, in order for the individual with a disability to fully understand the proceedings.

c. Opening the Hearing. At the beginning of the proceedings, the Hearing Representative will:

- (1) Note the date and time;
- (2) Identify all persons present by name;
- (3) Administer an oath to all persons testifying;
- (4) Make an opening statement which outlines the issues in question and ask the claimant if they concur; and
- (5) Afford the claimant (or their representative) an opportunity to make an opening statement.

d. Presentation. The claimant may offer evidence in any manner desired. Written evidence offered should be acknowledged and made a part of the record. If the hearing is conducted via telephone or video, the claimant will be asked to discuss the evidence that they wish to make part of the record. The hearing representative will then inform the claimant that the evidence discussed should be forwarded to the Office for inclusion into the file. If the hearing is conducted in person, the claimant will be asked to discuss the evidence that they wish to make part of the record, and the Hearing Representative will mark such evidence and introduce it into the record. The Hearing Representative will ensure that the evidence handed to them at the hearing is scanned into the case file. During the presentation, the Hearing Representative

should note any additional questions or areas for exploration and make appropriate inquiries before terminating the hearing.

e. Conclusion. When all witnesses have spoken, and the Hearing Representative has obtained all necessary clarification, the Hearing Representative will close the proceedings by noting the time of completion. The record will remain open for the submission of additional evidence for 30 days after the hearing is held. At the sole discretion of the Hearing Representative, one brief extension may be granted after the initial 30 days.

f. Summary Decisions. If evidence is presented on or before the date of the hearing, and such evidence is sufficient to warrant a remand or reversal of the Office's decision, the Hearing Representative should cancel the hearing with all parties in attendance at that time, and issue a Summary Decision by taking the following actions:

(1) The Hearing Representative should first enter into the record an opening statement summarizing the facts of the case. The Hearing Representative will then go off the record and confer with all participants, including the employing agency representative (if in attendance), that the case is in posture for a remand or reversal at the hearing.

(2) The Hearing Representative will consult all participants in attendance prior to the issuance of a Summary Decision and obtain concurrence from the claimant and/or representative.

(3) The Hearing Representative will go back on the record, acknowledge that the claimant and/or representative is in agreement with the Summary Decision, announce that the hearing has been cancelled and provide the employing agency representative (if in attendance) the opportunity to comment on the record, prior to issuing the Summary Decision. If the employing agency representative is not in attendance at the hearing, the Hearing Representative will proceed with the issuance of the Summary Decision.

(4) The Hearing Representative will announce the decision into the record, describe the evidence that is found sufficient to warrant a remand or reversal of the Office's decision, and may cite at their discretion any appropriate decisions from the Employees' Compensation Appeals Board, regulations, and/or Procedures to support the decision.

(5) The Hearing Representative will explain that the Summary Decision will be transcribed by the court reporter and that transcript will constitute the formal hearing decision which is made final upon receipt of the transcript.

(6) Upon receipt of the transcript into the case file, the Hearing Representative will issue a Summary Decision Letter to all required participants that includes the date of the hearing, the outcome, and the specific page and line in the transcript for the Summary Decision. As the hearing was cancelled and all parties in attendance agreed with Summary Decision, no further opportunity to provide comments in response to the transcript or decision will be afforded to any party.

(7) Examples of issues that may be in posture for a Summary Decision include:

- a. Primary Adjudication Cases denied on Fact of Injury Medical or Causal Relationship and sufficient medical documentation is presented prior to hearing.
- b. Schedule Award denials for no evidence of impairment and an impairment rating is presented prior to hearing.
- c. Wage loss denials and sufficient medical documentation is presented prior to hearing.
- d. Termination decisions and sufficient medical documentation is presented prior to hearing.
- e. Expansion of Claims/Consequential Condition denials and sufficient medical documentation is presented prior to hearing.

(8) Under no circumstances may a summary decision be used to issue an affirmation.

8. Reaching a Determination. In this paragraph, the actions taken after the hearing are described.

- a. Comments. The claimant (or the authorized representative) and the employing agency will be provided with a copy of the transcript. The employing agency will be allowed 20 days from the release of the transcript to submit any comments and/or documents believed relevant to the issue in question. Any comments or documents submitted by the agency will be forwarded to the claimant or his/her representative with the opportunity to submit written comments within 20 days.
- b. Further Development. If additional development is needed, the case may be remanded to the Office. However, if the issue can be resolved readily, the Hearing Representative will undertake the additional development and incorporate the results into the decision.
- c. Schedule Awards. The OWCP adopted the Third Edition of the AMA Guides to the Evaluation of Permanent Impairment effective March 8, 1989; the revised Third Edition of the Guides effective September 1, 1991; the Fourth Edition effective November 1, 1993; the Fifth Edition effective February 1, 2001; and the Sixth Edition effective May 1, 2009. Any recalculations of previous awards which result from Hearings and Review decisions issued on or after May 1, 2009, should be based on the Sixth Edition of the Guides. However, if the percentage of the award is affirmed but the case is remanded for further development of some other issue, e.g. pay rate, recalculation of the percentage of the award under the Sixth Edition is not required.

Where a calculation under the Sixth Edition results in a lower impairment rating to a schedule member than the original award under the Fifth Edition, the Office (consistent with past practice) will make the finding that the claimant has no more than the percentage of

impairment originally awarded; that the evidence does not establish an increased impairment; and that an overpayment will not be declared.

Similarly, if a claimant requests an increased schedule award due to a belief that his or her medical condition has deteriorated since the original award was issued, and additional development is undertaken to address this claim for an increased award, a new schedule award decision should be issued that addresses and substantiates the newly determined impairment rating. If a lesser degree of impairment than previously awarded is substantiated, the Office also will make the finding that the claimant has no more than the percentage of impairment originally awarded; that the evidence does not establish an increased impairment; and that an overpayment will not be declared.

If, during the course of the appeals process, it is determined that the initial schedule award decision must be set aside, a new schedule award decision should be issued that fully addresses the reasons for the change in rating. Declaring an overpayment thereafter is appropriate if the de novo decision substantiates a lesser degree of impairment than previously awarded, so long as both ratings are based on the same edition of the AMA Guides. The resulting overpayment should have a finding of without fault.

d. Final Decision. When all evidence and testimony has been evaluated, the Hearing Representative will issue a decision which affirms, reverses, remands, or modifies the Office decision. If ECAB citations are used, they should be relevant to the specific issue and contain a string citation and should generally include a current cite not less than five years since issuance if possible. If the issuance of a subpoena was in question, the final decision should include formal findings on this matter. If the decision is adverse to the claimant, the claimant's appeal rights will be noted.

9. Claims Office Actions. Any case requiring further action based on a decision issued by H&R should be promptly assigned to a CE for the required action.

a. Timeliness of Action. Substantive action should be taken within prescribed timeframes following return of the case file.

b. Reinstatement of Benefits. If the hearing decision concludes that the Office did not meet its burden of proof before reducing or terminating benefits, the following actions will be taken:

(1) The Hearing Representative will instruct the claimant or representative of his/her right to file Form CA-7 (or, in the case of death benefits, Form CA-12) to claim compensation.

(2) Upon receipt of the completed form, the office should promptly reinstate benefits to the claimant at the previous level, including retroactive payment to the date of reduction or termination.

(3) If the completed form shows earnings, employment, or receipt of an annuity, the CE should obtain an election or additional information, including a Form CA-1032 as necessary.

(4) The Form CA-7 is intended to cover the entire period during which benefits were terminated or reduced. Only one Form CA-7 need be completed. In general, further payments should be made on the periodic roll.

c. Review of the Remand Decision. If the Office, upon careful review, believes the remand decision issued by the Branch of Hearings and Review contains a serious error of fact or law, the Office Director should contact the Deputy Director, Operations and FECA Claims Management, within 15 days of receipt of the decision outlining the basis for the disagreement. This review process, rarely employed, should be reserved for cases where there is a material factual error or a misinterpretation of the statute, regulations, or procedures that is critical to the decision. If, upon review of the decision, the Deputy Director determines that the decision issued was in error, the decision may be vacated through 5 U.S.C. 8128, which provides for review of a decision allowing or denying compensation "at any time." If, upon review of the decision, the Deputy Director determines that the decision issued was appropriate, no action will be taken. This process does not apply to Employing Agencies.

This process also does not apply to claimants or their authorized representatives, since appeal rights are issued with every affirmation decision issued by the Branch of Hearings and Review.

Chapter 2-1602, Reconsiderations

1. Purpose. This chapter outlines procedures for handling reconsideration requests. It describes the filing requirements, the tests for sufficiency of applications, and the actions required to process them. All such requests are handled within the office having jurisdiction of the case.

2. Policy. The following policy considerations pertain to all requests for reconsideration:

a. Requirements. A claimant may apply for reconsideration of a final decision regardless of the date of injury or death. While no special form is required, the request must be in writing, be signed and dated by the claimant or the authorized representative and be accompanied by relevant new evidence or argument not considered previously. The request should also identify the decision and the specific issue(s) for which reconsideration is being requested. The request must be received within one year of the date of the contested decision if that date was after June 1, 1987 (see paragraphs 4d and 4e below).

b. Assignment and Signature Level. Each request for reconsideration must be handled by a Quality Assurance and Mentoring Examiner (QAM) or higher authority who was not involved in making the contested decision (with one exception, described in paragraph 3c below). All

reconsideration decisions, whether affirmative or negative, must be issued by a QAM or higher authority.

c. Timeliness for Issuing Decisions. The goal for issuing reconsideration decisions is 90 days from receipt of the request. To meet this goal, a final decision must be issued. In a case requiring further development it is not sufficient to vacate the previous decision and return the case to the responsible Claims Examiner (CE) for further action.

3. Preliminary Processing.

a. Review of Request. The CE will receive a reconsideration request in the incoming mail. Upon receipt of a request, the CE should refer the request to the designated individual who assigns reconsiderations. That individual will assign the reconsideration request to a QAM who was not previously involved in the contested decision.

(1) The request does not have to be submitted on the appeal request form; letter format is acceptable.

(2) The word "reconsideration" does not need to be stated in the request for it to be considered valid, but sufficient detail should be provided to discern the decision being contested and to ensure that another form of appeal is not being requested.

(a) If the claimant does not state the date of the specific decision contested, the CE, QAM, or the designated individual should review the reconsideration request and determine whether a final decision has been released on the issue for which reconsideration is requested.

(b) If no final decision has been released on the issue or the contested decision cannot be reasonably determined from the claimant's request, the CE, QAM, or designated individual should return a copy of the application to the claimant for clarification and inform the claimant that OWCP will take no further action on the request unless clarification is submitted. (This action is not a denial of application and should not be reported as a reconsideration decision; if such a request had been entered into the tracking system it should be deleted.)

(c) An example of "reasonably determined" includes an instance where only one final decision was issued in the case file so it can be reasonably determined that the one denial decision is the one being contested.

b. If a claimant is seeking an increased schedule award due to increased impairment and/or additional exposure, but not contesting the decision or prior award, this should not be treated as a reconsideration request. The responsible CE should develop entitlement to an additional award.

c. Non-receipt of a completed CA-1032 or CA-12. When compensation has been suspended for failure to submit a CA-1032 or CA-12 form, the claimant or beneficiary may request a reconsideration accompanied by a completed Form CA-1032 or CA-12. In this case, the CE currently assigned to the case may act on the reconsideration request and restore benefits since submission of the form itself satisfies the requirement for reinstatement. No reconsideration

assignment to a QAM is necessary, but the CE should notify the claimant or beneficiary that benefits have been reinstated.

4. Time Limitations. OWCP's regulations at 20 CFR §10.607(a) establish a one-year time limit for requesting reconsideration. The one-year period begins on the next day after the date of the original contested decision. For merit decisions issued on or after August 29, 2011, an application for reconsideration must be received by OWCP within one year of the OWCP decision for which review is sought.

Reference *W.H.*, Docket No. 14-92, issued April 28, 2014. In its April 29, 2013 decision, OWCP determined that the appellant filed an untimely request for reconsideration of its April 4, 2012 decision. The appellant's reconsideration was received by OWCP on April 4, 2013, a period of 365 days after the April 4, 2012 decision. The Employees' Compensation Appeals Board (ECAB) held that the request was received precisely within one year and was therefore timely.

See also, *C.B.*, Docket No. 13-1732, issued January 28, 2014. The ECAB held that for OWCP decisions issued on or after August 29, 2011, the date of the application for reconsideration is the "received date" as recorded in the Integrated Federal Employee's Compensation System (IFECS). In this case, the received date of the application was January 24, 2013, one year after the January 24, 2012 OWCP decision. Since the application for reconsideration was within one year of OWCP's decision for which review is sought, it was found to be timely.

In addition, when determining the one-year period for requesting reconsideration, the last day of the period should be included unless it is a Saturday, a Sunday or a legal holiday. See *M.A.*, Docket No. 13-1783, issued January 2, 2014. In this case, OWCP's denial decision was issued on October 26, 2011. A merit decision was subsequently issued on February 10, 2012. The appellant then requested reconsideration on February 11, 2013. In a February 27, 2013 decision, OWCP denied his request for reconsideration finding that it was not timely filed. The ECAB held that in computing the time for requesting reconsideration, the last day of the period shall be included unless it is a Saturday, a Sunday or a legal holiday. The merit decision was dated February 10, 2012 and the appellant's request for reconsideration was received by OWCP on Monday, February 11, 2013. The ECAB held that because February 10, 2013 was a Sunday, the appellant had until Monday, February 11, 2013 to request reconsideration and therefore his request was timely received by OWCP.

a. A right to reconsideration within one year accompanies any subsequent merit decision. This includes any decision issued by the Branch of Hearings and Review (H&R) after a hearing or review of the written record, any denial of modification following a reconsideration, any merit decision by the ECAB, and any merit decision following a remand from H&R or the ECAB, but does not include pre-recoupment hearing decisions.

b. The QAM should review the file to determine whether the application for reconsideration was received within one year of a merit decision. Timeliness is determined by the document receipt date (the "received date" in iFECS). If the request for reconsideration has a document received date greater than one year, the request must be considered untimely.

c. The one-year time limit to file a reconsideration request does not include any time following the decision that the claimant can establish (through medical evidence) an inability to communicate and that his testimony would be necessary. (See 20 CFR. §10.607(c); *J.H.*, Docket No. 14-118 (issued April 28, 2014) (ECAB held that to the extent that appellant asserted that her depression prevented her from filing a timely reconsideration request, "the Board finds this argument to be without merit. Appellant did not provide medical evidence to support that her depression or other condition rendered her unable to communicate in any way such that she could not timely request reconsideration."); John Crawford, 52 ECAB 395 (2001).

d. Decisions Issued Before June 1, 1987. No time limit applies to requests for reconsideration of these decisions because there was no regulatory time limit for requesting reconsideration prior to June 1, 1987. Therefore, a request for reconsideration may not be denied as untimely unless the claimant was advised of the one-year filing requirement in a later decision denying an application for reconsideration or denying modification of the contested decision. In these cases, the one-year time limit begins on the next day after the date of the decision that includes notice of the time limitation.

e. Decisions Issued on or after June 1, 1987 through August 28, 2011. For decisions issued during this period, there is still a one-year time limit for requesting reconsideration. The one-year period begins on the next day after the date of the original decision, and the application for reconsideration must be mailed to OWCP within one year of the OWCP decision for which review is sought.

5. Untimely Applications. The regulations at 20 CFR §10.607(b) provide that OWCP will consider an untimely application for reconsideration only if the application demonstrates clear evidence of error on the part of OWCP in its most recent merit decision.

a. Clear Evidence of Error. The term "clear evidence of error" is intended to represent a difficult standard. The claimant must present evidence which on its face shows that OWCP made a mistake. For example, a claimant provides proof that a schedule award was miscalculated, such as a marriage certificate showing that the claimant had a dependent but the award was not paid at the augmented rate. Evidence such as a detailed, well-rationalized medical report which, if submitted before the denial was issued would have created a conflict in medical opinion requiring further development, is not clear evidence of error. (*Dean D. Beets*, 43 ECAB 1153 (1992); *Leona N. Travis*, 43 ECAB 227 (1991)). *Compare J.H.* Docket No. 15-280 (issued November 18, 2015 (Where review of the file demonstrated OWCP had received documentation prior to its 2012 termination of compensation that the employing agency could no longer accommodate the employee's work restrictions, ECAB found clear evidence of error in denying appellant's untimely request for reconsideration.)

b. If clear evidence of error has not been presented, the request should be denied according to 20 CFR §10.608(b). The QAM should deny the application by letter decision, which includes a brief evaluation of the evidence submitted and a finding that clear evidence of error has not been shown. The claimant's only right of appeal from this decision is to ECAB.

c. If clear evidence of error has been presented with an untimely application, the QAM should issue two separate formal decisions. The first decision will deny the application due to timeliness; this can be a letter decision. The second is a merit review on the Director's own motion. Section 8128 of the Federal Employees Compensation Act provides the authority for the Secretary of Labor to review an award for or against payment of compensation at any time on the Director's own motion. This review may be made without regard to whether there is new evidence or information. See 20 CFR. §10.610.

(1) If the Director, or a designated person acting on the Director's behalf, determines that a review of the award is warranted (including, but not limited to circumstances indicating a mistake of fact or law or changed conditions), the Director or designee, (at any time and on the basis of existing evidence) may modify, rescind, decrease, or increase compensation previously awarded, or award compensation previously denied. A review on the Director's own motion is not subject to a request or petition and none shall be entertained.

(2) The decision whether or not to review an award under this section is solely within the discretion of the Director. The Director's exercise of this discretion is not subject to review by the ECAB, nor can it be the subject of a reconsideration or hearing request.

(3) Where the Director reviews an award on his or her own motion, any resulting decision is subject as appropriate to reconsideration, a hearing and/or appeal to the ECAB. Jurisdiction on review or on appeal to ECAB is limited to a review of the merits of the resulting decision. The Director's determination to review or not to review an award is not reviewable, i.e., is not subject to appeal.

6. Timely Applications. In accordance with the regulations set forth in 20 CFR 10.606, a timely application for reconsideration must be accompanied by specific evidence or argument.

a. Evidence or Argument Required. All requests for timely reconsideration should be accompanied by one of the following:

(1) Argument that the OWCP erroneously applied or interpreted a point of law. 20 CFR 606(b)(3)(i). For example, the CE failing to use the Shadrack formula when calculating a loss of wage earning capacity (LWEC), or failing to include all appropriate elements of pay when determining a pay rate for compensation purposes.

(2) Relevant legal argument not previously considered by OWCP. 20 CFR 606(b)(3)(ii). A statement from the claimant that he or she simply does not agree with basis of the decision does not constitute relevant legal argument. The statements or documentation submitted by the claimant would need to be accompanied by a legal premise material to the denied issue in order to have a reasonable color of validity for reopening of the case for further review on the merits.

For example, in a case that was denied on the basis of a medical opinion of a referee specialist, the introduction of evidence to support a prior connection between the referee physician and the employing agency would be sufficient to require the Office to reopen the case for a review of the merits. While a reopening of a case may be predicated solely on a legal premise not previously

considered, such reopening for further review on the merits is not required where the legal contention does not have a reasonable color of validity. See *Cleopatra McDougal-Saddler*, 50 ECAB 367 (1999), which indicates that an application should contain at least the assertion of an adequate legal premise, or the proffer of proof, or the attachment of a report or other form of written evidence, material to the kind of decision which the applicant expects to receive as the result of his application for reconsideration. See also *Thomas D. Joy*, Docket No. 98-1086 (issued March 16, 2000) (ECAB found appellant's arguments concerning procedural flaws in the hearing (including bias) lacked sufficient color of validity and did not warrant a reopening of his case for a review of the merits of his claim.)

(3) New evidence (not previously considered by OWCP) which is relevant to the issue upon denial. 20 CFR 606(b)(3)(iii). For example, the submission of a witness statement would be considered relevant if the claim had been denied because fact of injury had not been established. Such a statement would not be relevant if the claim had been denied because the claimant had not submitted medical evidence addressing causal relationship. See *Matthew Diekemper*, 31 ECAB 224 (1979) (new evidence which is submitted but is irrelevant to the pertinent issue is not sufficient to reopen the case on the merits). If the new medical reports are repetitious and cumulative of evidence previously submitted, they have no evidentiary value and do not constitute a basis for reopening the claimant's case. (*Bruce E. Martin*, 35 ECAB 1090, 1093-94; *Eugene F. Butler*, 36 ECAB 393 (1984). Evidence that is essentially duplicative (such as a duplicative narrative) does not form a basis for reopening a claim.) (See *James W. Scott*, 55 ECAB 606 (2004).)

b. Evaluating Sufficiency of Evidence. When the request for reconsideration is accompanied by new evidence, the QAM must determine whether it is sufficient to review the case on its merits. This step requires careful review of the file to assess what material it already contains. Such examination should not be confused with a merit review of the case.

(1) Nature of Evidence. The following kinds of evidence are not sufficient to reopen the claim for merit review:

(a) Cumulative evidence, which is substantially similar to material on file and has already been considered. For example, chart notes from the attending physician with new dates but similar content to those already of record and considered previously. See *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000) (Physician reports were similar to previously submitted reports).

(b) Repetitious evidence, which consists of copies of previously submitted evidence which was already considered in the contested decision. For example, a duplicate medical report that was already considered. See *David J. McDonald*, 50 ECAB 185, 190 (1998) (Documents previously considered by the Office).

(c) Irrelevant or immaterial evidence which has no bearing on the issue or which is frivolous or inconsequential in regard to the issue. For example, a knee injury was claimed but the medical submitted pertains to a back condition or a case was denied on Fact of Injury (FOI)-factual but medical evidence is submitted. See *Linda I. Sprague*, 49 ECAB 386 (1997).

(2) The QAM should use caution in characterizing medical evidence as "cumulative" or "irrelevant." A rationalized supporting statement from a physician not previously of record requires a merit review when the denial rested on medical issues. However, a checked "yes" on a form report would not require a merit review just because it was from a new physician.

c. Based on review of the evidence submitted in conjunction with the case file, the QAM must then decide whether a merit review should be performed, or whether the application for such a review should be denied.

Where the application is accompanied by new and relevant evidence or by an arguable case for error, the QAM should conduct a merit review of the case to determine whether the prior decision should be modified. See paragraph 8. If the only evidence submitted is cumulative, repetitious or irrelevant, or no evidence is submitted, a non-merit decision should be issued. See paragraph 7.

7. Non Merit Decisions. A timely application for review that is not supported by additional evidence or argument for error in fact or law is insufficient to warrant a merit review of the case.

For example, if a claimant submits a letter or appeal request form identifying the contested decision but provides no accompanying statement or additional evidence, or provides only cumulative, repetitious or irrelevant evidence, a non-merit review decision should be issued. See 20 CFR 10.608(b).

a. Protecting Claimant's Further Appeal Rights. The ECAB will accept appeals filed up to 180 days from the date of the last merit decision. If a reconsideration decision is delayed beyond 90 days, the claimant's right to review of the original decision by the ECAB is abrogated.

When a reconsideration decision is delayed beyond 90 days, and the delay jeopardizes the claimant's right to review of the merits of the case by the Board, OWCP should conduct a merit review. That is, the basis of the original decision and any new evidence should be considered and, if there is no basis to change the original decision, an order denying modification (rather than denying the application for review) should be prepared. There is no obligation to conduct a merit review on insufficient evidence if the maximum 180 day time limit for requesting review by the Board will have expired within the 90 day period following the OWCP's receipt of the claimant's reconsideration request. See C.L., Docket No. 10-1483 (May 12, 2011).

b. Decision. If the evidence submitted is not sufficient to require a merit review, the QAM should issue a decision which discusses the evidence submitted, or lack thereof, and explicitly state the basis for the finding of insufficiency. The decision should explain that the application for reconsideration is denied on the basis that the evidence submitted in support of the application is not sufficient to warrant review.

(1) The QAM should be careful not to include any language suggesting that a review on the merits of the claim was undertaken. Statements about whether an identical or similar document

or opinion was found in the file are appropriate. Evaluative statements regarding new or old evidence, such as "the evidence lacks substantial probative value," are not appropriate.

(2) If no evidence is submitted with the application for reconsideration, a letter decision is adequate.

(3) If evidence is submitted, a Notice of Decision in addition to the cover letter should usually be provided in order to adequately discuss the deficiencies in the evidence.

(4) The claimant's only appeal from this decision is to request review by the ECAB.

8. Merit Reviews. Where the application is accompanied by new and relevant evidence or by an arguable case for error, the QAM should conduct a merit review of the case to determine whether the prior decision should be modified.

a. Notice to Employing Agency. As soon as the QAM decides that an application is sufficient to warrant a merit review of the case, the employing agency should be notified; however, the requirement to provide a copy of the application and the evidence received differs depending on whether the issue for determination is medical in nature. See 20 CFR 10.609(a).

(1) Where there is a legal argument or factual basis for the merit review, the application together with copies of pertinent supporting documentation should be sent to the employing agency. The cover letter should explain that the employing agency may submit comments and/or documents but that any evidence must be received within 20 days. The employing agency should also be advised that any comment or evidence received is subject to review by the claimant.

Medical evidence submitted with the request shall not be furnished to the employing agency, since it does not constitute documentation that is "pertinent" for review and comment by the employing agency.

(2) Where a reconsideration request pertains only to a medical issue (such as disability or a schedule award), the employing agency should be notified that a request for reconsideration has been received, but no comments should be solicited from the employing agency if medical evidence is the sole basis for the review.

(a) OWCP is not required to wait 20 days for comment before reaching a determination, except when the claimant is deployed in an area of armed conflict.

(b) The QAM may provide notification of such a reconsideration request via the telephone. In this instance, the QAM should document the file with a CA-110 noting the agency representative who was provided with the notification.

(3) Any evidence submitted by the employing agency should be forwarded to the claimant with a letter allowing 20 days for comment before a final decision is issued on the reconsideration request.

(4) The QAM must ensure that the final decision addresses any additional evidence submitted and its disposition.

b. Development. The QAM should investigate the evidence independently of any previous determination, as follows:

(1) If the evidence submitted is sufficient to reopen the claim but not sufficient to reach a new decision, the QAM should develop the issue and maintain jurisdiction over it until a final decision is reached. A QAM has no authority to remand or return a case to a CE for further development actions.

(a) If an initial stress claim is received on reconsideration, the QAM should handle all appropriate adjudicatory actions pertaining to that particular claim. For example, if new evidence is submitted supporting a factor(s) of employment as work-related and causal relationship is now at issue, the QAM should prepare a Statement of Accepted Facts (SOAF) and refer the claimant for a second opinion examination.

(b) If a schedule award claim is received on reconsideration, the QAM should handle the case until a determination is made regarding the percentage of impairment. For example, if the claimant is disputing the percentage of award and submits new evidence, the case should be referred back to the DMA if appropriate, or for further examination if needed.

Note - OWCP adopted the Sixth Edition of the American Medical Association Guides to the Evaluation of Permanent Impairment effective May 1, 2009. Any recalculations of previous awards based on a prior edition of the Guides, which result from a reconsideration decision issued on or after May 1, 2009, should be based on the Sixth Edition of the Guides. See PM 2-808 for further discussion of appropriate actions after recalculation of a previous award.

(2) Any party from whom additional evidence is required should be asked to submit it within 20 days, so that the reconsideration request may be adjudicated within the 90-day time frame. If information requested from a claimant is not submitted in a timely manner, modification may be denied on the basis that the evidence is insufficient.

c. Decisions. After any necessary development, the QAM should issue one of the following formal decisions:

(1) Deny modification of the prior decision. If the evidence submitted is insufficient to alter the prior decision, the QAM should deny modification of the prior decision. To deny modification of the prior decision, the QAM should prepare a formal decision discussing the evidence received and include a detailed explanation why the evidence is not sufficient to modify the prior decision rendered. Such a denial does not carry the right to a hearing/review but does carry the right to request reconsideration again, or review by the ECAB.

(2) Vacate the prior decision. If a previous decision is to be vacated and a condition, period of disability, etc. is to be newly accepted, the QAM should prepare a decision to vacate and a cover letter which describes the acceptance in specific terms. The decision should explicitly point to

the evidence used to vacate the denial and provide a brief discussion as to how it is sufficient to overturn the prior decision. If this decision represents the initial acceptance for the claim, an acceptance letter with the attachment "Now That Your Claim Has Been Accepted" should be sent with the decision.

(3) Modification of the prior decision. Such a decision does not carry the right to a hearing/review but does carry the right to again request reconsideration or review by the ECAB.

(a) To modify an initial denial from one of the five basic elements to another, the QAM should prepare a decision explaining why the evidence is now sufficient to meet the prior element denied, but still insufficient to meet the next element(s). For example, if a case was previously denied on FOI-Factual for the reason that the claimant had not sufficiently explained how the injury occurred, and the claimant submitted a detailed factual statement with his/her reconsideration request that now meets FOI-Factual, but the case file remains devoid of a valid diagnosis, then the decision needs to explain that OWCP is modifying the prior decision to now meet FOI-Factual but the case remains denied on FOI-Medical.

(b) If a prior decision is to be affirmed in part and modified/vacated in part, the QAM will need to prepare a decision which incorporates both the previous and new findings. The cover letter to the claimant should describe in detail the elements of the new decision, explicitly stating which findings and/or conclusions are affirmed and which findings and/or conclusions are being modified. For example, all benefits, both compensation and medical, were terminated and upon reconsideration, the claimant submitted supportive medical evidence that indicates further medical treatment is still required. The termination of compensation benefits is affirmed but the decision to terminate all medical benefits is vacated. The reconsideration decision should explicitly explain that the evidence still supports that the work-related disability has resolved and therefore compensation benefits remain terminated. However, the new evidence submitted upon reconsideration now supports the work-related condition has not resolved and the claimant remains entitled to medical benefits.

Chapter 2-1603, Appeals

1. Purpose and Scope. This chapter describes the procedures for handling cases which have been requested by the Employees' Compensation Appeals Board (ECAB) for review of a final decision of the OWCP.

2. Function of the ECAB.

a. Origins. The ECAB was created as an entity separate from OWCP to give Federal employees the same administrative due process of law and right of appellate review which most non-Federal workers have under the various state workers' compensation laws. The Board consists of three members, one of whom is designated as Chairman of the Board and administrative officer.

- b. Jurisdiction. The ECAB may consider and decide appeals from the final decisions of the OWCP in any case arising under the FECA. The Board may review all relevant questions of law, fact, and exercise of discretion in such cases, except decisions concerning the amounts payable for medical services and decisions concerning exclusion and reinstatement of medical providers.
- c. Evidence. Only the evidence in the case record as it stood at the time of OWCP's final decision will be reviewed, and the ECAB will not consider new evidence. The Board may hear oral argument upon request, though any such argument must be based on the evidence of record.
- d. Timeliness of Filing. The claimant must file application for review by the Board within 180 days from the date of OWCP's decision.

3. Requests for Appeal and Information about Board Procedures. Requests for appeal must either be in writing and sent directly to the Board in accordance with the instructions that accompany formal OWCP decisions or may be filed electronically through ECAB's Electronic Filing System.

Occasionally, a written request for appeal to ECAB will be addressed to OWCP. When the office receives such a request, the Claims Examiner will release a letter informing the requestor that their request is being returned to them, and that all correspondence relating to an appeal should be sent directly to the Board.

If a final decision has not been issued, the requestor should be advised that the Board will review only final decisions and informed of the requirements for obtaining such a determination.

Persons requesting information about Board procedures should be informed that the Board is a separate entity from the OWCP and operates under its own explicit rules of procedure, and that any inquiries about those procedures must be directed to the Board. The ECAB is responsible for providing replies to all inquiries concerning the rules and procedures under which it operates.

Once an appeal is docketed, the office no longer has jurisdiction over the issue appealed. This is so even though the claims office maintains electronic access to the case record. However, in accordance with Douglas E. Billings, 41 ECAB 880, the office shall issue decisions on matters which do not relate to or affect the issue on appeal.

4. Processing of Cases on Appeal.

- a. Preliminary Review. Appeals are reviewed by an attorney from the Office of the Solicitor (SOL). Following SOL review, the case may be either submitted to the Board "on the record" without a pleading or with a pleading prepared by SOL on behalf of the Director. The pleadings take various forms such as a Memorandum in Justification, a Motion to Remand, or a Motion to Dismiss. SOL files pleadings and may represent the Director in oral argument before the Board, however no pleading is required and the failure to submit any such pleading does not prejudice the rights of either the claimant or the Director.

Once received, and after conducting a preliminary review, the ECAB notifies OWCP via nightly transmission that the case has been docketed. The transmission populates the docket number, docket date, ECAB and Claimant Request date in the Case Appeals – ECAB Application in iFECS. The claimant, and his or her representative, receive written notification from the Board that their case has been docketed, and a copy is bronzed into the case record.

b. Case Maintenance. Claims examiners reply to correspondence and telephone inquiries received in cases before the Board, and authorize medical care, bill payments, daily roll compensation payments and any other issues not before the Board.

c. Return of Case Record following ECAB's decision. After the Board issues its decision, no action should be taken until the decision is final, usually 30 days after decision.

5. Cases Returned to the Office. Any case requiring further action should be immediately assigned to a CE to take the action.

a. Timeliness of Action. Substantive action should be taken within prescribed timeframes following receipt of the case record.

b. Reinstatement of Benefits. If the Board has held that the Office did not meet its burden of proof before reducing or terminating benefits, the following actions will be taken as appropriate:

(1) National Office staff will release a letter to the claimant or representative enclosing a Form CA-1032 (or Form CA-12 in the case of death benefits) with instructions to complete the form and submit it to the office.

(2) On receipt of the completed form, the office should promptly reinstate benefits to the claimant at the previous level following any development necessitated by the responses to the form, including retroactive payment to the date of reduction or termination.

(3) If the completed form shows earnings, employment, or receipt of an annuity, the CE should obtain an election of benefits and other necessary information.

(4) The Form CA-1032 is intended to cover the entire period during which benefits were terminated or reduced. Only one Form CA-1032 need be completed. In general, further payments should be made on the periodic roll.

6. Representative's Fee. The Board must approve all fees for work done before it. The Board does not need the OWCP case file for fee approval. The Board's docket file contains the necessary information.

Chapter 2-1700, Special Act Cases

1. Purpose and Scope. From time to time laws are passed which extend benefits of the FECA to certain workers who are not regular employees of the U.S. government as defined in 5 U.S.C. 8101. Some of these workers are now considered civil employees, but benefits are limited by the legislation which provided coverage. This chapter addresses procedures for the development, adjudication, and management of claims filed under such laws.

2. Policy. Claims discussed in this chapter are adjudicated according to the procedures established for Federal employees, except for the modifications and special instructions described below.

3. Responsibilities. Most special jurisdiction cases adjudicated and managed in the Special Claims Unit. Some of the cases are forwarded to the appropriate office that has general jurisdiction after adjudication, and some are adjudicated and managed in the general jurisdiction offices. See FECA PM 1-0200 for case jurisdiction. Guidelines for developing claims are found in FECA PM Chapters 2-800 to 2-805.

4. Volunteers in Service to America (VISTA).

a. Statutory Authority. The Economic Opportunity Act of 1964 (EOA); 5 U.S.C. 8143 provides FECA coverage to all volunteers in the VISTA program. Cases of injuries to staff employees of VISTA are handled in the same manner as regular Federal employees.

b. Conditions of Coverage. VISTA personnel perform services within the United States similar to those which Peace Corps volunteers perform in foreign countries. Claims filed by VISTA volunteers will be adjudicated using the same procedures as for regular Federal employee.

c. The pay rate for injuries occurring after October 1, 1993, is set by statute at the beginning rate for a GS-5 employee. (Prior to that date, it was set at the beginning rate for a GS-7 employee.)

5. Job Corps.

a. Statutory Authority. The Economic Opportunity Act of 1964 (EOA) and 5 U.S.C. 8143 provide coverage for enrollees in the Job Corps. They are deemed to be civil employees of the United States within the meaning of the term as defined in 5 U.S.C. 8101. See 29 U.S.C. 3207 (a).

b. FECA Coverage.

(1) Job Corps enrollees are trained through Civilian Conservation Centers (CCC or Conservation Centers) and through Job Corps Centers. Consistent with the terms of a 2008 Cooperative Agreement between the Department of Labor and the Department of Agriculture (USDA),

USDA is responsible for the operational management of Job Corps CCCs funded by DOL. Injuries to USDA employees assigned to the operation of the Conservation Centers are to be reported and handled in the same manner as for other Federal employees.

(2) Operation of the Job Corps Centers has been awarded to private contractors. The employees of these contractors are not "employees" within the meaning of 5 U.S.C. 8101. They have no entitlement under the FECA.

(3) The employees of the operators of Job Corps Centers in paragraph (2) are not Federal officials, and they may not act as official superiors or reporting officials. With the Director's concurrence, the Job Corps has authorized the Centers' directors and their administrative officers to act in the capacity of the official superiors to sign Forms CA-1 and CA-2 and other reports relating to the injuries of enrollees. This authority may not be delegated to their subordinates. OWCP personnel should be particularly alert to this problem, being sure not to accept reports signed by persons subordinate to the Center directors and their administrative officers. Deviation from this rule is not permitted.

c. Conditions of Coverage.

(1) While at a Job Corps Center, an enrollee is under the continuous supervision and control of Job Corps officials. The Job Corps provides subsistence, quarters, clothing, medical care, training, work and recreation. For this reason an enrollee has the protection of the FECA for most incidents which occur while at the Center. Job Corps enrollees must, however, meet the same tests of compensability that apply to all other Federal employees.

(2) While away from the Center, an enrollee has the protection of the FECA if participating in an activity authorized by or under the direction and supervision of a Center official. This would include a group activity under the immediate direction of a supervisor as well as an authorized activity while the enrollee is on pass from the Center.

The record in such a case should include (1) a statement from a Center official showing whether at the time of the injury the enrollee was engaged in an authorized activity, and (2) a copy of the pass. Where a written pass was not issued, the Center official should be asked for a statement showing the inclusive dates and hours covered by the pass and the instructions or limitations relating to the activity permitted the enrollee.

(3) While on authorized pass or during travel between home and the Center, an enrollee has the protection of the FECA. In these cases, the record should include a statement from a Center official showing whether the travel or activity while on pass was authorized by or under the direction and supervision of the Job Corps.

(4) While absent from an assigned post of duty or participating in an unauthorized activity, an enrollee does not have the coverage of the Act.

(5) While at home, an enrollee (whether on "pass" or on "leave") does not have the protection of the FECA. However, an enrollee who is visiting the residence of another enrollee, with the

permission of the Job Corps, would be considered to be engaged in an authorized activity, and would therefore be covered during the entire absence from the Center.

(6) Some enrollees live off the premises of their Center and commute between their home and the Center for training. The usual rules governing coverage during travel to and from work apply in "off-premises" injury situations.

(7) Injuries resulting from "horseplay" and "fighting" are frequent among the enrollees. It is the OWCP's position that most of these injuries come within the scope of the FECA. The confining nature of the employment and the long absences from home are factors which contribute to this problem. The result is that "horseplay" and "fighting" are an expected element of the employment environment. Where so indicated, the offices should fully develop the facts in any case where it appears the exclusions of 5 U.S.C. 8102 (a) might require consideration.

e. Medical Care after Termination.

(1) Prior to the termination of enrollment, an enrollee may not be provided medical care at OWCP expense and the Job Corps may not properly issue an authorization for examination or treatment on behalf of OWCP. Any medical bills received for treatment provided prior to termination should be sent to the Job Corps for consideration. Further, if an enrollee who has been terminated should be reinstated in the Job Corps, that agency would reassume responsibility for medical coverage of any work-related injury.

(2) The Job Corps Center may issue a Form CA-16 or equivalent letter of authorization at the time of termination, if the enrollee is under medical care for a Job Corps-related injury and if continuing treatment for that injury is necessary. The Job Corps Center may issue authorization at the time of termination even though an enrollee is not under medical care, if immediate treatment is necessary for a Job Corps-related injury. In all other situations involving separated Job Corps enrollees, the office will issue authorization for medical care. The office will also assume responsibility for issuing authorization if the case has been previously received and considered by OWCP.

(3) If medical care is required after termination of enrollment, the ex-enrollee should be instructed to select a physician to render medical services. The enrollee then must furnish the Office with the provider's name and address. If the provider is qualified, the District Medical Adviser may issue an appropriate authorization to the physician.

(4) At the time of termination an enrollee may be receiving continuing medical care from a private physician which was provided at Job Corps expense. In this situation, the OWCP may pay reasonable charges for continuation of the medical care beginning on the day following termination where a claim has been approved. Payment may be made only for treatment for the approved condition. In these cases, the absence of a valid authorization will not defeat a medical expense claim which is otherwise in order.

f. Report of Injuries.

- (1) Enrollees are required to report injuries in the usual manner as stated in the regulations.
- (2) The Job Corps should submit Forms CA-1 and CA-2 only after the enrollee has been terminated, and only when:
 - (a) The condition causes disability for work for more than 14 days; or
 - (b) It is likely to result in a medical charge against the Compensation Fund after the enrollee's termination from the Job Corps; or
 - (c) It appears likely to require prolonged treatment; or
 - (d) It appears likely to result in future disability or permanent disability. The date of termination should appear in Block 24 of the CA-1, and in Block 34 of the CA-2.

g. Disability Claims.

- (1) Compensation is not payable prior to termination of enrollment, in keeping with Section 106(c)(2)(C) of P.L. 88-452.
- (2) The date of the enrollee's termination will be the date pay stops.
- (3) 5 U.S.C. 8118 does not apply to enrollees because they do not earn annual or sick leave.
- (4) Compensation for disability will be computed on a weekly basis. Because enrollees do not usually have a standard work week, 5 U.S.C. 8114 will not be applied. Job Corps enrollees are entitled to all applicable Consumer Price Index increases in compensation under 5 U.S.C. 8146a.
- (5) The three-day waiting period provided by 5 U.S.C. 8117 applies to these cases in the same manner as it applies to Federal employees.
- (6) Job Corps enrollees are not entitled to continuation of pay (COP) under 5 U.S.C. 8118.

h. Death Claims.

- (1) An enrollee receives an allowance for dependents and may also make an allotment from Job Corps pay. A copy of the allotment should be obtained from Center officials in any death case where dependency must be established to support a claim for death benefits.
- (2) In keeping with 5 U.S.C. 8134, if the death is employment-related, OWCP may pay up to \$800 for funeral and burial expenses plus the cost of embalming and transporting the body in a hermetically sealed casket to the enrollee's home, as well as the \$200 provided in 5 U.S.C. 8133(f).

i. Pay Rates.

- (1) 5 U.S.C. 8101 and 5 U.S.C. 8114 do not apply to Job Corps enrollees.
- (2) Where the injury occurred prior to November 8, 1966, compensation is computed on a monthly pay of \$150 in (a) all death cases and (b) any disability case where the enrollee had not reached the age of 21. After the enrollee reaches age 21, disability compensation must be computed on an annual pay rate of the entrance salary for GS-2.
- (3) Where the injury occurred after November 8, 1966, compensation is computed on an annual pay rate of the entrance salary for GS-2. (This figure will change any time the pay rates under the Classification Act of 1949 are amended.)
- (4) The minimum provisions of 5 U.S.C. 8112 and 5 U.S.C. 8133(e) do not apply to Job Corps enrollees.
- (5) 5 U.S.C. 8113 applies to these cases. Where so indicated, the pay rate may be redetermined in the same manner as any other Federal employee.

6. D. C. Metropolitan Police Reserve Corps. D. C. Metropolitan Police Reservists are entitled to FECA coverage if injured while serving in any sudden emergency (riot, pestilence, invasion, and insurrection) involving loss of life or property, or while serving on days of public election, ceremonies, or celebration. Each case will be considered on individual merit, and coverage will be extended only after careful study of all pertinent evidence.

- a. Pay rate for compensation purposes for injuries occurring during sudden emergencies would be that comparable to a regular police officer of any rank whose duties most nearly resemble those of the injured volunteer. In non-emergencies, pay is frozen at the level of a regular police private.
- b. Jurisdiction. Cases in this group will be developed and adjudicated in the Special Claims Unit.

7. National Fisheries Observers.

- a. Statutory Authority. Public Law 104-297, enacted on October 11, 1996, provides that observers on vessels that are under contract to carry out responsibilities under the Magnuson-Stevens Fishery Conservation and Management Act or the Marine Mammal Protection Act of 1972 shall be deemed to be civil employees of the United States for the purposes of coverage under 5 U.S.C. 8101.
- b. Conditions of Coverage. Contract observers are employed in private industry to carry out the requirements of the above Acts, which are under the jurisdiction of the Department of Commerce. Any person claiming coverage has the burden of establishing that he or she is an observer within the meaning of section 403 of the Magnuson-Stevens Act, that the injury was sustained while in performance of duty on a vessel, and that the claimed disability or impairment is due to the on-the-job injury. Therefore, once the determination that the claimant is a civil employee is made, the guidelines described in chapters 2-800 through 2-805 should be employed

in the adjudication of these claims. In particular, fisheries observers are extended coverage under the FECA only while on board the vessel, not while traveling to and from the vessel, or when performing off-vessel work while assigned to the cruise.

c. Jurisdiction. As these cases are anticipated to present unusual issues, they will be handled in one location. All claims for contract observers and their survivors will be forwarded to the Special Claims Unit. They will be assigned case file numbers with an OB- prefix, and will be adjudicated and maintained in the Special Claims Unit.

d. Other Considerations. Payment of compensation should be determined in accordance with Section 8114(d) of the FECA and PM Chapter 2-900. Increases in the pay rate due to the claimant being at sea when the injury occurred should be handled as described in 2-900-8b., Applying Increments of Pay. The increase in pay rate for sea duty should be treated in exactly the same way as premium pay, night differential pay, Sunday pay or FLSA extra pay is treated. According to section 8.b. of the chapter, the CE must obtain the dollar amount of additional pay received during the year previous to the work injury, and add it to the reported base pay to obtain the annual salary. (See Chapter 2-900-8. b.)

Due to the potential for third party liability of the vessel owner, Form CA-1045 should be released by the CE and the appropriate subrogation procedures followed. As possible entitlement to state workers' Compensation would not constitute a prohibited dual benefit, OWCP would not require an election of benefits by the claimant. This does not preclude the states from offsetting FECA benefits against any entitlement the claimant might have under the Jones Act.

Exhibit 1: Annual Pay Rates

ANNUAL PAY RATES FOR COMPUTING COMPENSATION OF PEACE CORPS AND VISTA VOLUNTEERS

Date of Injury	PC Volunteer	VISTA Volunteer	PC Volunteer Leaders/Heads of Households
09/22/61-10/13/62	\$ 5,355	5,355	7,560
10/14/62-01/04/64	5,540	5,540	8,045
01/05/64-07/04/64	5,795	5,795	8,410
07/05/64-10/09/65	6,050	6,050	8,650
10/10/65-07/02/66	6,269	6,269	8,921
07/03/66-10/07/67	6,451	6,451	9,221
10/08/67-07/13/68	6,734	6,734	9,657
07/14/68-07/12/69	6,981	6,981	10,203
07/13/69-12/27/69	7,639	7,639	11,233
12/28/69-01/09/71	8,098	8,098	11,905
01/10/71-01/08/72	8,582	8,582	12,615
01/09/72-01/06/73	9,053	9,053	13,309
01/07/73-10/13/73	9,520	9,520	13,996

10/14/73-10/12/74	9,969	9,969	14,671
10/13/74-10/11/75	10,520	10,520	15,481
10/12/75-10/09/76	11,046	11,046	16,255
10/10/76-10/08/77	11,523	11,523	17,056
10/09/77-10/07/78	12,336	12,336	18,258
10/08/78-10/06/79	13,014	13,014	19,263
10/07/79-10/04/80	13,925	13,925	20,611
10/05/80-10/03/81	15,193	15,193	22,486
10/04/81-10/02/82	15,922	15,922	23,566
10/03/82-01/07/84	16,559	16,559	24,508
01/08/84-01/05/85	17,138	17,138	25,366
01/06/85-01/03/87	17,824	17,824	26,381
01/04/87-01/02/88	18,358	18,358	27,172
01/03/88-12/31/88	18,726	18,726	27,716
01/01/89-01/13/90	19,493	19,493	28,852
01/14/90-01/12/91	20,195	20,195	29,891
01/13/91-01/11/92	21,023	21,023	31,116
01/12/92-01/09/93	21,906	21,906	32,423
01/10/93-09/30/93	21,906	21,906	33,623
10/01/93-01/07/95	22,717	18,340	33,623
01/08/95-01/06/96	23,171	18,707	34,295
01/07/96-01/04/97	23,634	19,081	34,981
01/05/97-01/03/98	24,178	19,520	35,786
01/04/98-01/02/99	24,734	19,969	36,609
01/03/99-01/01/00	25,501	20,588	37,744
01/02/00-01/13/01	26,470	21,370	39,178
01/14/01-01/12/02	27,185	21,947	40,236
01/13/02-01/11/03	28,164	22,737	41,684
01/12/03-01/10/04	29,037	23,442	42,976
01/11/04-01/08/05	29,821	24,075	44,136
01/09/05-01/07/06	30,567	24,677	45,239
01/08/06-	31,209	25,195	46,189

Chapter 2-1701, Peace Corps Cases

1. Introduction. The Peace Corps was established on September 22, 1961 by Public Law 87-293, known as the "Peace Corps Act." It authorizes the enrollment of qualified citizens and nationals of the United States as "volunteers" and "volunteer leaders" for service abroad in interested countries and areas, to help the people of such countries and areas in meeting their needs for trained workers, and to help promote a better understanding of the American people on the part of the peoples served and a better understanding of other peoples on the part of the American people.

The Sam Farr and Nick Castle Peace Corps Reform Act of 2018 (Farr-Castle) modified various aspects of the Peace Corps Act, including changes to the provision of health care to volunteers. Under an amendment to section 8142, the Farr-Castle Act directs the Secretary of the Department of Labor to authorize the Director of the Peace Corps to furnish medical benefits to a volunteer, who is injured during the volunteer's period of service, for a period of 120 days following the termination of such service if the Director certifies that the volunteer's injury probably meets the requirements set forth in 5 U.S.C. 8142(c)(3). See paragraphs 2 and 10, below.

The purpose of this chapter is to outline the unique aspects of coverage under the Federal Employees' Compensation Act (FECA) that pertain specifically to volunteers (and volunteer leaders) of the Peace Corps.

Claims for Peace Corps employees who work for the Peace Corps, other than as volunteers or volunteer leaders, are handled in the same manner as other claims. There are no special rules for handling claims from such employees.

2. Statutory Provisions of the FECA. 5 U.S.C. §8142 of the FECA provides that,

(a) For the purpose of this section, "volunteer" means--

- (1) a volunteer enrolled in the Peace Corps under section 2504 of title 22;
- (2) a volunteer leader enrolled in the Peace Corps under section 2505 of title 22; and
- (3) an applicant for enrollment as a volunteer or volunteer leader during a period of training under section 2507(a) of title 22 before enrollment.

(b) Subject to the provisions of this section, this subchapter applies to a volunteer, except that entitlement to disability compensation payments does not commence until the day after the date of termination of his service as a volunteer.

(c) For the purpose of this subchapter--

- (1) a volunteer is deemed receiving monthly pay at the minimum rate for GS-7;
- (2) a volunteer leader referred to by section 2505 of title 22, or a volunteer with one or more minor children as defined in section 2504 of title 22 is deemed receiving monthly pay at the minimum rate for GS-11;
- (3) an injury suffered by a volunteer when he is outside the several States and the District of Columbia is deemed proximately caused by his employment, unless the injury or disease is--

- (A) caused by willful misconduct of the volunteer;
 - (B) caused by the volunteer's intention to bring about the injury or death of himself or of another; or
 - (C) proximately caused by the intoxication of the injured volunteer; and
- (4) the period of service of an individual as a volunteer includes--
- (A) any period of training under section 2507(a) of title 22 before enrollment as a volunteer; and
 - (B) the period between enrollment as a volunteer and the termination of service as a volunteer by the President or by death or resignation.
- (d) (1) The Secretary shall authorize the Director of the Peace Corps to furnish medical benefits to a volunteer, who is injured during the volunteer's period of service, for a period of 120 days following the termination of such service if the Director certifies that the volunteer's injury probably meets the requirements under subsection (c)(3). The Secretary may then certify vouchers for these expenses for such volunteer out of the Employees' Compensation Fund.
- (2) The Secretary shall prescribe the form and content of the certification required under paragraph (1).
- (3) A certification under paragraph (1) will cease to be effective if the volunteer sustains compensable disability in connection with volunteer service.
- (4) Nothing in this subsection may be construed to authorize the furnishing of any medical benefit that the Secretary of Labor is not otherwise authorized to reimburse for former Peace Corps volunteers who receive treatment for injury or disease proximately caused by their service in the Peace Corps in accordance with this chapter.

3. Regulatory Provisions under the FECA. 20 C.F.R §§ 10.730 and 10.731 provide the following:

§ 10.730 What are the conditions of coverage for Peace Corps volunteers and volunteer leaders injured while serving outside the United States?

- (a) Any injury sustained by a volunteer or volunteer leader while he or she is located abroad is deemed proximately caused by Peace Corps employment and will be found by OWCP to have been sustained in the performance of duty, and any illness contracted while that volunteer is located abroad will be found by OWCP to be proximately caused by the employment unless the evidence establishes:

(1) The injury or illness was caused by the claimant's willful misconduct, intent to bring about the injury or death of self or another, or was proximately caused by the intoxication by alcohol or illegal drugs of the injured claimant; or

(2) The illness is shown to have pre-existed the period of service abroad; or

(3) The injury or illness claimed is a manifestation of symptoms of, or consequent to, a pre-existing congenital defect or abnormality.

(b) If the OWCP finds that the evidence indicates that the injury or illness may not have been sustained in the performance of duty due to the circumstances enumerated in paragraph (a)(2) and (3) of this section, the claimant may still prove his claim by the submittal of substantial and probative evidence that such injury or illness was sustained in the performance of duty with the Peace Corps.

(c) If an injury or illness, or episode thereof, comes within one of the exceptions described in paragraph (a)(2) or (3) of this section, the claimant may nonetheless be entitled to compensation. This will be so provided he or she meets the burden of proving by the submittal of substantial, probative and rationalized medical evidence that the illness or injury was proximately caused by factors or conditions of Peace Corps service, or that it was materially aggravated, accelerated or precipitated by factors of Peace Corps service; if the injury or illness was temporarily aggravated by factors of Peace Corps service, disability compensation is payable for the period of such aggravation.

§ 10.731 What is the pay rate of Peace Corps volunteers and volunteer leaders for compensation purposes?

The pay rate for these claimants is defined as the pay rate in effect on the date following separation, provided that the rate equals or exceeds the pay rate on the date of injury. It is defined in accordance with 5 U.S.C. 8142(a), not 8101(4).

4. Statutory Authority for Peace Corps. OWCP is principally concerned with the following sections of the Peace Corps Act, 22 U.S.C. 2501 et seq:

(a) Section 2507, which provides (1) for appropriate training for applicants for enrollment as volunteers and volunteer leaders, (2) the enrollment period shall include the period of training, and (3) all provisos of the Act relating to volunteers and volunteer leaders are applicable to applicants for enrollment during the period of training.

(b) Sections 2511 and 2512, which provide for the appointment of a Peace Corps National Advisory Council and employment of experts and consultants.

(c) Section 2522(1) and (6), which define the term "abroad" to mean any area outside the several states and the District of Columbia United States.

5. Jurisdiction. Peace Corps claims are assigned to a claims examiner by rotation within the offices. See PM 01-200.2.

6. FECA Coverage of Employees/Volunteers. The Peace Corps Act extends the benefits of the FECA to volunteers.

In 1974, Section 8142(c)(2) of the FECA was amended to designate Peace Corps Volunteers with one or more minor children as "Heads of Household." By virtue of this amendment, these volunteers are entitled to compensation at the same rate as the Volunteer Leaders. Reports of injury should indicate whether a claimant is a Volunteer, Head of Household, or Volunteer Leader.

- a. Peace Corps National Advisory Council members and the associated experts/consultants have the protection of the FECA while performing their assigned duties under section 8101(1)(B) of the FECA. However, decisions concerning these individuals will be made on a case-by-case basis, and an opinion from the Solicitor of Labor should be requested if necessary.
- b. Staff Employees. These employees fall within the definition of "employee" outlined in 5 U.S.C. 8101(1). They have full coverage of the FECA.
- c. Staff Spouses. The spouses of Peace Corps staff members serving in foreign countries have the protection of the FECA while performing service or engaged in official travel. In addition to Form CA-1 or CA-2, a copy of the travel authorization is required. Performance of duty will be determined on a case-by-case basis. (See FECA PM 2-804) The pay rate for computing compensation will be determined in the manner used for persons coming within the scope of section 8101(1)(B) of the FECA.

7. Conditions of Coverage During Training. All applicants for enrollment as volunteers undergo training prior to actual enrollment; during this period they are referred as trainees. In keeping with the Peace Corps Act, applicants have the protection of the FECA during the training period.

8. Conditions of Coverage while Serving Abroad. Injuries of trainees and volunteers while abroad are deemed to have occurred while in the performance of duty, and any disease contracted abroad is deemed to have been proximately caused by the employment. Except for the exclusions of willful misconduct, intent to bring about injury or death of self or another, or intoxication, which appear in section 8142 of the FECA, volunteers have the protection of the FECA for all injuries sustained and diseases contracted during such service.

In cases involving disease, the examining physician or other qualified physician generally must state that the disease was contracted abroad in order to accept it as Peace Corps related. In some situations, this determination includes consideration of the incubation period for the disease. Coverage may also be extended if a pre-existing condition is aggravated, accelerated or

precipitated by Peace Corps service. The District Medical Advisor (DMA) may also be consulted and asked to provide an opinion in this matter.

The broad coverage for disease may present unusual medical problems. In general, the following rules may be observed:

- a. For episodic conditions, the medical evidence must show that the episode resulted from a condition contracted abroad. In the case of a disease, a medical report showing that the disease was contracted while the volunteer was serving abroad is sufficient. This requirement is satisfied by a statement from a physician stating that the disease was contracted during the period of service abroad. For certain diseases, this evaluation must include consideration of the incubation period.
- b. Dental Disease. Cavities, abscesses, etc., may be considered contracted abroad if comparison with the pre-induction dental examination so indicates. In the case an acute dental emergency that occurs within 120 days of separation of service, a CA 15 may be issued. See paragraph 10 in this chapter.
- c. Mental Illness. If it is determined that the psychiatric condition is related to Peace Corps service, treatment can be authorized until the attending physician indicates that the condition or episode has resolved and it is determined that no further disability exists. If a recurrence of the mental disease is alleged, it must be determined whether the recurrence is due to the Peace Corps experience or to other factors, including pre-existing conditions. In the case of a mental or emotional condition that the Director of the Peace Corps has determined is probably related to Peace Corps service, a CA 15 may be issued. A condition stemming from a volunteer's readjustment to activities of daily living post separation from Peace Corps are not covered under the FECA.
- d. Intestinal Parasites. If the separation medical examination indicates the presence of intestinal or other types of parasites, further examination and treatment may be authorized by issuance of a CA 15. A positive serology or skin test alone will not necessarily be considered evidence of a disease. However, see paragraph 10 in this chapter.
- e. Tuberculosis. If the separation medical examination indicates the presence of tuberculosis, further examination and treatment may be authorized, as may provision of prophylactic medication. See also paragraph 10 in this chapter concerning issuance of a CA 15. See also 20 C.F.R. 10.313c.
- f. Pregnancy. In accordance with the Pregnancy Discrimination Act, FECA coverage is extended to Peace Corps volunteers for pregnancies which occur during Peace Corps service overseas and continue past the date of termination. See also paragraph 10 in this chapter concerning issuance of a CA 15
 - (1) Such pregnancies are to be considered in the same light as any covered injury, but FECA coverage is limited to Peace Corps volunteers. Therefore, FECA benefits may not be extended to the children born of such pregnancies.

(2) Coverage extends to pregnancy-related conditions, including miscarriages, prenatal and postnatal care of the mother. Any prenatal care is to be considered part of the treatment for the disability (pregnancy) of the volunteer, and not preventive treatment or treatment for the unborn child.

(3) Except in the case of rape, incest or the health of the mother, OWCP may not pay for an abortion for a Peace Corps volunteer. (Except as authorized by law, the Employees' Compensation Fund may not be reimbursed for such expenditure.)

(4) Compensation for loss of wages may be paid only during the time when the medical evidence of record shows that the mother is disabled for the duties she would have been performing as a volunteer due to her pregnancy or its aftereffects. Thus, at least during the early months of the pregnancy, there may be no basis for paying compensation for wage loss.

(5) An unmarried volunteer without a wholly dependent parent is entitled to compensation at the 66 2/3 percent rate prior to the birth of the child and at the 75 percent rate after the child is born.

g. Assault/Sexual Assault. As injury during volunteer service abroad is deemed proximately caused by such service, injury due to assault or sexual assault (including treatment for sexually transmitted disease and mental health treatment) are covered under the FECA.

h. HIV/AIDS. Peace Corps volunteers are tested for HIV infection before being sent overseas. If comparison with this test shows that the infection has developed during the Peace Corps Service, medical and compensation benefits for the resulting condition are payable. Aggravation and acceleration of preexisting HIV due to conditions of service or limitations on medical care would also be covered.

9. Conditions of Coverage Returning from Service Abroad. A volunteer who returns to the United States immediately after completing service abroad has the protection of the FECA while traveling to the United States unless a material deviation occurs.

A volunteer may also choose to be terminated at a foreign post of duty. In this case the volunteer has the protection of the FECA only during that part of the trip back when on the direct or most usually traveled route between the foreign post of duty and the United States. The facts about any deviation from this route must be developed carefully. The question will be determined according to the usual criteria for cases involving travel status. See FECA PM 2-804.

10. Initial Authorization for Medical Care. Form CA-15, Peace Corps Volunteer Authorization for Examination and/or Treatment, may be used to authorize medical treatment for recently terminated Peace Corps volunteers who require medical treatment for injuries/exposure sustained in the performance of their volunteer service.

- a. Access to the CA-15. Issuance of the CA-15 will solely be at the discretion of the Peace Corps. No other agencies may use this form.
- b. Applicability to All Claims. The CA-15 may be issued following claims for traumatic injury (CA-1) and claims for occupational disease (CA-2).
- c. Choice of Provider. The injured volunteer may use the CA-15 to seek treatment at the hospital and/or physician of his/her choice.
- d. Covered Services. The CA-15 will cover emergency and non-emergency services for a period of 120 days following separation from service. Emergency services include but are not limited to ambulance and/or other medical evacuation, hospital services (emergency room, physician, inpatient stay) and emergency surgery. Non-emergency services include but are not limited to primary care physician visits, specialist physician visits, psychiatric care (including therapy), diagnostic testing, laboratory tests, prescription medications, and durable medical equipment (DME).
- e. Covered Conditions. As any injury or disease contracted abroad by a volunteer is deemed to have been proximately caused by the employment, the CA-15 provides coverage for all injuries or diseases sustained, to include but not limited to orthopedic conditions, dental conditions, hearing loss, cardiac conditions, mental illness, intestinal parasites, assault, tuberculosis and pregnancy.
- f. Period of Authorization. Form CA-15 authorizes treatment for 120 days following separation from service unless OWCP terminates the authorization sooner by formal decision. Once a case is accepted, the case will be accepted to cover necessary services for the accepted condition(s). Additional authorization (such as for surgery) will be handled in accordance with FECA program procedures. If a case is denied, however, authorization for further treatment must be revoked even if 120 days have not elapsed.

11. Reporting Injuries and Deaths. Volunteers are required to report injuries in the manner required by 20 C.F.R § 10.100 and 10.101.

- a. Timely Filing. If the volunteer sustains an injury or occupational disease while abroad, he or she will have the ability to submit a claim via ECOMP, or any other similar electronic system identified by OWCP. The volunteer should submit Form CA-1 (for traumatic injury) or Form CA-2 (for occupational disease) to the Peace Corps. A single claim form should be filed for each traumatic injury; however, if more than one occupational disease is claimed due to the same time in service, all conditions should be claimed, when possible, on a single Form CA-2.

The Peace Corps then typically provides for any medical care needed while abroad for the duration of the volunteer's service, and should document the volunteer's medical treatment upon receipt of the CA-1 by indicating the name of the physician that first provided medical care as well as the date of such care. Any medical treatment provided can be documented by uploading the medical records into the official OWCP case file via ECOMP. The Peace Corps

should submit all medical evidence via ECOMP in the event the volunteer cannot do so while abroad. See FECA PM 2-0801, which in part provides the following:

For Injuries (and Deaths) on or After September 7, 1974, an original claim for compensation for disability (or death) must be filed within three years after the occurrence of the injury or death under 5 U.S.C. 8122.

(1) If the claim is not filed within three years, compensation may still be allowed if written notice of injury or death was given within 30 days as specified in 5 U.S.C. 8119; or the immediate superior had actual knowledge (including verbal notification) of the injury or death within 30 days after occurrence. The knowledge or notification must be such as to put the immediate superior reasonably on notice of an on-the-job injury or death. Wherever practicable, the Peace Corps should assist the injured volunteer in filing the claim, or file on behalf of the volunteer.

(2) Knowledge by the immediate superior, another official at the employing agency, or any agency physician or dispensary (including in Peace Corps medical files) that an employee has sustained an injury, alleges that an injury has been sustained, or alleges that some factor of the employment has resulted in a physical condition constitutes actual knowledge. Such knowledge does not have to be firsthand or acquired as an eyewitness to the accident.

b. Because 5 U.S.C. 8142 (b) precludes volunteers from receiving disability compensation prior to the termination of their Peace Corps service, a volunteer who filed the CA-1 or CA-2 via ECOMP may certainly file a CA-7 FECA claim for compensation via ECOMP upon separation.

c. Upon receipt of a form via ECOMP, the Peace Corps should assist with questions; complete its part of the form; and forward the claim to OWCP.

d. The Peace Corps should provide the dates of enrollment and separation (if applicable), and the dates of service abroad with any claim submitted.

e. Medical File. With the claim form, the Peace Corps should also submit the volunteer's medical record via ECOMP. The Peace Corps maintains a complete medical file for its volunteers. The file usually includes the results of the pre-employment and termination examinations and a record of medical care received during service. This medical information is needed when adjudicating claims. Peace Corps may initially upload in ECOMP those portions of the file it deems relevant but OWCP reserves discretion to request and receive the entire medical file.

f. Death Claims. When a death is reported by the Peace Corps, typically via submission of a Form CA-6, the Claims Examiner should promptly send a Form CA-5 to the next of kin, if identified by the Peace Corps.

20 C.F.R§ 10.105 provides detail pertaining to the filing of a death claim and should be referenced as general guidance; however, for Peace Corps cases (that have been reported to OWCP directly by Peace Corps), the Attending Physician's Report on the reverse of Form CA-5 need not be completed, and claimants may be advised to return this form directly to OWCP.

If compensation is ultimately paid, it is computed on a monthly basis, just as it is for Federal employees.

12. Claims for Disability Compensation. 20 C.F.R. §10.102 provides detail pertaining to the filing of a compensation claims (CA-7) and should be referenced as general guidance.

- a. If it appears that entitlement to compensation may exist, upon acceptance of a claim the Claims Examiner should alert the volunteer that he/she may file a Form CA-7, if one has not already been received with the Form CA-1 or CA-2. The Peace Corps should also alert the volunteer to the provision of the FECA pertaining to payment of wage loss benefits if it is known that the volunteer is disabled due to a condition stemming from service in the Peace Corps.
- b. The date of the volunteer's separation will be the date pay stops. Entitlement to compensation for temporary or permanent disability begins on the date following the date of separation.
- c. Peace Corps volunteers are not entitled to continuation of pay (COP).
- d. The three-day waiting period provided by 5 U.S.C. 8117 applies to these cases in the same manner as it applies to non-Postal Federal employees.
- e. Pay Rate. In keeping with 5 U.S.C. 8142, the monthly pay rate for volunteers is at the minimum rate for a Grade 7. The monthly pay for volunteer leaders is the lowest rate provided for Grade 11 of the general schedule. The annual pay rates for computing compensation are found in Exhibit 1. Note that locality pay is not included.
- f. Even though the statute prescribes "monthly" pay, like all other types of claims, payrate calculations are then broken down to a weekly amount for entry into the compensation system.
- g. Effective Payrate Date. Section 5 U.S.C. 8101(4), which provides that the pay rate may be based on pay at date of injury, date of recurrence or date of disability, does not apply to Peace Corps volunteers. The effective date of the payrate is the GS schedule payrate on the date following the date of separation.
- h. Volunteers are entitled to CPI increases in compensation as provided by 5 U.S.C. 8146a.
- i. If a claim for compensation is submitted, the Peace Corps should send a copy of the volunteer's country assignment documentation for the file.

13. Disability Management. Peace Corps volunteers (and all employees of the Peace Corps) are entitled to all services provided for under the FECA. This includes the full complement of nurse intervention and vocational rehabilitation services provided as part of the Disability Management process. See PM 2-0600.

Exhibit 1 - Annual Pay Rates for Computing Compensation for Peace Corps Volunteers

Date of Injury (Separation)	Volunteers	Volunteer Leaders
09/22/61-10/13/62	\$ 5,355	\$ 7,560
10/14/62-01/04/64	5,540	8,045
01/05/64-07/04/64	5,795	8,410
07/05/64-10/09/65	6,050	8,650
10/10/65-07/02/66	6,269	8,921
07/03/66-10/07/67	6,451	9,221
10/08/67-07/13/68	6,734	9,657
07/14/68-07/12/69	6,981	10,203
07/13/69-12/27/69	7,639	11,233
12/28/69-01/09/71	8,098	11,905
01/10/71-01/08/72	8,582	12,615
01/09/72-01/06/73	9,053	13,309
01/07/73-10/13/73	9,520	13,996
10/14/73-10/12/74	9,969	14,671
10/13/74-10/11/75	10,520	15,481
10/12/75-10/09/76	11,046	16,255
10/10/76-10/08/77	11,523	17,056
10/09/77-10/07/78	12,336	18,258
10/08/78-10/06/79	13,014	19,263
10/07/79-10/04/80	13,925	20,611
10/05/80-10/03/81	15,193	22,486
10/04/81-10/02/82	15,922	23,566
10/03/82-01/07/84	16,559	24,508
01/08/84-01/05/85	17,138	25,366
01/06/85-01/03/87	17,824	26,381
01/04/87-01/02/88	18,358	27,172
01/03/88-12/31/88	18,726	27,716
01/01/89-01/13/90	19,493	28,852

Exhibit 1 - Annual Pay Rates for Computing Compensation for Peace Corps Volunteers

Date of Injury (Separation)	Volunteers	Volunteer Leaders
01/14/90-01/12/91	20,195	29,891
01/13/91-01/11/92	21,023	31,116
01/12/92-01/09/93	21,906	32,423
01/10/93-09/30/93	21,906	33,623
10/01/93-01/07/95	22,717	33,623
01/08/95-01/06/96	23,171	34,295
01/07/96-01/04/97	23,634	34,981
01/05/97-01/03/98	24,178	35,786
01/04/98-01/02/99	24,734	36,609
01/03/99-01/01/00	25,501	37,744
01/02/00-01/13/01	26,470	39,178
01/14/01-01/12/02	27,185	40,236
01/13/02-01/11/03	28,164	41,684
01/12/03-01/10/04	29,037	42,976
01/11/04-01/08/05	29,821	44,136
01/09/05-1/07/06	30,567	45,239
01/08/06-01/06/07	31,209	46,189
01/07/07-04/05/08	31,740	46,974
01/06/08-01/03/09	32,534	48,148
01/04/09-01/02/10	33,477	49,544
01/03/10-01/01/11	33,979	50,287
01/02/11-12/31/11	33,979	50,287
01/01/12-01/12/13	33,979	50,287
01/13/13-12/31/13	33,979	50,287
01/01/14-12/31/14	34,319	50,790
01/01/15-12/31/15	34,662	51,298
01/01/16-12/31/16	35,009	51,811
01/01/17-12/31/17	35,359	52,329
01/01/18-12/31/18	35,854	53,062
01/01/19-12/31/19	36,356	53,805
01/01/20-12/31/20	37,301	55,204
01/01/21-	37,674	55,756

Chapter 2-1800, Housing and Vehicle Modifications

1. Purpose and Scope. This chapter furnishes guidelines and procedures for considering requests for housing and vehicle modifications. Such medical rehabilitation services help the claimant to maintain or increase independence and quality of life, and, consequently, may reduce the need for future services and their associated costs. Modifications may in some circumstances also reduce or delay the need for residential care and nursing services.

2. Authority. Housing and vehicle modifications come under the authority of 5 U.S.C. 8103(a) which provides for services, appliances and supplies prescribed or recommended by a qualified physician, which the Secretary considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation. See, D.T., Docket No. 05-1012 (issued August 23, 2006) (ECAB held that OWCP has broad administrative discretion in choosing the means to achieve the goals of section 8103 of the FECA. As the only limitation on the OWCP's authority is reasonableness, abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment, or actions which are contrary to both logic and probable deductions from known facts).

3. Eligibility. To be eligible for housing or vehicle modifications, the claimant must be severely restricted in terms of mobility, functionality and independence in normal living functions, on a permanent basis, due to the work-related injury. Examples are impairments that require the use of a prosthesis, wheelchair, motorized scooter, leg braces, crutches, cane, or other self-help device. Such medical conditions include quadriplegia, paraplegia, amputation, total loss of use of limbs, blindness and profound deafness bilaterally.

4. Medical Development. When a request is received for housing or vehicle modifications, the Claims Examiner (CE) should take initial action within five working days of receipt. The CE should ensure that the original acceptance of the case was proper and that the disability for which the benefit is claimed is related to the accepted injury.

Before considering the technicalities of housing and vehicle modification proposals (paragraphs 5, 6 and 7 below), a determination must be made on the medical necessity of the requested modification. See William D. Farrior, 54 ECAB 566 (2003) (ECAB held that OWCP properly exercised its discretionary authority in denying appellant's request for a new vehicle, as there was insufficient rationalized medical evidence addressing appellant's physical restrictions due to his accepted knee conditions or the need for a motor vehicle modification or new vehicle purchase.)

There are several aspects to consider when reviewing the evidence of record:

- (1) Does the level of impairment rise to the level delineated in the eligibility section above?
- (2) Does the medical evidence support that the claimant has restrictions or physical limitations which necessitate the modification?

(3) Are these restrictions caused by the accepted work-related condition?

(4) Does the physician provide detailed findings and rationale for the opinion that the claimant's work injury has caused restrictions which necessitate the requested modification? This should come from a physician who is a recognized authority in the appropriate medical specialty.

Note that the modification should result from a restriction. For example, the purchase of a wheelchair or scooter for a claimant does not necessarily mandate that the concomitant modification to a vehicle be made. If the restriction leading to the wheelchair/scooter also prevents the claimant from driving without it, then the vehicle modification would be compensable. On the other hand, if the scooter was provided because the claimant cannot walk long distances but is able to drive an unmodified vehicle, then the OWCP is not responsible for vehicle modifications. In this instance, there is no injury-related restriction that requires the claimant to drive a modified vehicle. (See, M.B., Docket No. 06-701 (issued December 4, 2006) (ECAB held that appellant's physician did not explain why appellant's employment-related accepted conditions required medical treatment which could only be accommodated by purchase of a van.) Similarly, if the claimant is requesting a modified vehicle purchase but is not a vehicle owner at present (and did not own a vehicle on DOI), medical evidence must explain why the employment-related conditions require medical treatment which can only be accommodated by purchase of a vehicle rather than by other options (e.g. public, community and/or specialized disability transportation; transportation similar to what the claimant has been relying on).

If the evidence of record fails to establish medical necessity in consideration of the above criteria, the claims examiner should take the appropriate medical development actions. The claimant should be provided with 30 days to submit the needed medical documentation. Questions posed to the physician should be specific in regard to the injury related restriction which necessitates the requested modification. The case may also be referred to a Field Nurse to assist with determination of medical eligibility.

Requests for modification are not routinely sent to the District Medical Advisor (DMA). However, if there is a complicated medical issue that requires DMA review, the medical evidence should be forwarded to the DMA for an opinion on the necessity and work-relatedness of the requested modification(s).

Once medical eligibility is established, then the CE should refer the case to a Rehabilitation Specialist to begin the technical development of the proposed modification in conjunction with the criteria outlined in paragraphs 5, 6 and 7. This usually includes a request for a detailed proposal to address the technical, financial and practical elements of the requested modifications. Typically, OWCP will assist in developing such proposals by referring the case to a Rehabilitation Specialist (RS), who will assign a Rehabilitation Counselor (RC) to assist the claimant in developing a detailed proposal for the requested modifications. If approved, the RC, under the supervision of the RS, will assist with coordination and completion of the modification. If the proposed modification is not supported, a formal decision is required as outlined in paragraph 8.

5. Vehicle Modifications.

a. General Criteria. No vehicle modification should be undertaken without a signed agreement that specifies the nature of the modification and the claimant's responsibilities and obligations under the agreement.

(1) Modifications to a vehicle must be established as necessary and desirable for increased mobility or independence by a recommendation of a physiatrist or other medical specialist appropriate to the type of injury sustained. The medical evidence must establish that the requested modifications are needed because of restrictions caused by the accepted condition(s). See paragraph 4.

(2) Modifications of the present vehicle must be explored before considering a new purchase.

(3) Modifications must be consistent with the claimant's pre-injury standard of living and should approximate that standard insofar as practical. If accessories and equipment are needed for the claimant's present vehicle, OWCP will modify it if it is practical to do so, as determined by the type of vehicle, its age and condition, and the type of equipment needed.

(4) If it is established that the claimant cannot drive his or her present car due to the inability to place a wheelchair in it without assistance, or if it is not practical to modify the present vehicle, OWCP will pay for a suitable car or van (if necessary), taking credit for the trade-in value of the vehicle with the greatest current fair market value owned by the claimant; however, OWCP will not be named on the title for the vehicle.

(a) If the claimant purchases a used car, OWCP will pay the depreciated price of a base-line, otherwise comparable, used car or van of comparable age and condition, with equipment required for the accepted disability. The claimant is responsible for paying the difference between the new or used vehicle allowed by OWCP and the car or van actually purchased and additionally equipped as the claimant desires.

(b) If the claimant purchases a new car or van, OWCP will pay the discounted price of a base-line vehicle of suitable size. The base line vehicle is the most cost effective model upon which the necessary modifications can safely be made. OWCP will also pay the discounted price for additional options required for the effects of the injury and any necessary after-market add-ons, such as hand controls. Wherever possible, optional equipment should be factory-installed.

(5) If a car or van must be purchased by OWCP, it will be the most cost-effective modifiable model with the optional equipment required for the effects of the injury. Hand controls or other special devices will be added to it. If the claimant desires a model that is more costly because of nonessential factors, or desires accessories not required for the injury, he or she must pay the difference in price. OWCP will pay only the discounted price for the suitably sized base-line vehicle with the necessary options and modifications. The claimant will pay any difference resulting from the selection of a more expensive model and/or additional accessories not necessitated by the injury.

(6) Modifications and the additional costs of a new vehicle (when warranted) over the value of the present vehicle will be paid for by OWCP. When a new or used vehicle is purchased, the amount paid by OWCP will be reduced by the trade-in value of the vehicle owned by the claimant with the greatest current fair market value.

(7) Vehicle modifications should be no more expensive than necessary to accomplish the required purpose. Special hand and foot controls and any items which need not be built in should be removable where feasible for transfer to other vehicles.

(8) Vehicle modifications may include what are normally considered comfort or convenience options, if documented by the medical specialist to be necessary for the effects of the compensable disability. In specific cases, it would be appropriate to make payment for such equipment as air conditioning, power brakes, power steering, automatic transmission, power door locks, power windows, rear defogger, or six-way power seat.

(9) Equipment furnished for a vehicle by OWCP should be maintained and repaired at OWCP expense and may be replaced after normal wear and tear. Equipment required for the injury will be repaired and maintained at OWCP expense. Other parts of the vehicle will be repaired, maintained and replaced at the owner's expense even if OWCP paid for the vehicle. Replacement equipment for the present vehicle or similar equipment will be provided on a replacement vehicle if the claimant can establish that the vehicle should be replaced. OWCP may only consider the purchase of a subsequent vehicle when the estimated cost of reasonable mechanical repairs on the current vehicle exceeds its lowest current Blue Book value.

(10) The claimant is required to provide proof of adequate insurance and proper registration of the vehicle in the state of residency. The costs of insurance and registration are the responsibility of the claimant. Claimants are required to carry fire, theft, comprehensive and collision insurance on vehicles paid for in whole or in part by OWCP, but need not maintain collision insurance if the equipment furnished is worth under \$200.

(11) The Government is entitled to reimbursement for the value of the modifications when relinquished or no longer needed by the claimant, if the value of the modifications exceeds \$10,000 at that time. Reimbursement is due to the Government only in situations where the claimant has had use of the vehicle or vehicle modifications for less than ten years. The value of a vehicle purchased for a claimant, or of automotive accessories such as power steering, automatic transmission and power door locks, will be determined by the lowest current Blue Book figure when the vehicle is sold, traded, or no longer needed by the claimant.

At the time the vehicle or automotive accessory is sold, traded, or otherwise disposed of, the current value of the item is reduced by 10 percent for each year used by the claimant in order to obtain the figure for reimbursement. For example, where the value of the modified vehicle is \$10,000 at the time of disposal and the claimant has used it for six years, reimbursement to the Government should be \$4,000. The RS should multiply 10 percent by the number of years used ($.10 \times 6 = .60$), and multiply the result by the current value of the modified vehicle ($.60 \times \$10,000 = \$6,000$), and subtract the result from the current value ($\$10,000 - \$6,000 = \$4,000$) to

obtain the reimbursement amount. If the current value is less than \$10,000, the above formula will not be applied and the claimant will not be required to reimburse OWCP.

(12) The claimant (and authorized representative if applicable) should be notified of these reimbursement requirements and should sign an acknowledgment of these reimbursement responsibilities. If the vehicle is also titled to the claimant's spouse or another party, that individual must also be informed of and sign acknowledgment of these reimbursement responsibilities. See Exhibit 1.

b. Technical Development.

If medical eligibility has been satisfied, the claimant should be advised of the criteria mentioned in this section. Specifically, the claimant should be notified from the outset that an existing vehicle will be modified whenever feasible, but that any new or used vehicle purchased must be at the discounted price of the most cost-effective base-line vehicle of suitable size, taking credit for the trade-in value of the claimant's present vehicle. If the claimant owns more than one vehicle, the vehicle with the greatest current fair market value will be used to calculate trade-in value. The additional expense of a higher priced vehicle or personal preference options will normally be the claimant's obligation. When possible, the claimant should submit at least three estimates. If it is not possible to obtain 3 bids, the reason should be documented for the record.

Typically, the CE will refer the case to a Rehabilitation Specialist (RS), who will assign a Rehabilitation Counselor (RC) to assist the claimant in obtaining the estimates/bids and developing the proposal for the requested modifications. Once approved, the RC, under the supervision of the RS, will assist with coordination and completion of the modification. If the proposed modification is not supported, the RS will issue a formal decision as outlined in paragraph 8.

Proposals should include the following information:

- (1) An itemization of all vehicle modifications proposed. Where substantial modifications are required, the detailed changes should be recommended by a medical rehabilitation professional familiar with the needs of the disabled.
- (2) Vehicle modification proposals must include the year, make, model and body style of the present vehicle, the number of miles it has been driven, and a description of its general mechanical condition, including any repairs currently needed or anticipated.
- (3) If the evidence supports that the claimant's current vehicle cannot be modified and a new vehicle must be purchased, then additional information is needed. Estimates should be provided for the most cost-effective model that can be modified. If the base-line model available comes with extras (like a CD player), then these need not be deducted from the estimate. Any additional options which are not included in the baseline model and not necessitated by the work injury (e.g., a sunroof) are the financial responsibility of the claimant and should be deducted from the estimate.

(4) No fee will be paid for attorneys or similar representatives engaged by the claimant to assist with a proposal. Approved representative's fees remain the claimant's obligation, as discussed in FECA PM 2-1200.

6. Housing Modifications for Home Owners.

a. General Criteria. No housing modification should be undertaken without a signed agreement that specifies the nature of the modification and the claimant's responsibilities and obligations under the agreement.

(1) Housing modifications must be recommended by a physiatrist or other medical specialist appropriate to the accepted employment condition as necessary and desirable for increased mobility or independence. Before proceeding with a housing modification, the medical recommendation must be current and supported by adequate medical rationale. Rehabilitation services should then be utilized in conjunction with the medical recommendations in order to assist with an on-site visit by a RC and/or other medical rehabilitation professional. The purpose of the on-site visit will be to provide a report of general requirements that will be necessary to accomplish the medically necessary housing modifications. In addition, the RC or other medical rehabilitation professional will assist in locating architects to draw up plans for modifications when needed, and contractors for building and installing the modifications.

(2) Modifications to a house must be consistent with the claimant's pre-injury standard of living and should approximate that standard insofar as practical. The purpose of the FECA is not to provide an enrichment program in proportion with the severity of the injury sustained. To do so would extend the program beyond the intent and scope of the FECA which is to provide an adequate substitute for an employee's loss of earning ability to provide for his or her living needs. For example: If a claimant must purchase or build a new home because the current residence would not be structurally sound to modify, the new residence must be comparable in size (i.e. square feet of living area) and quality to the currently owned home. Or, if new doors and special door knobs must be installed in the claimant's residence, the quality of the hardware and finish of the doors, the hardware itself, and any molding should be comparable to those being replaced. See Janice Kirby, 47 ECAB 220 (1995) (ECAB held that OWCP did not abuse its discretion to restrict benefits under section 8103 to the new construction of those items necessary to accommodate appellant's injury-related condition. In this case, appellant's parents acknowledge that the construction of the new home intended to accommodate appellant was based on personal and financial considerations and not on the structural unsoundness of appellant's existing home.)

(3) In analyzing a housing modification proposal, it is OWCP's policy to fully explore modifications to a present house before consideration of a purchase or building of a new home. If the claimant elects to purchase a new home or build a new structure, for any reason other than that it would be structurally unsound to attempt to modify the present house, it must be made clear that the OWCP is responsible only for the modifications and relevant plans for the new house which are necessitated by the work injury. In such a situation, OWCP is not responsible for the cost of the new house. The only situations which warrant that the OWCP be involved with helping to purchase or build a new home is where it would be impossible to make the

necessary modifications to the present home or that such modifications would cause structural damage to the house.

(a) OWCP will not find that the purchase of or building of a new home is warranted solely on the basis that modifying the present home is too costly. As long as the needed modifications can be achieved without structural damage to the property, OWCP will cover the cost. Also, it would not be considered sufficient reason for the OWCP to assist in the purchase or construction of a new house if the claimant finds that it would be aesthetically undesirable to make an addition to his or her present home. In addition, a claimant's concern that modifications will negatively affect the home's property value is insufficient to warrant purchasing or building a new home for modification rather than modifying the existing structure.

(b) The claimant is required to establish with written certification from at least two professional sources that his or her present home is not structurally modifiable. Such certification from an architect or a licensed building contractor must include a full explanation of why the present home is not structurally modifiable. The OWCP RC may also assist with obtaining this information.

(c) If it is accepted that the present home cannot be structurally modified, other existing home purchase options must be explored and precluded prior to considering new construction. New construction will generally add more delays, time and money, as well as a degree of complexity, and therefore should only be considered if no other option exists. Justifications for construction of a new house must be related to the work injury and not on the basis of personal preference.

(d) Where the present home cannot be modified without structural damage, OWCP will be responsible for the difference between the cost of the new house and that of the existing house. If the claimant purchases a house that represents an increase in his or her standard of living, due to personal preference, the cost of the upgrade will be the claimant's responsibility. For example: If the claimant owns a house worth \$100,000 with a mortgage at the time of sale of that house of \$85,000, his or her position at the time of purchasing or building the new home should be that he or she owes \$85,000 on the new mortgage. OWCP does not purchase the house but will make up the difference up to the worth of the present residence, i.e., \$100,000. In such a case, the responsibility of OWCP would also include housing modifications and modifications to the architectural plans. See, e.g., Wayne G. Rogers, 54 ECAB 482 (2003). However, OWCP is providing purchase assistance and is not purchasing the house. Therefore, neither OWCP nor any Government agency will be named on the deed to the house in such an arrangement.

(4) If the claimant lived in his or her own house at the time of injury and makes the decision to buy or build a new home for reasons other than those described above, OWCP will pay only the cost of modifying a suitable house. The OWCP will not pay moving expenses. If the claimant decides on his or her own to purchase or build a new house, the OWCP will only pay any extra expenses in altering the plans and for medically necessitated modifications to the new house.

(5) Modifications will be consistent with the current home and no more expensive than necessary to accomplish the required purpose. For example, in remodeling a bathroom, it may be feasible to remove and reinstall an existing sink to wheelchair height, rather than discard it and buy a new

sink. If the existing sink cannot be used, purchase of the most cost-effective comparable sink that will fulfill the purpose of providing accessibility will be approved. Another example involves access issues related to ramps, lifts and elevators. When determining the most appropriate mode of access to or within a home, the most cost-effective modification should be selected. Each item for modification should be assessed in terms of safety, accessibility and cost-effectiveness, as well as meeting the injured worker's pre-injury standard of living, as is practical. The specification of a particular product brand should be avoided unless it is established that a single name brand is the most cost-effective means of meeting the requirement for the modification.

(6) The cost-effectiveness of modifications to meet a temporary need, when the physician anticipates a prolonged recovery, should be considered against long-range tangible and intangible benefits, such as facilitating recovery, reducing the length of hospitalization or confinement in other care facilities, or reducing the need for an attendant.

(7) Modifications may include what are normally considered to be comfort or convenience accessories, if needed for the effects of the compensable injury. In specific cases, special heating, air conditioning and air filtration devices may be necessary based on the nature of the accepted condition. For example, such items might be required for an individual with a respiratory or cardiac ailment, and the physician recommending the accessories would be responsible to explain such needs. In addition, if a generator is being requested, the CE/RS should consider if there is equipment that needs to be backed up by a generator in the event of a temporary power outage in order to preserve health or life.

(8) Once a Housing Modification Plan is approved, any changes to the OWCP funded modifications must be submitted by the contractor. The changes must be approved by OWCP via written change orders prior to the change being initiated, unless the change is related to items that the claimant will be responsible for paying.

(9) Once the housing modification is approved, the contractor may find more extensive repairs are needed in order to pass inspection. For example, after tearing down a wall more extensive work is needed due to problems hidden by the wall. While the repairs may not be specifically related to the disability, the contractor cannot proceed without correcting the new problem. These additional repairs should be approved if necessary to complete the approved modifications.

(10) Contractors are required to provide proof of license and insurance. Prior to authorizing a plan, the local licensing board or other similar entity should be contacted to insure that there are no significant infractions reported against the contractor, such as poor work or fraudulent activity.

(11) Local permit requirements must be verified. Permits are to be obtained in localities where they are required. If no permit is required and completed work is questionable, OWCP can pay for a 3rd party inspection such as a city or county building inspector.

(12) Equipment required due to the work injury and furnished by OWCP for the present house or new house will be maintained, repaired and replaced as needed after normal wear and tear at OWCP expense.

(13) The claimant is required to provide proof of adequate insurance. Claimants must carry home owner's insurance that reflects the present value of their house, unless the modifications were furnished at a cost under \$1,000.

(14) The Government is entitled to reimbursement for the value of any housing modifications when relinquished or no longer needed by the claimant if the value at that time exceeds \$10,000 after applying a sliding scale, which is explained below. When disposing of modified property, the sliding scale must be applied to any enhanced value over \$10,000, and that amount must be returned to the Government. See Minne B. Lewis, 53 ECAB 606 (2002) (ECAB upheld OWCP's repayment provisions as they "prevent unjust enrichment." ECAB stated that without them a claimant who has received a Government subsidy to purchase property could turn a quick profit by simply selling the property. OWCP procedures requiring reimbursement to the government attempt to return the claimant, after the property is relinquished, to substantially the same position he or she enjoyed previously.)

For example, if an elevator is installed in the claimant's house and the house is later sold, the OWCP should be reimbursed from the proceeds of the sale for the current value of the elevator, if it exceeds \$10,000 after applying the sliding scale. The current value may be determined in any reasonable, equitable manner, such as estimates from real estate sources, bank appraisers, or by comparing recent sale prices of similar houses without the special equipment.

A sliding scale is used to determine the remaining enhanced value at the time the house or housing modification is relinquished or no longer needed by the claimant. The amount of reimbursement due to the Government will be reduced gradually. If the claimant leaves the modified home after one year of residence, the amount of reimbursement due the Government would be 90% of the total disbursements made for the purchase and/or housing modifications. After two years of residence in the modified home, the amount of the reimbursement to be sought by OWCP would be 80% of the disbursements. The amount of the reimbursement due the Government would continue to reduce annually, with a reduction to zero after ten years of residency has elapsed. In the event that the claimant pre-deceases a spouse or other co-owner of the house, the co-owner is responsible for reimbursement to the government as per the same parameters as discussed.

While some modifications may decrease rather than increase the value of a home, no reimbursement to the claimant can be made for any reduction in the value of the house resulting from modifications which may inconvenience prospective purchasers.

(15) The claimant (and authorized representative or co-owner, if applicable) should be notified of these reimbursement requirements and should sign an acknowledgment of these reimbursement responsibilities. See Exhibit 2.

(16) If a house has been modified, the claimant must notify OWCP before any move which may result in a claim for further housing modifications. A claimant who sells a modified house is liable for modifying any future residence absent a claims-related reason for the move and prior OWCP approval (see paragraph 10 below).

b. Technical Development. If medical eligibility has been satisfied, the claimant should be advised of the criteria mentioned in this section. Specifically, The claimant should be advised that proposed housing modifications should be of a quality and finish level consistent with his or her present residence but not superior to it. (For example, builder grade cabinets will be replaced with similar cabinets, not expensive custom cabinets). Likewise, proposals should mention the type of materials being used rather than concentrating on a specific brand name. The most cost-effective means of accomplishing the modification should be provided in the proposal. The claimant should also be advised that if it is established that it is not structurally feasible to modify the present residence, a move to a comparable residence which could be properly modified should be considered. While it is the claimant's own decision, OWCP will not pay for modifications that would compromise the structural soundness of the residence.

When possible, the claimant should submit at least three bids in the proposal. If it is not possible to obtain three bids, the reason should be documented for the record. The bids should be commensurate in the level of detail provided and address all needed modifications so that comparisons between them will be accurate. Bids should be submitted by licensed and insured contractors. Typically, the CE will refer the case to a Rehabilitation Specialist (RS), who will assign a Rehabilitation Counselor (RC) to assist the claimant in obtaining the estimates/bids and developing the proposal for the requested modifications. If approved, the RC, under the supervision of the RS, will assist with coordination and completion of the modification. If the proposed modification is not supported, the RS will issue a formal decision as outlined in paragraph 8.

Proposals should include the following information:

(1) Three bids which contain an itemization of all modifications proposed. The materials, labor, and associated fees for accomplishing these modifications should be listed and a time frame for completing them provided. Only modifications approved by the OWCP (based on medical evidence) will be paid for by the OWCP. Additional modifications and/or optional material upgrades are the responsibility of the claimant. For ease of comparison, each bid should separate the costs assumed by each party (claimant and OWCP) where necessary.

(2) When the cost for modifications exceeds \$5,000, the RC coordinating the modifications must ensure that an on-site review is performed to justify the need for and adequacy of the proposed modifications. Reasonable fees will be paid for the medical rehabilitation professional's visit to the home and detailed recommendations. If necessary, the RC can utilize an accessibility specialist and OWCP will pay a reasonable fee for an on-site analysis. Documentation of the site visit should be included with the proposal.

(3) If construction work is required, a binding estimate of the cost from three reputable contractors is needed. Customarily, no fee will be paid for such bids, since they are normally

supplied to prospective purchasers free of charge. Reasonable fees for bids can be considered for extensive home modifications if it can be established that it is the usual practice for the extent and degree of the home modification in the specific locale. Reasonable fees will be paid for preliminary architect's sketches when significant structural changes requiring architectural services are needed. If special accessories or devices are requested, the RS should stipulate that the price given by the vendor includes any necessary installation. The bid selected will be the lowest of any acceptable means of achieving the desired result. The lowest prices will be accepted unless there is sound reason for a higher price, such as increased durability or degree of contractor experience and/or established record of working with accessibility design issues.

(4) No fee will be paid for attorneys or similar representatives engaged by the claimant to assist with a proposal. Approved representative's fees remain the claimant's obligation, as discussed in FECA PM 2-1200.

7. Housing Modifications for Renters.

a. General Criteria. The status of renter includes claimants who are or were living with parents or other family members at the time the work injury occurred. Modifications to rental property must be approved by the property owner. A signed agreement is required which acknowledges that the modifications are being paid for because the property owner has agreed to house the claimant and further acknowledges the property owner's reimbursement responsibilities to OWCP.

No housing modification should be undertaken without this kind of signed agreement that specifies the nature of the modification and the claimant's, as well as the home owner's or apartment owner's, responsibilities and obligations under the agreement. The specific agreement to be signed depends on whether the claimant is renting from a landlord or living with a family member. See Exhibits 3, 4 and 5.

Many of the criteria outlined in paragraph 6 for home owners apply also to claimants who rent housing. A few specific criteria for renters are below:

(1) In a rental property, all modifications proposed must be recommended by a psychiatrist or other medical specialist appropriate to the accepted employment condition, just as in a property owned by the claimant. The CE must determine that the recommended modifications are medically necessary and desirable for increased mobility or independence.

(2) If the claimant lives in rented premises, a statement from the property owner authorizing the proposed changes should be included in the proposal. This includes a situation in which the claimant is living in a parent's or other relative's home. OWCP should conduct a conference with the landlord/property owner to assess the level of commitment to continue renting to the injured worker after the modifications are accomplished. There should be some level of assurance that the landlord will continue to rent the modified property to the injured worker for an extended period of time considering the extent and cost of the modifications.

(3) If the claimant is renting and the owner of the property will not permit necessary modifications, other living arrangements may be subsidized, such as paying moving expenses to

other rented quarters as comparable as possible to the present residence. OWCP should also pay any difference in rent. However, a claimant who is renting his or her living quarters should not expect any assistance from OWCP for purchasing or constructing a new house.

(4) Modifications to a property must be in keeping with the standard of the decor of the current or pre-injury property accoutrements. For example, if the claimant's apartment has two sinks in the master bath and the claimant needs a special sink for wheelchair access, both sinks will be replaced or modified in order to preserve the symmetry of the room. If the tile in the bathrooms or kitchen needs to be replaced in order to accomplish the proposed modification, the new tile should be of a quality equal to that which must be replaced.

On the other hand, just as in a privately-owned residence, cost-effectiveness and practicality are essential criteria to be used when considering proposed modifications. If an existing sink can be reinstalled at another height [see this chapter paragraph 6.a(5)] to achieve the required modification, this is preferable to discarding it and replacing it with a new sink.

(5) Similarly, when a claimant lives in a rented walk-up property prior to the injury and can no longer climb stairs, the difference in rent may be paid for the most nearly comparable elevator property available. OWCP must ensure that the proposed property is equivalent to the pre-injury living quarters in terms of living area, amenities and community desirability.

(6) If a renter living in a remote area needs a modification not allowed by the property owner, and there is no rental property available within a reasonable distance, the feasibility of relocation, new construction, or any other viable option should be weighed.

(7) For true rental situations, the claimant is required to provide proof of adequate insurance. Claimants must carry renter's insurance that reflects the present value of the belongings within the residence, unless the modifications were furnished at a cost under \$1,000. If the claimant is living with a family member, the home owner should carry the insurance.

b. Technical Development. The technical development of the housing modification will take the same course for renters as for the home owners described in the prior paragraph, with the exception that the landlord or home owner must agree to the modifications.

8. Adjudication of Proposals.

a. Medical evidence as described in paragraph 4 above is required. A claimant seeking a housing or vehicle modification should be advised to submit the requested documentation needed to establish medical necessity. The CE will determine whether the medical evidence is sufficient, and if the claimant fails to submit the necessary documentation, issue formal decision with appeal rights. This decision should discuss the evidence of record and provide an explanation of why it is insufficient to support the medical necessity. Technical development of a proposal, or review of a submitted proposal, by a RS is not necessary if the evidence of record does not establish that the proposed modifications are necessitated by work-related restrictions.

b. If medical necessity is established, then technical development to establish the criteria noted in paragraphs 5, 6 or 7 is warranted. As noted previously, it is often necessary to have an OWCP RC involved in this process. Typically, the CE will refer the case to a Rehabilitation Specialist (RS), who will assign a Rehabilitation Counselor (RC) to assist the claimant in obtaining any necessary estimates/bids and developing the proposal for the requested modifications.

c. The RS will review the itemized proposal and determine whether the specified modifications are appropriate and within the scope of what the CE has determined to be medically necessary. The RS will approve or deny the proposal accordingly. If needed, the RS will arrange a tele-conference between relevant parties to discuss the proposal, particularly if changes to, or clarification of, the proposal are needed before authorization can be given. The conference may include, but is not limited to, the CE, the claimant, the RS, the RC, the Lead and/or Supervisory Rehabilitation Specialist, the FN and/or the party performing the modification (as appropriate).

d. If the RS recommends approval of the proposal based on the criteria noted above, he/she will proceed as appropriate based on the cost of the project. See paragraph 9, Payment for Modifications. If the cost of the project is within the RS's payment authority, the RS will draft and send an approval letter and written agreement to the claimant which details the terms and conditions of the authorization (See Exhibits 1 – 6). If the cost of the project exceeds the RS's payment authority, the proposal will be forwarded to the Lead Rehabilitation Specialist and/or Rehabilitation Supervisor for review and approval. If approved, the Lead RS or Rehabilitation Supervisor will sign the agreement letter authorizing payment of the requested modification. The RS will send the approval letter and written agreement to the claimant. The claimant must sign and return the agreement before a modification project may begin. The RC, with the RS's supervision, will be directed to coordinate the authorized modification.

e. The RS may recommend denial of the proposal, in whole or in part, if it is not within the scope of what has been determined to be medically necessary by the CE, or if it appears that further medical development may be needed. If further medical development is necessary, the case will return to the CE for appropriate development actions. Once clarified the case can be referred back to the RS to move forward with the proposed modification. If medical necessity is clearly defined, and the issue remaining is specific to the proposed modification project, the RS may issue a formal decision with appeal rights if deemed necessary.

f. If an authorized modification project is underway and additional work or equipment is requested by the claimant or contractor, the RS will proceed as in paragraphs d and e above to determine whether to approve or deny the request. The RS will consult with the CE if there is a question regarding medical necessity.

9. Payment for Modifications.

a. Rehabilitation Specialists are required to review all proposals and may authorize housing and vehicle modifications in amounts up to \$50,000. The Lead Rehabilitation Specialist is authorized to approve housing and vehicle modifications in amounts up to \$100,000. Housing and vehicle modifications in amounts over \$100,000 are to be approved by the Rehabilitation Supervisor.

b. Bills including installation work or construction work must be accompanied by the claimant's (or the RC's) statement showing that the work covered by the payment has been accomplished satisfactorily. Construction expenses should be paid promptly as the job progresses, to coincide with "draws" on the claimant's construction contract. The RS is typically responsible for review and payment of bills associated with modification projects.

10. Later Requests for Modification. After a vehicle or house has been modified, the claimant may request modification of a different vehicle or house.

a. Vehicle. It is expected that even a vehicle which is regularly maintained will eventually require replacement. Its value should be determined by the lowest current Blue Book figure when the vehicle is sold, by the actual purchase price, or by the trade-in value, whichever is highest. The amount should be subtracted from the cost of any new vehicle authorized.

b. House. Payment for modification of a subsequent residence for both home owners and renters may be authorized under very limited circumstances. Any subsequent move must be undertaken for a reason related to the claim, and detailed rationale should be provided before the move is to occur.

Acceptable reasons include the need to obtain more sophisticated medical care or a medical need to live in a different environment. Reasons not accepted as justification for modification of a different house include personal preference for a different locale or the desire to be closer to family for additional support. If the reason given is deemed acceptable, the RS should document the file to reflect this decision so that any expenditure in modifying the new house can be justified. See e.g. John Yera, Docket No. 00-2476 (issued June 18, 2002) (ECAB held that OWCP was within its guidelines and discretion in denying appellant's request for a modification of a different residence as appellant voluntarily transferred to Virginia in an effort to utilize his specialized skills in the area of Internet crimes. ECAB found that the reasons advanced by appellant for accepting the position in Virginia were neither persuasive nor convincing to justify an approval of a modification to a second home.)

Exhibit 1 - Sample Agreement-OWCP Vehicle Purchase or Modification

Memorandum of Agreement - Vehicle Modification

This agreement establishes the parameters under which the Office of Workers' Compensation Programs (OWCP) agrees to pay for the purchase of and/or the modifications to your vehicle. These vehicle modifications are approved based upon limitations caused by your accepted work injury.

The undersigned agree to the following:

1. OWCP will pay for the purchase of the following vehicle and the specific modifications identified below. In purchasing your vehicle, OWCP will take credit for the trade-in value of the vehicle you own with the highest current fair market value.

For new vehicle purchase, list trade-in vehicle, approved new vehicle and all approved modifications.

OR

OWCP will pay for the specific modifications to your existing vehicle as identified below.

For existing vehicle modifications, identify existing vehicle and list all approved modifications.

2. You will provide proof of adequate insurance and proper registration of the vehicle in the state of residency. You are required to carry fire, theft, comprehensive and collision insurance on vehicles paid for in whole or in part by OWCP, unless the equipment furnished is worth under \$200. You understand that you are responsible for paying annual taxes, insurance costs, and all registration fees for the vehicle.

3. Equipment required for your injury and furnished for your vehicle by OWCP will be repaired and maintained at OWCP expense. All other parts of the vehicle will be repaired, maintained, and replaced at your expense even if OWCP has paid for the vehicle.

4. You understand that if and when the vehicle, item, or modification is no longer needed, you will be entitled to retain it if the value (or enhanced value) is less than \$10,000. If the value of a vehicle, an enhancement to a vehicle, or any other item furnished for your vehicle is greater than \$10,000 when relinquished by you, the amount of value above \$10,000 must be reimbursed to the Department of Labor in a percentage of the total value based on the period of use. If you have used the vehicle, enhancement, or other item for one year, the amount to be reimbursed to the Department of Labor would be 90% of the value above \$10,000. The amount to be reimbursed will be reduced by 10% annually until it reaches zero (0%) after 10 years of your use.

By signing this agreement, all parties indicate an understanding of and agreement with the conditions set forth above regarding the vehicle purchase and/or modifications.

Claimant
CLAIMANT NAME

Date: _____

Claimant's Representative (if applicable)
REPRESENTATIVE'S NAME

Date: _____

Agreement Prepared By:

Name:

Title:

Date:

Exhibit 2 - Sample Agreement-OWCP Housing Modification for Home Owners

Memorandum of Agreement - Housing Modification

This agreement establishes the parameters under which the Office of Workers' Compensation Programs (OWCP) agrees to pay for modifications to your property at ADDRESS. These housing modifications are approved based on limitations caused by your accepted work injury.

The undersigned agree to the following:

1. You agree to the renovations described below. OWCP will pay for these modifications, and only these modifications, as described in the attached document from CONTRACTOR NAME.

List all approved modifications here. If necessary, list subcategories such as general construction, plumbing work, etc.

2. You will notify OWCP before any move which may result in a claim for a new house or a claim for modifications on a new house.

3. You agree that you will provide proof of adequate insurance, including home owner's insurance that reflects the value of your house, upon completion of the approved renovations. You will send proof of insurance to OWCP once renovations have been completed.

4. You must notify OWCP if you intend to relinquish your ownership of the house.

5. You understand that the Government is entitled to reimbursement for the value of the home modifications described in this agreement if the property is relinquished or the modifications are no longer needed if the value at that time exceeds \$10,000. If the value is greater than \$10,000 when relinquished or no longer needed by you, the amount of value above \$10,000 must be reimbursed to the Department of Labor in a percentage of the total value based on the period of use. The Government agrees that the value of the home modifications will decrease at the rate of 10 percent of the total per year for every year that you reside at the property. For example: If the home modifications are completed in December of 2009 and you reside in the house until December of 2015, the value of the renovations would have decreased by 60% in that time. The Government at that time would be entitled to reimbursement for 40% of the amount paid for the modifications. If you live in the home and require the modifications for 10 years, the Government is no longer entitled to any reimbursement amount. The government will not seek reimbursement of any amount until you no longer have need for the modifications or the home.

By signing this agreement, all parties indicate an understanding of and agreement with the conditions set forth above regarding the housing modifications to be completed at ADDRESS.

Claimant
CLAIMANT NAME

Date: _____

Co-owner(s) of the home (if applicable)
CO-OWNER'S NAME

Date: _____

Claimant's Representative (if applicable)
REPRESENTATIVE'S NAME

Date: _____

Agreement Prepared By:

Name:
Title:
Date:

Exhibit 3 - Sample Agreement-OWCP Housing Modification for Renters

Memorandum of Agreement - Modification to Rental Property

(Office of Workers' Compensation Programs and Claimant)

This agreement establishes the parameters under which the Office of Workers' Compensation Programs (OWCP) agrees to pay for the modification of an apartment to be used as your primary residence. The apartment at ADDRESS is a # bedroom, # bath unit with # square feet. The initial length of lease will be # years.

The undersigned agrees to the following:

1. OWCP will pay for modifications to the apartment and building common areas as detailed below, provided that the landlord concurs with the proposed modifications. The modifications to the apartment are as follows:

List all approved modifications here. If necessary, list subcategories such as general construction, plumbing work or common area work (such as handicapped parking spots or ramps not actually inside the rental unit).

2. The claimant agrees to occupy the apartment for the entire period of the lease as his or her residence and to obtain renter's insurance. The claimant will send proof of insurance to OWCP once renovations have been completed.
3. The claimant agrees to reside in the apartment for the length of the lease as noted above and to notify OWCP before any move which may result in a claim for new modifications.
4. The claimant agrees that the apartment may not be subleased to any other party or parties, and that the claimant has obtained signed written concurrence of the building management for these modifications, a copy of which is attached to this agreement.

Claimant
CLAIMANT NAME

Date: _____

Claimant's Representative (if applicable)
REPRESENTATIVE'S NAME

Date: _____

Agreement Prepared By:

Name:
Title:
Date:

Memorandum of Agreement - Modification to Rental Property

(Office of Workers' Compensation Programs and Landlord)

LANDLORD'S WRITTEN CONCURRENCE TO THE PROPOSED MODIFICATIONS

I, OWNER'S NAME, the owner of ADDRESS consent to the physical modifications planned by CLAIMANT and his/her representative in order for CLAIMANT to live in the apartment. The initial length of the lease will be # years. I understand that these modifications to the apartment and common areas (and only these modifications) will be paid for by the Office of Workers' Compensation Programs as outlined below:

- The items listed here should be the same as those provided on the claimant agreement.

Owner's signature
OWNER'S NAME
ADDRESS, WITH APT #

Date: _____

Agreement Prepared By:

Name:
Title:
Date:

Exhibit 4 - Sample Agreement-OWCP Housing Modification for Family-Owned Homes

Memorandum of Agreement - Housing Modification

(Office of Workers' Compensation Programs and Claimant)

This agreement establishes the parameters under which the Office of Workers' Compensation Programs (OWCP) agrees to pay for the modification of your primary residence, even though you are not the owner of said residence.

It is understood that you do not own the property at ADDRESS, but that you are living with a family member (SPECIFY) and plan to continue living at this residence. These housing modifications are therefore being approved based on the property owner's (OWNER NAME) agreement to provide housing to you on an ongoing and continuous basis and that the modifications in question are needed due to the limitations caused by your accepted work injury.

The undersigned agrees to the following:

1. OWCP will pay for modifications to the residence as detailed below, provided that the property owner concurs with the proposed modifications. The modifications to the residence are as follows:

List all approved modifications here. If necessary, list subcategories such as general construction, plumbing work, etc.

2. The claimant agrees to reside in this residence and to notify OWCP before any move which may result in a claim for new modifications.

Claimant
CLAIMANT NAME

Date: _____

Claimant's Representative (if applicable)
REPRESENTATIVE'S NAME

Date: _____

Agreement Prepared By:

Name:
Title:
Date:

FECA Part 3 – Medical: Addresses medical services and supplies. It describes how medical examinations are arranged and the kinds of information medical reports should contain.

Chapter 3-0100, Overview

1. **Purpose.** This part of the procedure manual describes for both physicians and claims personnel the procedures for administering the medical care program under the Federal Employees' Compensation Act (FECA). Examination of case files and authorization of medical care are conducted through the cooperative efforts of the Medical Unit and the Claims Units within each district office.

2. **Benefits.** The FECA provides the following benefits for Federal employees:

a. **Medical Care.** Services prescribed or recommended by a qualified physician which are likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation may be authorized. These services include surgery and hospitalization as well as appliances and supplies.

b. **Disability Benefits.** Compensation is paid for lost wages resulting from the employment-related injury, disease or illness.

(1) **Total Disability.** A claimant is paid compensation for total disability when the employee is medically unable to perform gainful employment due to employment-related injury, disease or illness. The loss of use of both hands, both arms, both feet or both legs, or the loss of sight of both eyes, is considered prima facie evidence of permanent total disability (section 8105 (b) of FECA), though claimants with these disabilities are sometimes still able to work.

(2) **Partial Disability.** Reduced benefits are paid when the employee is not totally disabled but is capable of performing duties which are compatible with the medically imposed work limitations resulting from the injury, disease, or illness. The amount of compensation paid commensurate with the employee's loss of wage-earning capacity (sections 8106 and 8115 of FECA).

c. **Schedule Award.** Compensation for permanent impairment of certain members or functions of the body may be paid regardless of the employee's ability to work. A schedule award is payable when the condition has reached maximum medical improvement. The AMA Guides to the Evaluation of Permanent Impairment form the basis for awards. Awards are also payable for disfigurement of the face, head or neck which is likely to handicap the claimant in maintaining or securing employment (section 8107 of the FECA).

d. Vocational Rehabilitation. Vocational rehabilitation services are provided when an injured employee is unable to return to his previous work (section 8104 of FECA).

e. Death Benefits. A range of benefits for the dependents of an employee whose death was employment-related is provided (sections 8133 and 8134 of the FECA).

f. Miscellaneous Benefits. Other benefits include reimbursement for transportation costs incurred in obtaining medical treatment or rehabilitation services. Nursing and other paramedical services are included when they are likely to be beneficial, and an attendant's allowance is payable in addition to compensation to severely disabled claimants.

3. Definitions. By statute, the term "physician" includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, osteopathic practitioners, and chiropractors within the scope of their practice as defined by state law.

a. Psychologists. OWCP has accepted the American Psychological Association's definition of a clinical psychologist as an individual who:

(1) Is licensed or certified as a psychologist at the independent practice level of psychology by the state in which he or she practices, and

(2) Either possesses a doctoral degree in psychology from an educational institution accredited by an organization recognized by the Council on Post-Secondary Accreditation or is listed in a national register of health service providers in psychology which the Secretary of the Department of Labor deems appropriate, and

(3) Possesses two years of supervised experience in health service, at least one year of which is post degree.

b. Chiropractors. These practitioners are defined as "physicians" only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. A chiropractor has the right to interpret his or her own X-rays to determine whether they support the diagnosis of subluxation and to determine any period of disability resulting from that condition. OWCP defines subluxation as an incomplete dislocation, off-centering, misalignment, fixation or abnormal spacing of the vertebrae.

c. Physicians' Assistants. These practitioners, who are not physicians under the Act, receive academic training and clinical experience and may be certified by the National Commission on the Certification of Physician's Assistants. A report prepared by a physician's assistant which is countersigned by a physician should be accepted as medical evidence.

d. Religious Practitioners. The Christian Science Church permits treatment of its members only by its own practitioners, though it has no objection to periodic examinations to determine entitlement to compensation and to assess whether maximum medical improvement has been reached. The FECA does not authorize treatment by nonmedical practitioners of the healing arts,

such as psychic healers or faith healers, although they may be permitted at the claimant's expense.

4. Subjects Covered. The roles of the District Medical Director, District Medical Adviser, Medical Management Assistant, and Staff Nurse are discussed briefly in Chapter 3-200, and the Staff Nurse's work is addressed more fully in Chapter 3-201. Chapter 3-202 addresses certification procedures for contract nurses. The procedures for authorizing treatment and the provision of supplies are described in Chapter 3-300, while treatments and supplies which may be authorized under the FECA are detailed in Chapter 3-400. The process of obtaining medical evaluations is described in Chapter 3-500, and requirements for medical reports are detailed in Chapter 3-600. Schedule award determinations are considered in Chapter 3-700. Procedures for excluding a medical provider are detailed in Chapter 3-800, and administrative matters are considered in Chapter 3-900.

Chapter 3-0200, Functions of the Medical Unit

1. Purpose. This chapter describes the roles and responsibilities of OWCP medical staff, which usually includes a senior Federally employed physician as District Medical Director, (DMD), one or more District Medical Advisers (DMA), one or more Medical Management Assistant(s) (MMA), and a Staff Nurse.

2. Structure of the Medical Unit. The responsibility for oversight of the Office's medical benefits program is vested in the DMD, who works under the medical guidance of the OWCP National Office Medical Director and the administrative supervision of the Regional Director (RD) or the District Director (DD). A district office may have one or more DMAs (usually contract employees), and the functions of each office's Medical Unit are aided by one or more MMAs. The Staff Nurse coordinates the work of the Field Nurses who act on behalf of each district office in the case management process.

3. District Medical Director (DMD). The functions of the DMD include the following:

a. Establishes liaison with regional professional societies State health departments, and individual providers within the district office's jurisdiction. The DMD can familiarize the medical community with the nature of the program and its needs and objectives. Specific areas which may be addressed include types of medical reports and their use within the program; requirements for content and quality of medical reports and the impact of these factors on the length of the adjudicatory process as well as continued use of a particular consultant; the Office's commitment to the rehabilitation of the employee and the resources available to this end; and new policies and procedures as warranted.

Such meetings allow the DMD to transmit concerns and suggestions from the medical community to district office managers. These contacts may be arranged by the DMD alone, or by the DMD in conjunction with district office management, and it may take the form of contacts with local medical societies and other groups of physicians such as the medical staff of local

hospitals, and providers in group practices. The DMD may also obtain from district office files the names of physicians who have served as consultants in cases involving a particular disease, such as asbestosis, and sponsor meetings to discuss changes in diagnosis and treatment as well as administrative matters.

b. Visits with major employing agencies within the district office's jurisdiction. The DMD can also perform a useful function by encouraging employing agency personnel to conduct limited outreach efforts with physicians in their respective geographic areas. Such efforts may include tours of the employing agency and demonstrations of the types of light duty which may be available to partially disabled workers, so that physicians will be more aware of options other than continuing the claimant on total disability.

c. Identifies and evaluates the credentials of physicians willing to serve as consultants (DMAs) to manage workloads. (The method of selecting a consultant for this function is identical to the procedure for obtaining second opinion examinations, which is described in Chapter 3-900).

d. Establishes and administers a network of medical specialists (second opinion specialists) and DMAs who provide the Office with medical opinions (see Chapter 3-900).

e. Provides training and guidance to Claims Examiners (CEs) and other district office staff regarding medical issues. The DMD may properly advise CE's concerning the tone and content of letters sent to members of the medical community. He or she may provide formal and/or informal training on common conditions and medical treatment issues to the district office staff. The DMD also has an advisory role to bill pay staff within the district office.

f. Identifies and reports medical trends to district office management and the OWCP Medical Director. The DMD advises the DD or RD concerning customary ranges of fees for various services in the area and advises the RD concerning exclusion of medical providers. The DMD will monitor the performance of referral specialists and advise the DD or RD of physicians whose reports are consistently incomplete, unreliable, or late.

g. Provides professional opinions and technical advice in connection with the adjudication and management of complex claims.

The DMD does not perform medical examinations or functions of a clinical nature except for participating in evaluation of claimants who seek an award for disfigurement of the face, head or neck (see Chapter 3-700). Moreover, while the DMD does not act in a supervisory capacity per se, he or she does have administrative oversight with respect to the medical functions of the district office.

4. **District Medical Adviser (DMA).** The functions of the DMA (and the DMD insofar as he or she performs medical evaluations of case files) include interpretation of medical reports; rendering medical evaluations in his or her own right; and providing guidance or instruction to claims staff regarding general medical issues which are in compensation claims.

a. Interpreting Medical Reports. The CE seeks the interpretive function of the DMA where the medical evidence is complete and sufficient prior to such review. In this form of review, the DMA may determine the percentage of permanent partial impairment, evaluate test results, or "translate" technical language. The DMA may also be asked to review reports from referee specialists where a schedule award is at issue (see Chapter 3-600).

b. Rendering Medical Evaluations. The CE seeks advice from the DMA to proceed with developing and weighing the medical evidence where the report from the attending physician, second opinion or referee specialist is not clear and well rationalized, and the DMA provides written opinions on medical questions posed by members of the claims staff.

In this capacity, the DMA may advise whether a claimant's condition is employment-related, whether the effects of an accepted condition continue, and whether the claimant is receiving appropriate medical care, including whether recommended procedures, appliances or treatment are useful or necessary. The DMA may also be asked to comment on proper development of the medical evidence where an unusual condition is under consideration.

The Employees' Compensation Appeals Board has addressed the role of the DMA in its decision in the case of Carlton L. Owens, 36 ECAB 608:

The role of the Office medical adviser is to act as a consultant in reviewing cases under the Federal Employees' Compensation Act. Claims examiners make use of the services of medical advisers in adjudicating the issues of causal relationship, extent of disability, degree of permanent impairment, and suitability of work. The Office medical adviser's role is not to act in an adjudicatory capacity or address legal issues in the case, and the Office should carefully observe the distinction between adjudicatory questions which are not appropriate and medical questions which are appropriate.

c. Monitoring Medical Care. While the DMA does not routinely monitor cases to ensure adequacy of medical care, he or she is expected to recognize issues regarding the quality of care arising in the cases he or she evaluates. CEs may also identify cases where the propriety of medical care is in question and should refer them to the DMA for action or advice. Issues may include:

(1) Appropriateness/Usefulness of Treatment. The criteria used in assessing the suitability of medical care as well as Office policies regarding specific treatments and appliances which may be authorized are discussed in Chapter 3-400.

(2) Length of Treatment. The duration or frequency of treatment appears excessive for the condition or incompatible with the norm for the medical community.

(3) Transfer of Medical Care. Claimants not infrequently request changes in attending physician, but the Office seldom initiates this action. Transfers of care should be handled according to the claimant's medical needs with due regard for medical protocol.

A case sent to the DMA for evaluation of another matter may reveal issues pertaining to the suitability of medical care, and the DMA is expected to use his or her medical expertise to recognize such problems and bring them to the CE's attention.

5. Medical Management Assistant (MMA). The MMA's function is to assist the DMD in the administration of the Medical Unit and to perform associated support functions, which include:

- a. Screening. The MMA examines incoming case files to ensure that all necessary information is present, including a list of questions and Statement of Accepted Facts.
- b. Scheduling. The MMA schedules appointments for second opinion and referee examinations in accordance with the Office's procurement and rotation policies and the specific requirements of each type of examination.
- c. Advising of Arrangements. The MMA prepares letters to claimants and physicians once such examinations have been scheduled and ensure that all necessary information and material is provided to each party.
- d. Record-Keeping. The MMA maintains records concerning utilization of physicians in each category as well as logs pertaining to prompt payment of bills; keep records of cases out of the office and contact physicians when reports and cases are overdue.
- e. Documenting Exclusion Data. The MMA maintains information concerning exclusion of medical providers and ensures that documentation of alleged infractions is routed to the correct parties within the district office.
- f. Keying. The MMA may key outgoing cases to other parts of the district office. The MMA ensures that location printouts reflect only the cases actually present in the medical unit, and initiates searches for any other cases.

6. Staff Nurse. The OWCP Staff Nurse is responsible for coordinating the nurse intervention process in the district office, which in turn is directed toward managing disability claims to facilitate recovery and, if possible, return to work. This function includes:

- a. Selecting cases for intervention, in some district offices, and assigning them to Field Nurses with the CEs' concurrence.
- b. Acting as liaison between the Field Nurses and CEs. This function includes answering questions from both parties, interpreting OWCP practices to the Field Nurses, and helping the CEs to understand the nurses' role in managing cases.
- c. Procuring and selecting enough field Nurses to provide high quality services to OWCP claimants, and managing and monitoring their activities on a case by case basis as well as cumulatively.

d. Training Field Nurses on intervention procedures and formal and informal training of CEs and OWCP staff on these procedures and other medical topics as warranted in the particular office.

e. Performing other liaison activities such as outreach to the medical community and scheduling certain second opinion and impartial examinations to ensure that these are performed in a timely fashion and the resulting reports address CEs' concerns fully.

See PM 3-201 for a fuller discussion of the Staff Nurse's duties.

Chapter 3-0201, Staff Nurse Services

1. Purpose and Scope. The role of the Staff Nurse in the FEC district offices is to aid in managing disability cases. The Staff Nurse's role and functions in this process are the subject of this chapter. Included in the discussion will be specific nursing functions, intervention and liaison activities which will assist the Claims Examiner (CE) in managing cases.

2. Definition. In its broadest scope, case management is a comprehensive approach to minimize the length and perhaps the extent of disability in some compensation cases. In this process, nurses will play a vital role by participating in the early, aggressive medical management of cases. The primary focus of the nurses' activities will be to encourage recovery and the return to work through direct interventions with the claimants, treating physicians, and employing agencies.

3. Nurses' Roles in the District Offices. Nurses involved in case management may be OWCP staff members or private sector professionals working with the program on a contractual basis. While the latter (Field Nurse) can perform only the actual interventions, the OWCP Staff Nurse may coordinate nurse intervention as well as actually intervening in cases.

a. The Nurse Intervenor Role. The Staff or Field Nurse functioning in this role will be working closely with OWCP office staff and claimants, physicians in the community, and employing agencies to assist in the return to work effort. For clarity, a nurse acting in this role will be designated as Field Nurse throughout this chapter.

b. The Nurse Coordinator Role. The OWCP Staff Nurse acting in this capacity is responsible for coordinating the nurse intervention process in the district office. This function includes:

- (1) Selecting cases and assigning them to the Field Nurse(s),
- (2) Managing Field Nurses and monitoring their activities on a case by case basis as well as cumulatively,
- (3) Acting as liaison between the Field Nurses and CEs,

(4) Procuring and selecting enough field Nurses to provide high quality services to OWCP claimants,

(5) Training Field Nurses on intervention procedures and formal and informal training of CEs and OWCP staff on these procedures and other medical topics as warranted in the particular office, and

(6) Performing other liaison activities such as outreach to the medical community and scheduling certain second opinion and impartial examinations to ensure that these are performed in a timely fashion and the resulting reports address CEs' concerns fully.

4. Types of Nurse Intervention. The nurse intervention process can be classified according to the degree of interaction: limited, moderate or intensive. The Staff Nurse determines the appropriate type of intervention based on the diagnosis, the severity of the injury or illness and demographic considerations.

a. Limited intervention consists of telephone interaction only. This method provides the ability to reach a greater number of claimants and is most effective in uncomplicated sprains and strains with a delayed return to work date. Phone contact is initiated with the claimant and details of the injury are discussed. In the follow-up phone calls, the nurse reinforces the treatment regimes of the treating physician and formulates return to work plans with the claimant and treating physician.

While phone contacts are not restricted as to frequency, the nurse must keep in mind that too many phone contacts may inadvertently reinforce patients who exhibit high levels of pain and illness behavior. If contacts are set up on an as-needed basis, patients having the most difficulty will likely get the most contact. Intervention, to be effective, should be completed within four months.

b. Moderate intervention combines both phone calls and face-to-face interaction. This type of intervention begins with phone contact but as the intervention continues, evolving circumstances may warrant face to face contact.

For example, if in the course of phone intervention, it becomes apparent that the claimant's physician is planning surgery, a re-operative/post-operative visit by the nurse will assist to reinforce return to work goals. Typically, these interventions will not exceed four months' duration. However, there will be cases (complicated post-operative period) requiring an extension of the nurse's time, and the CE must provide authorization for this extension.

c. Intensive intervention is reserved for catastrophic cases such as head or spinal cord injuries with extensive functional deficits where the medical recovery is expected to extend over long or indefinite periods of time. In these cases, the immediate intervention is directed at the claimant's needs during the acute phase of injury (coordinating hospital care with the variety of specialists in the case) and continues until stabilization (e.g., placement in a rehabilitation facility or home with modifications) has been achieved and vocational rehabilitation can be recommended.

Usually vocational rehabilitation services do not begin until nurse services end, but in these cases it may be important to begin vocational counseling during the period of nurse intervention. The Field Nurse assigned to the case is responsible for identifying cases that may benefit from vocational services. He or she should communicate this recommendation to the CE involved in the case.

5. Phases in the Intervention Process. The intervention process, regardless of the type, can be divided into four stages as briefly described below. Throughout each phase, the nurse monitors the quality of medical care rendered to the claimant and communicates frequently with the CE regarding the claimant's progress.

a. Identification Phase. The Staff Nurse, CE or other staff identifies cases for intervention according to standard criteria. Communication is initiated with all parties: claimants, treating physicians and employing agencies.

b. Monitoring Phase. The Field Nurse reviews the physician's overall treatment plan and identifies areas needing CE attention (prior authorization for surgery, prolonged bed rest, etc.) As necessary, the nurse discusses issues with the parties concerned and participates in updating or modifying the treatment plan to fit the claimant's changing health status.

c. Assessment Phase. The Field Nurse determines whether return to work is possible and whether return to work plans are available and feasible. Collaborates with all parties (CE, physician, agency, claimant) to implement the return to work.

d. Discharge Planning Phase. The Staff Nurse assesses the outcome of the intervention and, as necessary, follows up in the case to ensure continuity in its management. If the claimant has returned to work, the Field Nurse will provide follow-up for 60 days. In cases where the nurse intervention period has expired and the return to work has not occurred, the Staff Nurse will refer the case to the CE with appropriate recommendations such as referral for vocational rehabilitation services, second opinion, etc.

6. Preliminary Steps. Nurse intervention early during the period of disability is one of the major components of the quality case management procedures. This section details all the important aspects and steps in this process.

a. Criteria for Case Selection. Cases which have been traditionally associated with poor outcomes in terms of return to work, cases where the outcome is uncertain, and cases where specific medical issues need to be clarified, should be referred for nurse intervention.

(1) Traumatic Injury Cases. Although the ideal time for nurse intervention is from 45-90 days after the day of injury, the CE may refer traumatic injury cases for nurse intervention regardless of the time elapsed since the injury if:

(a) The medical evidence does not state a return to work date;

(b) The return to work date is unrealistic (i.e., not in keeping with the magnitude of the original injury);

(c) The return to work date is extended without clear medical reasons;

(d) The claimant is partially disabled but the file does not contain a description of work limitations;

(e) The CE requires additional medical information for the initial or continuing authorization of unusual and/or prolonged services such as intensive home nursing, housing modifications and extensive surgery or physical therapy.

(2) Occupational Illness Cases. These cases ordinarily require more than 90 days to adjudicate, thus placing them outside the optimum time frame for nurse intervention. Therefore they will not routinely be referred for continuing nurse intervention, though they may be referred for advice and assistance with particular issues [see paragraph a(1)(e) above]. Referral for vocational rehabilitation services will likely be more appropriate in most occupational illness cases.

b. Sources of Cases for Nurse Intervention.

(1) CE Referrals. CEs are tasked with identifying cases that meet the criteria indicated above. The CEs will identify a significant number of these cases at the time of the authorization for the first compensation payment (excluding most leave buy-backs and schedule awards).

(2) Automated Reports. Staff Nurses may identify cases that meet the above criteria using automated reports of CA-7 payments or other reports containing similar information.

(3) Other Sources. In some instances, employing agencies, Vocational Rehabilitation Specialists, District Medical Directors or Advisors and others can identify cases which may benefit from nurse services. All cases referred in this fashion should be discussed with the CE before nurse intervention is offered to the claimant since the final authority to intervene with the claimant remains a prerogative of the CE.

c. Work/No Work Call. The initial interaction with claimants occurs during the initial telephone call. The purpose of this call is to ascertain the work status of the claimant and to inform those claimants who meet the above indicated criteria of the intended nurse intervention in his or her case. The CE may make this call. However, in those offices where the Staff Nurse identifies potentially eligible cases from automated reports, this call will be the responsibility of the OWCP Staff Nurse and he or she should follow the steps detailed below:

(1) If the claimant has returned to full duty, the nurse notifies the CE. In most instances, the nurse recommends that further intervention is not necessary. However, in some cases where the nurse has reason to believe that the medical condition is unstable or that the claimant might stop working for other reasons, he or she may recommend a follow-up call in four weeks to verify that the claimant remains at work;

(2) If the claimant has returned to modified and/or part time duty, the nurse will notify the CE, who will make a decision as to whether the claimant is to be followed until he or she returns to full-time employment.

(3) If the claimant has not returned to work but knows when the return to duty will occur, and the date appears realistic according to the medical evidence, medical matrix or MEDGUIDE in Folioviews, the Staff Nurse sets up a call-up for the date specified and calls the employing agency on that date to find out if the claimant has in fact returned to work.

(4) If the claimant has not returned to work at the time of the follow-up call, and either does not state a plan to return to duty or offers a date inconsistent with the nature and severity of the injury, the nurse explains the nurse intervention program to the claimant and attempts to engage the claimant in the program.

(5) Once the call is completed, the nurse notifies the CE of the result using a Form CA-110 and recommending appropriate action on Form OWCP-57. Although the intervention program is voluntary, participation should be strongly encouraged. A claimant who refuses to be visited may nonetheless allow intervention by telephone. If the claimant refuses to participate altogether, the nurse ends the telephone conversation but reports this result to the CE. The nurse should attempt to secure a medical release from the claimant so that communication may be initiated with the attending physician.

7. Performing Interventions. The Staff Nurse selects the type of intervention needed based on the nature and severity of the claimant's condition, the claimant's geographic location and other factors. At the same time, he or she assigns the case to a nurse who will actually perform the intervention, and notifies the claimant, physician, employing agency and the CE.

a. Initial Contacts.

(1) Claimant. The Field Nurse notifies the claimant that they will be working together through the recovery stage. He or she also advises the claimant that the treating physician will be made a part of this collaborative return to work effort.

(2) Treating Physician. The Field Nurse will contact the treating physician to discuss current and future treatment regimes. Emphasis is placed on identifying and managing open-ended treatments such as bed rest and physical therapy, as well as prolonged therapy with pain medications. As necessary, the nurse may discuss medical issues with the District Medical Director (DMD) or Advisor (DMA), or may recommend a second opinion to clarify issues. Ultimately, a return to work date and concrete work limitations, if needed, will be discussed and formulated using Form OWCP-5. As with the claimant, contact is made initially by phone followed by a confirmation letter.

(3) Employing Agency. The agency will also be contacted by the Field Nurse. Communication with the agency begins with the claimant's supervisor or the injury compensation specialist because this person can furnish important information regarding the job in question as well as

provide some sense of pre-existing interpersonal issues which may affect the return to work effort.

There are a variety of reasons for the nurse to contact the employing agency. For example, the nurse notifies the compensation specialist that one of their employees has been contacted by a nurse, verifies that the employee has or has not returned to work and, when applicable, informs the agency that the physician has imposed some physical limitations for the return to work.

b. Intervention Guidelines. The Field Nurse assigned to the case performs the intervention. The nurse is responsible for structuring the intervention in terms of the number, content and the length of contacts with the claimant and other parties involved. To do so, the nurse should keep in mind the following guidelines:

(1) The focus of the program is the return to work and the claimant should be encouraged to participate actively in the treatment plan and in the resolution of problems which may impact on the recovery effort.

(2) Visits or calls to the claimant should be scheduled on time-contingent basis rather than as a response to the appearance or exacerbation of symptoms.

(3) The treating physician should participate in this process by producing a treatment plan and a projected length of disability which are commensurate with the claimant's signs and symptoms. If these are not forthcoming or if the physician refuses to communicate with the nurse, the intervention with the claimant and employing agency should continue and the MD's refusal to participate should be communicated to the CE.

(4) Although the Field Nurse is responsible for structuring the number, length, content and medium (telephone, face-to-face) of the interactions with all participants, he or she should be aware that the intervention is a finite process. The intervention is limited to 120 days from the date of referral. In some instances, where there is substantive evidence that the return to work will occur shortly, the CE may authorize an additional period of 30 days. Once the period for nurse intervention has been exhausted, the case is referred to the CE for further action.

c. Intervention Process.

(1) During the first 30 days of intervention, the Field Nurse determines whether the physician has formulated a treatment plan and whether the claimant's physical condition is improving. As necessary, the nurse discusses the formulation or modification of the plan with the physician and the claimant.

As soon as the Field Nurse completes the visits with the claimant and treating physician, the nurse discusses findings from the visits and the subsequent plans for follow up action with the CE and the Staff Nurse. The DMD/DMA may be consulted to ensure that the treatment is appropriate for the claimant's condition. The CE is made aware of the need to authorize particular therapies, and that the return to work is part of the treatment plan.

Once the plan has been formulated, the nurse monitors the physical progress of the claimant and obtains a return to work date from the physician, when appropriate. If necessary, the nurse forwards a OWCP-5 form to the treating physician to define the work restrictions present and the level of function of the individual. He or she may discuss the content and the use of the form by OWCP and the employing agency with the physician.

The nurse may also recommend a second opinion examination, and with the CE's concurrence, schedule it. However, if the physician selected is not listed in the Physicians' Directory System, the nurse should advise the Medical Management Assistant of the physician's name and address so that this information can be added to the system.

(2) The nurse works with the employing agency to ensure that the physical demands of the job are in keeping with any restrictions imposed by the physician, that there are no significant barriers to the return to work, and verifies that the return to work occurs on or near the expected date.

If the return to work is delayed, the Field Nurse communicates this to the CE and discusses the reasons with all parties concerned as necessary. The nurse endeavors to re-establish the return to work emphasis, define a new date and verify that indeed the claimant returns to work on or near the expected date.

(3) If the return to work date obtained is not within 120 days from the beginning of the intervention, there is no significant improvement in the condition of the claimant, or the physician does not produce a plan, the Staff Nurse ends the intervention and refers the case to the CE for action. Upon closing the case, the Staff or Field Nurse may choose to offer specific recommendations such as referral for a second opinion examination, referral to vocational rehabilitation, or change of physician.

(4) If the claimant does not return to work on or near the return to work date, or remains at work less than 60 days, the nurse needs to determine the underlying reasons and take appropriate action. If a job adjustment problem (difficulty with the employing agency) is the cause for the continuing lack of employment or stopping work, the nurse refers the case to the CE for further action, clearly stating the nature of the problem.

However, if medical problems prevent or cut short the return to work, the nurse ensures the completion of OWCP-5 by the physician, closes the intervention and refers the case to the CE. Where the OWCP-5 indicates that the claimant is able, or will be able, to work four hours or more, the nurse recommends vocational rehabilitation services. The SN may complete Form OWCP-14 to refer the case for vocational rehabilitation services, but may not sign the form. The actual referral remains the CE's responsibility.

If there are no job adjustment or medical problems, but the nurse has reason to believe that there is non-cooperation on the part of the claimant, he or she refers the case to CE for further action, presenting well reasoned justification for his or her opinion.

(5) The CE may decide that a conference call involving the injured worker, employing agency, Field Nurse, Staff Nurse, CE and Senior CE will help clarify return to work issues at this point.

d. Case Closure. Nurse intervention can result in various outcomes. If the intervention has been continuing in nature, the expected result is the return to work. In most instances, the claimant will return to the pre-injury position, with or without modifications, or to a light duty arrangement. Although it is possible that the worker will return to a position outside of his or her agency during the nurse intervention period, this is not considered likely. In a number of cases, the return to work will not occur within the intervention time frames. In both instances, the Staff Nurse will ultimately close the case from the nurse intervention viewpoint and refer it to the CE for further action.

(1) To ensure that the adjustment to work is satisfactory, contact is made with the claimant at least three times during the course of 60 days: on the first day of work, at the end of the first month and at the end of the 60 days. The Field Nurse will accompany the claimant to the facility on the first day back on the job. A meeting is held by the Field Nurse with all concerned (claimant, supervisor, injury compensation specialist) to confirm an understanding of the basis of the return to work requirements and to clarify roles.

Should the Field Nurse identify physical or psychological barriers, deterioration of the medical condition, or any other indication that the return to work may not be successful, he or she contacts all interested parties as necessary to resolve the issues within the 60 day time frame. Monitoring the return to work beyond this period requires CE approval.

(2) At the end of the 60 days or later if an additional follow-up period has been approved, the Field Nurse prepares a memorandum to the Staff Nurse describing the intervention, the type of work accepted by the claimant, and the date of the placement. In turn, the Staff Nurse forwards the memorandum to the CE assigned to the case, closes the case from a nursing viewpoint and notes the return to work in the tracking system.

(3) If the claimant does not return to work during the intervention, does not remain at work for 60 days, or does not accept the intervention or cooperate with the nurse, the Field Nurse prepares a memorandum for the Staff Nurse stating the problem and recommending closure of the case and a future course of action (second opinion, change of physician, referral to vocational rehabilitation, etc.) The Staff Nurse reviews the case and the Field Nurse reports, closes the case if warranted and advises the CE of the particular issues of the case and makes appropriate recommendations.

8. Extensions and Interruptions of Nurse Services. The nurse intervention will usually last 120 days or less. In catastrophic injury cases, or in cases where the time and/or dollar limits are exceeded by small amounts and it is clear that the claimant will return to work within a short period of time, the intervention may extend beyond this limit if the CE authorizes extensions of time or money.

Extensions of services may also be necessary or desirable in other cases to ensure that initial return to work is successful, or to help the claimant reach higher levels of physical capacity,

resulting if possible in return to full-time full duty. Extensions may also be granted if work-related surgery is necessary, or if the injury is a catastrophic one. Interruptions of services may be desirable because other medical conditions, either work-related or not, hinder the return to work effort.

a. Extensions.

(1) Initial Return to Work. The CE may approve a 30-day extension (60 days if requested so that the nurse can provide follow-up services after return to work). During this period, the Field Nurse may charge for 60 professional hours or \$3,000, whichever comes first.

(2) Increase in Duty Status. Where the claimant has not returned to full-time full duty, the FN should stress the need to return to maximum functioning and work potential. The FN should also continue to pursue increases in work tolerance limitations and obtain descriptions of them on Form OWCP-5 at periodic intervals if the claimant does not return to full-time full duty. These attempts should be made at approximately two to three week intervals unless the facts of the case suggest a different plan.

After the 60-day follow-up period ends, the FN may continue to work toward full-time full duty if the medical evidence shows that such an outcome is likely. The FN and the Staff Nurse should recommend additional time in increments of no more than 30 days each, up to a total of 60 days. The CE must authorize each increment.

(3) Need for Surgery. Below are listed some common surgical procedures and their usual recovery times. In general, the simple procedures should require no more than 8-10 hours of professional services within the 30-day period. The moderately complex procedures will require about 12-16 hours of services within the 60-day period. Since the complex procedures will typically result in work limitations which may warrant referral for vocational rehabilitation services, the FN should work toward stabilizing the claimant's condition and obtaining Form OWCP-5 in these cases.

TYPE OF SURGERY	PROCEDURE	EXTENSION
A. Simple, uncomplicated	Endoscopies, diagnostic arthroscopy, herniorrhaphy	30 day extension, for a maximum of 150 days
B. Moderately complex	Discectomies	60 day extension, for a maximum of 180 days

C. Very complex surgery or surgery with serious complications	Multiple fusions, open heart surgery, amputation of limb	Work with claimant until stable, then refer for rehabilitation services

b. Interruptions. Return to work may be affected by other medical conditions (work-related or not), including pregnancy. The CE must approve interrupted status, which should not continue more than six months. The status code "NIN" (Nurse Interrupt) should be used.

(1) Concurrent Conditions. For a concurrent non-work-related condition, or surgery (whether work-related or not), the SN should determine whether continued FN services will likely be needed within six months. If so, and the CE concurs, the SN should place the case in interrupted status until the time of expected recovery. (Interrupted status, rather than an extension, is appropriate since the claimant would require little or no active involvement by the FN during this time.)

(2) FN Actions. During the interruption, the FN should stay in touch with the claimant to monitor medical issues and maintain a focus on return to work. If surgery is involved, the FN will typically review the attending physician's orders with the claimant after surgery and monitor the claimant's course at home. Also, the FN may discuss the post-operative plan with the physician by telephone and monitor the claimant's compliance with these orders. The RN may perform these services up to five hours per month.

9. Communications between the CE and the RN. The Field Nurse should inform the Staff Nurse of the medical progress of the claimant and of issues which may hinder the recovery process. As necessary, the nurse should provide thoughtful recommendations for further action. An initial evaluation after the first contact with the claimant and the treating physician, and monthly reports thereafter are expected. For these reports, the nurse uses the Initial Evaluation and Progress Report Form shown in [Exhibits 1](#) and [2](#).

Periodically during the intervention and/or at the end of 120 days, the nurse and the CE or Staff Nurse will confer, either by mail, written memorandum or face-to-face meeting, to determine the next actions to be taken. The nurse is encouraged to communicate either with the CE or the Staff Nurse informally as well as by written report whenever this is necessary during the return to work effort.

10. Tracking the Nurse Intervention. Using the data described below, the Staff Nurse will be able to analyze various aspects of the program and obtain the basic statistics necessary to manage the nurse intervention effort. These statistics include: the numbers of claimants and nurses participating in the intervention program at any given time, the duration and result of the intervention by case or in a cumulative fashion in the district office, the rotation of cases among the Field Nurses and other data.

a. Claimant Data. From the moment a claimant is selected for intervention, the Staff Nurse or another designated individual must track the case through the Case Management File (CMF) Tracking System and, in district offices where it is installed, the Nurse Tracking System (NTS). The CMF system will include the dates on which the case is referred from the CE to the Staff Nurse and then to the Field Nurse. A return to work date is also captured on this system.

b. Field Nurse Data. Information regarding the Field Nurses should also be maintained, including the name of each nurse, his or her geographic location, and hourly rate.

11. Liaison Activities. By definition, case management includes the referral of certain injured workers for second opinion and referee examinations by medical specialists to ensure the appropriateness of the treatment plan, verify the level of disability and address other issues related to the medical recovery. To have the expected impact, these examinations need to occur on a timely basis.

At district office option, the Staff Nurse can assist this process by: actually scheduling these examinations; reviewing the outgoing CE questions and assessing the incoming medical reports; interacting with the medical community to acquaint them with FEC policies and procedures; and enlisting their participation in second opinions and/or referee examinations. The nurse may also coordinate with the DMD/DMA in identifying geographical areas requiring outreach activity and in assisting in the recruiting and retaining of physicians for second opinion referrals.

a. Scheduling Examinations. The use of the Physicians' Directory System (PDS), an automated directory and tracking mechanism, is mandatory in scheduling all referee examinations and is optional in the scheduling of second opinions. Details of this system are found in PM 3-500.7. The nurse should consult FECA PM 3-500.3 and 3-500.4 for the procedures to be used in scheduling second opinion and referee examinations respectively.

The CE determines the need for these examinations and prepares a list of questions to be answered by the examining physician. He or she should indicate the type of specialist required. Claimants are to be scheduled as close to home as is feasible (25 miles is considered reasonable in most urban areas). In rural areas, and in some urban areas with shortages of physicians, the claimant will have to travel over 25 miles.

b. Reviewing Outgoing Material. The nurse may review outgoing material for comprehensiveness of medical data and clarity of the questions posed by the CE. He or she may recommend changes and discuss issues with CE as necessary.

c. Tracking Second Opinion and Referee Examinations. Usually, 30 days is a sufficient time period after the second opinion or referee examination for the specialist to submit the report. Follow-up phone calls should be made in cases where no report has been received in the office within 30 days of the examination. Once received, the report should be reviewed in light of several factors:

(1) Timeliness is an important consideration in the assessment of the quality of medical reports. District offices may set their own criteria in this respect or use six weeks as the standard. Reports

that are not timely should be noted in the NOTES section of the PDS for monitoring purposes. If the physician is late in submitting the report, the nurse contacts his or her office and appraises him or her of this fact and obtains a copy of the report as soon as possible. However, if no report is forthcoming after a reasonable waiting period, the nurse notifies the CE for further action.

(2) Content is also crucial. When the report does not address all questions posed by the CE, or contains equivocal answers, the nurse so notifies the CE. Upon request of the CE, the nurse may notify the physician's office of these deficiencies and request clarification or completion of the report. This second request is also tracked and reimbursement for the examination may be withheld until clarification is obtained.

12. Supervising Field Nurses. The Staff Nurse is responsible for procuring, training and managing Field Nurses who will work directly with OWCP claimants in the return to work effort.

a. Procurement and Selection. The Staff Nurse develops a structure and a timetable for the procurement and selection of Field Nurses taking into account the geographic, volume, and operational requirements of the district office.

(1) Once the number and location of the Field Nurses needed has been determined, the Staff Nurse solicits the services of nurses through advertisements placed in local newspapers, occupational health journals or other nursing newsletters. Advertisements may also be distributed to local hospitals, universities, nursing schools and vocational rehabilitation companies. A sample advertisement to procure contact nurse services is included in Exhibit 3.

(2) Field Nurses must be selected according to standard criteria which include educational background, licensing, clinical experience, medical case management, and specific workers' compensation or occupational health experience. Selection criteria guidelines are detailed in Exhibit 4.

(3) All applicants should be appraised by the Staff Nurse and any other staff designated by the district office. The appraisals and the reasons for the selections must be well documented by the Staff Nurse.

(4) After the selection of candidates, the Staff Nurse ensures that each receives and signs a memorandum of agreement. The document details the various responsibilities of the nurse and the time frames within which he or she is to accomplish them. The agreement also details the nurse's hourly professional and administrative reimbursement.

b. Training Field Nurses. Most commonly training of Field Nurses is done at the district office location. The training for nurses contracted for this project should not exceed one and a half days since there is no effective way to reimburse them for their time. One day should be devoted to discussing various FEC policies and procedures and one half day should be allocated to addressing the nurse functions (report compliance and completion, billing forms and coding schemes).

In those areas where travel by the Field Nurse to the district office would require several hours or necessitate air travel, the Staff Nurse may wish to consider travel to cities where the Field Nurses are located. The length of training and the agenda topics should be the same. A suggested training outline has been enclosed as Exhibit 5.

c. Managing Field Nurses. Once Field Nurse selections have been made and memoranda of agreements have been signed, the nurse's name, phone and address need to be recorded into the Nurse Tracking System, where available, or into a manual log.

(1) Referring Cases to the Field Nurses.

(a) The Staff Nurse will refer cases to the Field Nurses using geographic rotation. However, sometimes the special needs of the claimant rather than locale may dictate the choice of nurse for a specific case. For example, a claimant with a psychiatric or neurologic disorder would benefit from the intervention of a nurse having this kind of expertise. In this instance, the case would be referred to the nurse having these qualifications rather than to the next nurse on the rotation.

(b) Once the selection is made, a letter which serves as an authorization to perform these services is forwarded to the nurse. This authorization letter reiterates the nurse's functions, responsibilities and reimbursement rate as listed in the memorandum of agreement. The authorization letter also includes the claimant's name as well as all available medical data for use by the nurse in his or her intervention. A sample of this authorization letter may be found in Exhibit 6.

(c) It is recommended that the Staff Nurse maintain a file on each Field Nurse. Data pertaining only to the nurse, e.g. memorandum of agreement, credentials, warnings or assessments of his or her work, can be kept in this folder. Any data pertaining to claimants must be referred to their files.

(2) Field Nurses' Reports. The Field Nurse should complete the Initial Evaluation Form, as shown in Exhibit 1, and return it to the Staff Nurse within 30 days after initial contact with the claimant and the physician. The Progress Report should be submitted to the Staff Nurse on a monthly basis. However, Field Nurses may submit verbal or written reports at any time to the Staff Nurse if issues needing immediate attention arise.

The Staff Nurse should have reviewed and clarified the elements of each of these reports during the Field Nurse training session. It may prove useful to review these data elements again when the case is referred. A supply of these forms may be included in the initial authorization packet or sent to the Field Nurse under separate cover with instructions for completion.

(3) Warning and Termination Procedures. The memorandum of agreement with FEC identifies the responsibilities of the Field Nurse. When any of these responsibilities are not fulfilled by the Field Nurse, the Staff Nurse needs to take immediate corrective action.

For example, the nurse's reports are consistently late or there has been no follow up either by phone or in person with the treating physician. Such delays may hamper possible return to work opportunities. The staff nurse needs to issue verbal warnings to the field nurse after the first two

violations, issue written warnings to the field nurse after the second two violations, and terminate the field nurse's working relationship with OWCP after the fifth violation, ensuring that there has been 30 days' prior written notice.

13. Other Medical Management Functions of the Staff Nurse. While the primary function of the Staff Nurse is to coordinate nurse services, there are other medically related activities which require his or her expertise. These areas include:

a. Complex Medical Bills. The automated enhancements to the medical bill processing system will suspend bills for a variety of medical issues. The nurse may be called on to evaluate such issues as: assessing the relatedness of a procedure to the accepted condition; clarifying the need for continued prior authorized services (physical therapy, TENS units, home nursing services); resolving excessive charges submitted by consultant physicians; and performing random quality control reviews of bills after payment approval.

b. Training on Medically Related Issues. The nurse may offer training to CEs and other district office staff on an as-needed basis using any of the following methods:

(1) A one-on-one session would be appropriate at the time a CE requested information pertaining to a treatment modality, i.e., a specific drug, diagnostic examination or operative procedure.

(2) An informal group session may prove helpful if the nurse is approached by a Supervisory CE (SCE) to assist the module in a specific issue, e.g., formulating the questions posed to treating, second opinion and referee physicians.

(3) Formal group sessions may be organized when the nurse identifies the expertise of a medical consultant, either in-house (DMD/DMA) or from outside the Office, and arranges for that doctor to discuss his or her specialty with the CEs and other office staff. Training by the nurse may also be initiated with new DMDs/DMA, contact representatives and office staff resolving bill problems.

14. Billing by the Field Nurse. Billing periods are to correspond to the report (either Initial or Progress) service periods, i.e., monthly, and the program will not accept bills that arrive without a report. A bill must not contain charges for services that fall outside the billing period or for unpaid balances from prior billing periods.

a. The following requirements must also be met for reimbursement approval:

(1) Form. The only acceptable billing form will be the HCFA-1500.

(2) Codes. Only the specific internal codes with appropriate terminology and dollar amounts designated for professional and non-professional services will be acceptable.

(3) Submission of Bills. A HCFA-1500 needs to be completed in duplicate for each claimant receiving nursing service. A duplicate report (initial/progress) must also be attached to the

duplicate HCFA form. The words "PROMPT PAY" should be written at the top and bottom of the original HCFA billing form. The envelope should also be marked "PROMPT PAY" to the attention of a designated individual. A sample of a correctly completed HCFA-1500 form is shown as [Exhibit 7 \(Link to Image\)](#).

15. Functional Capacity Evaluations (FCEs). These evaluations may be classified in two types according to their purpose, duration and content: a general-purpose FCE, and an FCE for placement into an Occupational Rehabilitation Program (ORP) such as Return to Work or Work Readiness (commonly called work-hardening, work conditioning, etc.)

a. A CE or SN may authorize a general-purpose FCE in cases where management of disability calls for clarification of job tolerances, job modifications, etc., and the treating physician, second opinion or referee specialist recommends or requires this service. However, only a Rehabilitation Specialist can authorize an FCE in connection with an ORP (see PM 2-813).

b. Before authorizing the FCE, the CE or SN should review the case and verify that the injury occurred more than three months ago, the functional impairment is of moderate to high complexity, and the services recommended by the physician exceed routine physical performance tests and measurements (e.g. CPT 97750). More detailed guidelines appear in Chapter 1 of MEDGUIDE.

c. The CE or SN advises the recommending physician that the FCE is approved. Based on the severity of the case and whether or not any complicating factors are present, up to eight hours can be approved for a general-purpose FCE.

d. The CE or SN completes the authorization form and enters the authorization in the "Notes" section of the Case Management File (CMF). To ensure the accurate processing of bills for the FCE, the following information must be included: the approved service code, the number of hours approved, the name of the provider, and, as necessary, the use of modifiers.

The CE or SN also notifies the Field Nurse (FN) assigned to the case of the authorization of the FCE and provides the FN with a copy of the authorization.

Exhibit 1: Initial Evaluation of Claimant

TO: NAME OF CE OR COORDINATOR	File #:
FROM: NAME OF NURSE	ICD Accepted Condition:
PHONE #: NURSE'S TELEPHONE NUMBER	
Claimant Name:	Address:
Primary Physician:	Address:

Phone:

Employer:

A. PERSONAL INFORMATION

Family Dynamics and Home Situation (detail only those factors which relate to claimant's return to work):

B. JOB HISTORY

Description of Injury (including date of injury):

INITIAL EVALUATION OF CLAIMANT, Continued

C. MEDICAL HISTORY

Current Medical Status (include consulting physicians)

History of Previous Injuries

Non-Injury-Related Medical Conditions

Current Medications

Physician(s) Contacts/Conclusions

D. NURSING CARE PLAN

Potential Problems

Recommendations

Planned Services During the Next 30 days

Planned On-site Visit to Agency/Work Site

Exhibit 2: Progress Record

Report Date:

Claimant Name:

Case File #:

Claimant Address:

ICD Accepted
Condition:

Name of Nurse:

Phone:

A. DATES OF SERVICE

From:

To:

B. SUMMARY OF PROGRESS TO DATE

C. ACTIONS TAKENDATESD. NURSING CARE PLAN

Planned Services For the Next 30 Days

Potential Problems Recommendations

Exhibit 3: Sample Advertisement for Nurse Services

The U.S. Department of Labor, Federal Employees' Compensation Program (FEC) is currently seeking to contract with nurses to work with claimants and their treating physicians to coordinate treatment, promote recovery and ultimately facilitate the return to work of the claimant.

An applicant must have the following minimum qualifications to be considered for this service: a registered nurse (R.N.) license; at least two years of general medical-surgical clinical experience; and at least two years of case management experience. Additional expertise desired includes: a basic knowledge of workers' compensation injuries and illness; excellent oral and written communication skills; good organizational and time-management skills, and proven decision-making abilities. Selection will be based on the combination of education and expertise that best meets the needs of the Department of Labor.

The hourly rate for a contract registered nurse is \$00.00 for professional services and \$00.00 for administrative services.

If you wish to pursue this opportunity, please submit your curriculum vitae showing the qualifications as listed above, along with a copy of your current nursing license to:

DISTRICT OFFICE ADDRESS

All applications must be received in this office no later than DATE.

If you need further information, you may contact:

NAME, TITLE AND PHONE NUMBER
OF DISTRICT OFFICE CONTACT

Exhibit 4: General Selection Guidelines

General Selection Guidelines

Describe qualifications under the following categories:

A. Nursing Degree (R.N.) License Number _____

B. Clinical Experience Dates

Specialty

General Medical-Surgical

Emergency

Critical Care Unit (CCU, ICU, etc.)

Other

C. Positions Held Dates

Staff Nurse

Team Leader

Head Nurse

Other

D. Additional Experience Factors

- demonstrates in the C.V. that he/she has medical case management experience.

- shows workers' compensation case experience through past positions held, e.g. with DOL, State or private sector carrier.

Exhibit 5: Suggested Training Topics

SUGGESTED TRAINING TOPICS

A. Introduction

- Overview of Nurse Intervention
- Objectives of the Training

B. Training Outline

The Federal Employees' Compensation Program: CA-810 and CA-550

1. Coverage of FECA

- Constituency (variety of occupations)
- Kinds of Claims--traumatic, occupational diseases
- Kinds of Benefits--compensation, medical, vocational rehabilitation etc.
- Philosophy of the program--non-adversarial
- Organization of program; geographical distribution, district office structure

2. How claims are adjudicated and managed (brief description)

- Notice of Injury
- Forms CA-1 and CA-2
- Acceptance, ICD diagnoses codes
- Continuation of Pay
- Compensation, short/long term
- Reemployment and Vocational Rehabilitation

3. Nurse Intervention Process

- Roles/responsibilities
- Reporting Mechanisms
- Claimant/Physician Communication
- Billing Procedures
- Security of Files
- Schedule for additional training/problem-solving sessions

4. Tour of the District Office

Exhibit 6: Sample Letter Authorizing Nurse Services

Case File #:
Claimant Name:
Employing Agency:

Dear NAME OF NURSE:

This letter serves as a referral and authorization to you to provide medical management services to the above-named injured worker. It also serves as notification that you may contact the treating physician to coordinate the medical treatment, and the employing agency to clarify the requirements of the injured worker's job. As previously discussed, your hourly rate will be \$00.00 for professional services and \$00.00 for non-professional charges. There is a \$3,000 or 60 hours of nursing service maximum limit per case. On an exception basis, one extension only can be authorized, so that the total services per case may not exceed 120 hours or \$6,000.

In case(s) assigned to you, your responsibility will be to communicate directly with the injured worker and his/her family as deemed necessary to explain and monitor medical treatment and progress. As needed, you will obtain concrete work limitations and communicate directly with physician and agency about light duty opportunities.

Enclosed is a summary of case information and the significant medical reports for your official and confidential use. This information must be kept in a secure location which only you have access to. When the case is closed, please return the case information to this office. The case information supplied to you is the property of OWCP and cannot be discussed with parties other than the claimant, (claims examiner/ coordinator), physician and employing agency.

Should you have any questions or comments regarding the contents of this letter, please contact NAME OF CE OR COORDINATOR on PHONE NUMBER.

Sincerely,

STAFF NURSE

[Exhibit 7: Prompt Pay Authorization \(Link to Image\)](#)

Chapter 3-0202, Contract Field Nurse Certification

1. Purpose and Scope. The program uses contract field nurses to perform nurse intervention in Quality Case Management (QCM) cases as well as in other case management initiatives. This chapter describes and standardizes the Office of Workers' Compensation Programs' (OWCP's) procedures for soliciting, recruiting and selecting contract field nurses.

In addition, the chapter also defines the role of the staff nurse in managing and tracking the activities of the contract field nurse.

Each district office will contract with the specific number of nurses which have been identified as the number needed to adequately serve the injured workers within a specific geographical area. The staff nurse will act as the coordinator at the district office level. The National Office will assist in the certification process by coordinating the solicitation for contract nurses on a national basis, sending out the application packet to applicants and responding to certification questions or concerns raised by the staff nurse or other individuals.

2. Certification Process. The certification process provides for a standardized approach for procuring the services of contract field nurses. This process consists of soliciting, recruiting, selecting and contracting with registered nurses to work with claimants. The contract or memorandum of agreement is valid for a period of two (2) years. After this initial period, field nurse services may be renewed yearly for three option years. National certifications of field nurses occur at five (5) year intervals, however the individual district offices may hold local certification drives when needed. The staff nurse determines that additional field nurses are necessary to fulfill specific needs when:

- a. Field nurses voluntarily withdraw from OWCP's program and need replacement.
- b. The number of claimants requiring the services of a field nurse increase in a certain geographic area.
- c. The performance of a field nurse (late reports, refusing case referrals) may prompt the staff nurse to discontinue referrals to particular nurses and require additional recruitment.
- d. Option year attrition occurs.

Once the need for a local certification drive is established, the district office submits a memo requesting additional field nurses to the Chief, Branch of Medical Standards (BMSR) in the National Office for consideration. The letter must contain: the anticipated dates and location of

the training, the geographic areas involved by zip code clusters, and the number of field nurses needed to satisfy the additional need. After the request is approved, the Chief, BMSR, determines the schedule for the additional certification training workshop and ensures the availability of adequate support resources.

3. Field Nurse Allocation. The FEC staff nurse (SN) in each district office determines the number of field nurses (FN) needed for each geographical area and reports the number to BMSR. The staff nurse may use the same allocation or clustering established for the vocational rehabilitation counselors. A cluster consists of a number of adjacent zip codes grouped together based on reasonable size, ease of travel within the cluster, and the number of claimants located within this area. Once the geographic unit or cluster is established, automated reports detailing the number of claimants residing in the cluster can be obtained. The staff nurse uses this information and her own experience to establish the number of nurses needed in the cluster. This number is then reported to BMSR.

4. Recruitment. Solicitation for the services of registered nurses to perform contract field nurse activities is made both at the National and District Office levels.

a. The Chief, Branch of Medical Standards and Rehabilitation (BMSR), places the advertisement in the Commerce Business Daily and in other selected national publications (ANA newsletter, National Black Nurses' Association newsletter, etc.)

b. The district office conducts advertisement at the regional level in local nursing organization newsletters, and newspapers. The names of nurses who have previously expressed interest in joining the program should be maintained in a file so that they are included in the district office solicitation. Field nurses who are currently certified also need to be mailed a copy of the advertisement by the district office.

c. The advertisement contains the minimum qualifications required, the geographical region(s) for which the field nurses are needed, instructions for responding and a response due date. If the district office plans to conduct interviews as part of the selection process, this also needs to be mentioned in the advertisement.

d. BMSR receives the responses to the advertisement, categorizes these responses by geographic area and distributes a list to the district offices. BMSR sends all timely respondents an application package. Only responses postmarked on or before the due date are processed further; late respondents will be notified that they are not eligible for this certification but will be notified when an advertisement is placed for the next certification. The DO staff nurse maintains alphabetically organized late response files for this purpose.

5. Nurse Selection Method.

a. The Staff Nurse in each DO acts as the coordinator for the selection process. Upon receipt of the completed application forms (OF-612 is shown in Exhibit 1 ([Link to Image](#))), the staff nurse, or designated district office staff, compiles them by geographic area/cluster, ensuring that only

applications received on a timely basis are included. Late applications will not be rated and the applicants will be sent a postcard by the district office explaining the rejection.

b. The Field Nurse Panel evaluates the applications from the field nurses based on pre-determined criteria and selects qualified candidates to be part of the OWCP nurse intervention program. The panel is composed of the district office staff nurse and national office staff. The panel members evaluate each application independently, and then, via telephone, reach a consensus regarding the ranking of the field nurse candidates. As needed, a third panel member may be used in those circumstances when a "tie-breaker" decision is needed.

c. The panel uses the scoring sheets (see Exhibits 3 and 4) to rate each application considering the following factors: work experience in case management, specialized nursing skills, educational background and certifications. The first step in the rating is to verify that the applicant meets the minimum requirements by checking Block 13. If no R.N. license number is listed, or if there is no photocopy of the license attached, the reviewer does not proceed and the applicant is disqualified.

In addition, the other minimum requirements of two (2) years generalized medical/surgical clinical experience and two (2) years in case management or an equivalent (Block 8) need to be clearly indicated in the applicant's work experience. Absent these factors, the applicant is disqualified. An unsatisfactory performance evaluation should be grounds for non-selection.

d. The specific aspects of how to score experience and education are detailed further on the instruction sheet attached to the rating form (see Exhibit 2). Each member needs to obtain a copy of the candidates OF-612 application form and the rating sheet. Data contained on this sheet is self-explanatory. However, it is important to document reasons for disqualifying an applicant. It is also important to indicate the reason(s) for 0 points in any category. When the rating process of an application is completed, panel members total the number of points awarded in each section, sign and date the rating form.

e. Ranking and Selection.

(1) Panel members rank the qualified applicants by the total number of points awarded on the application form, placing the applicant with the most points at the top of the list. In cases where applicants receive identical scores and one is above the cut-off line but the other is not, each is selected for certification.

(2) Once the list is completed, panel members draw a cut-off line so that the number of applicants above the line corresponds to the number of field nurses that the district office wants to certify.

(3) All application materials are returned to the staff nurse coordinator.

(4) The staff nurse takes the applications of those considered qualified and verifies the accuracy of the licenses with the applicable state licensing board for currency and good standing status. In addition, the name and/or company which employs the field nurse needs to be checked against

the U.S. General Services Administration (GSA) list of Excluded Parties From Federal Procurement Programs. This monthly publication identifies those parties excluded throughout the U.S. Government from receiving Federal contracts. If the nurse or company employing the nurse appears in the book, the applicant cannot be selected. A field nurse who is not selected for this reason needs to be notified that his or her non-selection was based on this information. The publication can be procured from the regional OASAM office or electronically from G.S.A.

6. Interview.

a. At this point in the selection process, the staff nurse may interview those eligible candidates in the office's regional jurisdiction who are within a competitive range. For the purpose of nurse certification, a competitive range is defined as the number of nurses who are qualified and selected plus those who are qualified but not selected. Within this group the staff nurse defines a fair and reasonable number of nurses to interview. To do this, the staff nurse considers her own time constraints and the availability of the candidates. Since an interview is a subjective process, and the points earned from this process should not substantially alter the original rating score. For this reason, the points assigned to an interview should not exceed three (3).

b. The selecting official (staff nurse) has the authority to determine the extent of the competitive range based on a fair and reasonable estimate. For example, if the pre-determined number of nurses for a specific area is 10, and 15 applicants are found qualified, the interview should include all 15. However, if the pre-determined number for an area is 10 and 35 applicants are eligible, it is not reasonable to interview the 25 additional applicants.

c. Questions posed during the interview must:

(1) Be the same for everyone.

(2) Relate to job performance, the strengths/weaknesses the applicant brings to the job, and what is expected of him or her.

(3) Be documented together with the applicant's response.

7. Notification to Applicants. At the conclusion of the rating or interview process, whichever is the final selection factor, all nurses are notified of their individual status. Nurses selected for the program are made aware of the selection and given the necessary information on the certification training workshop. Those not selected will be given reasons for this action. Sample acceptance and denial response letters are included in Exhibits 5 and 6.

8. Certification Training Workshop. The certification process ends with the training workshop. Throughout the course of the certification process, the staff nurse prepares for the training session. A suggested organizational time table has been developed for the staff nurses' use in planning the workshop and can be referenced on Exhibit 7.

The training will typically last only one day since there is no effective way to reimburse the nurses for their time. The training is divided into two parts: a description of the FEC policies and procedures, and the contract nurse responsibilities (e.g. report compliance and completion, billing forms and coding schemes, etc.) At the completion of the Certification Workshop the staff nurse ensures that all newly certified field nurses sign and date a new memorandum of agreement. It is at this expiration date that the option years begin.

It may be necessary to conduct the workshop more than once if the number of nurses is very large or if the geography is such that prolonged travel is required to reach the city where the training is held.

9. Option Year Renewal. On each option year the staff nurse will need to decide whether to renew the services of each field nurse. To do that, the staff nurse reviews the field nurse's work performance in terms of timeliness, quality, billing characteristics, intervention successes, compliments or complaints received from employing agencies, claimants, FEC staff, presence or absence of verbal and/or written warnings. This yearly evaluation is a composite of all the case-related evaluations performed when a case is either closed or transferred to another field nurse. A sample of this evaluation is found on Exhibit 8. Each field nurse is notified by letter as to whether his or her contract was renewed or not for the option year.

If the contract is renewed, the field nurse signs another memorandum of agreement providing the staff nurse with updated information (R.N.license expiration date, home address/phone changes). The staff nurse also assesses whether another training (abridged) session is necessary. Applicants will be notified if a training session is planned. BMSR also needs to be made aware of the

10. Contract Field Nurse Management. Staff nurses will be responsible for the managing of contract field nurses within their geographical jurisdiction. The staff nurse will: maintain all manual and automated records referring field nurses, generate case referrals, supervise their work performance and provide them with periodic reviews, reserving the authority to terminate those field nurses whose performance is not in keeping with OWCP policies and procedures. A more extensive explanation of the staff nurses responsibilities in managing the field nurse activities may be found in the FECA PM Chapter 3-0201.

11. Referring Cases to the Field Nurses.

a. The staff nurse will refer cases sequentially to the field nurses using a geographic rotation. The district offices may use an automated system, i.e., Rehabilitation Tracking System (RTS), Nurse Tracking System (NTS) or maintain the rotation through use of a manual log.

The rotation is based on a geographic match between the first three digits of injured worker's zip code and that of the field nurse. Ideally, the field nurse should be located within 25 miles of the injured worker's residence but may be located as far away as 50 miles. If there are no available field nurses within a 50 mile limit, the staff nurse may refer the case to the field nurse having the best method of access to the injured worker even if that nurse is located in a different zip code area. This situation typically occurs when the injured worker is on the border of one geographic

cluster, it may be more efficient in time and money to assign a field nurse from a different zip code range or cluster since it is closer geographically.

b. Sometimes the special needs of the claimant rather than locale may dictate the choice of a nurse on a specific case. When a particular case requires special skills or knowledge that the next field nurse in sequence does not possess, the staff nurse may select the field nurse out of sequence. Documentation as to the reason for not following the rotation needs to be maintained in whatever system is in use (manual or automated system) in the district office.

c. Once the case assignment is made, a letter which serves as an authorization to perform these services is forwarded to the field nurse. This authorization letter reiterates the nurse's functions and responsibilities as listed in the memorandum of agreement. In addition to the authorization letter, the field nurse will also receive relevant CA forms, all available medical data (reports and objective findings) and the Form OWCP-5.

d. The staff nurse maintains a file on each field nurse. Data pertaining to the nurse such as a copy of memorandum of agreement, credentials, warnings and/or assessments of his or her work can be kept in this folder.

12. Tracking the Field Nurse Intervention. Using the data described below, the staff nurse will be able to analyze various aspects of the program and obtain the basic statistics necessary to manage the nurse intervention effort. These statistics include: the number of claimants and nurses participating in the intervention program at any given time, the duration and result of the intervention by case or in a cumulative fashion, the rotation of cases among the field nurses and other data.

a. Claimant Data. From the moment a claimant is selected for nurse intervention, data is entered by the CE on the QCM screen. The staff nurse will also enter information on the name of the field nurse and the date the case was referred out. A return to work date is also captured on this screen.

b. Field Nurse Data. Information regarding the field nurses should also be maintained including the name of each nurse, home address, phone number and geographical location.

13. Warning and Termination Procedures. The memorandum of agreement with OWCP identifies the duties and responsibilities of the field nurse. When any of these responsibilities are not fulfilled by the field nurse, the staff nurse needs to take immediate corrective action in the form of a warning. At any point in the warning/termination process, the staff nurse may opt to decrease the workload of the field nurse as an incentive for a change in behavior. The decrease in workload needs to be documented and maintained only for a finite time period. If the field nurse's work improves, she is restored to the rotation. If there is no improvement, the staff nurse proceeds with the verbal warnings. If there is a serious violation of ethics such as breach of confidentiality, falsifying documents or other fraudulent activities, dismissal is immediate.

The staff nurse needs to document each stage of the termination process by entering the date and type of violation and the date and type of staff nurse response (verbal warning, final letter etc.)

- a. Verbal Warning. The staff nurse may issue a verbal warning when the field nurse demonstrates a lack of professionalism or violates any of the conditions in the memorandum of agreement.
- b. First Termination Warning Letter. The staff nurse will send the "First termination warning letter" after he/she has issued a verbal warning within a twelve-month period and the field nurse continues to demonstrate a lack of professionalism or violates the conditions of the memorandum a second time. Copies of this letter are placed in the field nurse's file.
- c. Final Termination Letter. The staff nurse will send a termination letter when the field nurse continues to demonstrate a lack of professionalism or violates conditions of the memorandum again within twelve months after receiving the first termination warning letter. The staff nurse calls the field nurse and advises that, as of the date of mailing, no further services should be provided or billed for because his or her cases have been transferred to another field nurse. A copy of this letter is also placed in the field nurse's file and sent to the Regional Director and Chief, BMSR.
- d. Reconsiderations and Appeals. The field nurse may request a reconsideration or appeal within 30 days after receiving a termination letter or, in the case of appeals, a reconsideration decision. A reconsideration request should be accompanied by relevant evidence to support the field nurse's arguments. The Regional Director will decide all reconsiderations within 90 days of receiving the request. The Director, Planning, Policy and Standards Division in the OWCP's National Office will decide all appeals based on the evidence of record within 90 days of receiving the request.

Exhibit 1: Optional Form (OF) 612 Application Form ([Link to Image](#))

Exhibit 2: Completion Instructions For Optional Form 612

INSTRUCTIONS TO APPLICANTS:

This application form is being forwarded to you in response to the OWCP solicitation to contract with registered nurses for early intervention of injured employees.

Please complete only those items listed below and return to (Name/Address of the District Office) postmarked no later than (Insert Date).

The information which you submit on this OF-612 Application Form will be compared to the minimum requirements developed by OWCP for contract field nurses. The minimum requirements are:

1. Evidence of two years' specialized case management experience (experience can be in workers' compensation, occupational or community health, utilization review, discharge planning or rehabilitation nursing (Block 8).
2. Evidence of two years' general med-surgical clinical experience (Block 8).
3. Evidence of a valid, current R.N. license. Your R.N. license number(s) needs to be present in Block 13 or a photocopy of the license needs to be attached to the application.
4. All applications must be accompanied by your latest performance appraisal. If this appraisal is more than five years old, please submit three letters of reference from three clients (employers).

Failure to meet the above requirements or to return the form by the deadline date will result in disqualification of your application.

<u>ITEM NO.</u>	<u>EXPLANATION</u>

4, 5, 7	Personal data--self-explanatory.
6	Applicant's home address (NOT employer's).
8	(Include prior work with OWCP)

In describing your most recent work experience, CLEARLY indicate evidence of:

(1) case management skills (identify experiences in workers' compensation, occupational or community health, utilization review, discharge planning, rehabilitation nursing.

(2) at least two years in general med-surgical nursing.

(3) any specialized clinical nursing expertise e.g. ICU, CCU, neurology, orthopedics, psychiatry.

Additional sheets may be used if necessary

10-12	Educational Data. Self-Explanatory. This section must at a <u>minimum</u> indicate that applicant attained: Associate Degree, Diploma or Bachelor's Degree.

Graduate level degrees will be awarded points on the highest level of college work completed.

13	Other Qualifications. An additional sheet may be used for this section if necessary.

**** At a minimum this block MUST contain an R.N. license number(s) or a photocopy of the R.N. license must be attached. If this info is missing, applicant is disqualified.**

Additional items to address in this area include:

(a) when applicable, certification credentials, e.g. COHN, CCM, CIRS etc.

(b) special skills when applicable e.g. psychiatric, catastrophic nursing expertise.

18

Signature.

This certifies that all information completed in the specific blocks is correct.

Exhibit 3: Scoring Instructions for Contract Field Nurse Applications

SCORING INSTRUCTIONS FOR CONTRACT FIELD NURSE APPLICATIONS

Introduction

These sheets will be used by the reviewer to score the applicant's information submitted on the Optional Form (OF) 612 and supplemental sheets.

Information on the OF-612 will be compared to the minimum requirements developed by OWCP for contract field nurses. The minimum requirements are:

1. Evidence of two years' specialized case management experience (experience can be in workers' compensation, occupational or community health, utilization review, discharge planning or rehabilitation nursing). (Block 8)
2. Evidence of two years' general med-surgical clinical experience. (Block 8)
3. Evidence of a valid, current R.N. license. R.N. license number needs to be either present in Block 13 or a photocopy of the license needs to be attached to the application.
4. The latest performance appraisal. If this appraisal is more than five years old, three letters of reference from three clients (former employers) MUST also be enclosed.

In scoring the application, it is important for the reviewer to first check to see if the work experiences indicating case-management and med-surgical expertise as well as the R.N. License Number/photocopy of license are present. If any of these factors are NOT present, the candidate is disqualified and no further review of the application is necessary.

Exhibit 4: Scoring Sheets

SCORING SHEETS

The following three items reflect the minimum requirements and must be clearly indicated on applicant's form. If any of the three items are not present, discontinue your review, applicant is disqualified.

<u>Block #</u>	<u>Data</u>	<u>Score</u>
8	Review for Specialized Experience Applicants must show two years' case management work, e.g., Workers' Compensation, Occupational/Community Health, Utilization Review, Disc. Plan., Rehabilitation Nursing. ** If none appear, Disqualify	N= 0
	If 2-3 years' experience	2
	If 3 + years' experience	3
	Review for Med-Surg Experience Applicant must clearly show minimum of two years' general med-surg. work ** If none appear, Disqualify	N= 0
	If 2-3 years' experience	2
	If 3 + years' experience	3
13	Check for R.N. license numbers ** If no license number is indicated or photocopy of the license is not attached, Disqualify	N= 0 R.N.#=1
The additional items are to be scored in addition to the above requirements.		
4-7	Personal Data	N= 0
8	Work Experience	
	Review for previous work with OWCP - accepts cases most of the time (85%)	Y= 1 N= 0
	- reports/communication timely & complete	Y= 1 N= 0
	- billing accurate & timely (85%)	Y= 1 N= 0
	- works well with claimants, staff, physicians, employing agencies	Y= 1 N= 0
	- no previous OWCP work experience	N= 0
	Review for additional areas of clinical expertise in any of these areas, e.g., orthopedics, neurology, neurosurgery, psychiatry, ICU, CCU. If 1-2 years' experience	1
	If 3 + years' experience	2
10-12	Educational Background--	

Review for evidence that applicant earned at least one:

Associate Degree

Diploma

Bachelors Degree

2

Additional points will be given for the highest level of college work completed, e.g.:

Masters Degree

1

Ph.D Degree

2

- 13 In addition to R.N. license number(s), Other Certifications related to case management may be entered here, e.g.,
 Certification in Occupational Health--COHN,
 Certification in Case Management--CCM,
 Certified Insurance Rehab. Spec.--CIRS.

No additional points will be given for this now but at next certification additional points will be given.

Total Points=

Name of Reviewer _____

Date of Review _____

Exhibit 5: Sample Response To Field Nurse--Acceptance

Dear FIELD NURSE:

I am pleased to accept you as an OWCP contract field nurse. To complete the certification process, a training workshop is planned for:

DATE: _____

TIME: _____

PLACE: _____

Please detach and return the lower portion of this letter to me at the above address. Your workshop reservation must be postmarked by the following date: _____

You may contact me at ____ - ____ - ____ if there are any questions on this workshop.

Sincerely,

STAFF NURSE

____ I will attend the workshop. ____ I will not attend the workshop.

Please print your name:

Home Address:

Exhibit 6: Sample Response To Field Nurse--Denial

Dear FIELD NURSE:

Thank you for your interest in the Office of Workers' Compensation Programs' (OWCP's) nurse intervention program. As a result of the certification process, I am unable to select you to provide services to OWCP injured workers for the reason (s) indicated below:

____ You are qualified for selection. However, we selected the maximum number of field nurses needed to provide services within the geographical area of the District Office. You may be selected at a later date if we have a need for new field nurses.

____ Your application did not meet our minimum qualifications based on either case management and/or med-surgical clinical experience.

____ Your application was incomplete.

Your response to our solicitation for contract field nurses to provide services to our injured workers is appreciated.

Sincerely,

STAFF NURSE

Exhibit 7: Organizational Timetable For Certification Process

<u>WEEKS TO WS</u>	<u>ACTION</u>	<u>STATUS</u>
10 weeks	1. Determines the number of or earlier field nurses, presents geographic distribution plan to RD, NO.	
	2. Advertises Contract Field Nurse Position in local nursing journals, newsletters, newspapers etc.	
9 weeks	3. Coordinates date and location of the workshop with DO and NO.	
	1. Confirms attendance of district and NO staff (BMSR) who will deliver welcoming and closing remarks, as well as part of the actual training.	
	2. Reserves space for the workshop, preferably in a Federal Building.	
	3. Ascertains that all necessary furniture, equipment, and supplies will be available.	
7 weeks	1. Rejects incomplete applications.	
	2. Refers completed forms to panel for evaluation and ranking.	
	3. Organizes application materials after panel completes selection.	
	4. Creates folder for "Selected" Applicants.	
	5. Creates additional folders marked "Qualified-Not Selected" and "Disqualified" Applicants.	
5 weeks	1. Completes/mails acceptance letter or earlier which includes date/time/place of training workshop. Include to <u>whom form should be returned and by what date</u> (should be no later than three weeks before the workshop).	
	2. Sends notification to the "Qualified-Not Selected" and "Disqualified" applicants. Advise they may discuss non-selection with staff nurse or file written appeal for BMSR review.	

2 weeks	1. Compiles training materials, draws up final agenda, sends this information to BMSR for concurrence. 2. Makes sure all available spaces for the workshop are filled. 3. Prepares Workshop Attendance Log. 4. Contacts FNs who did not respond to the letter and verify their attendance. 5. Notes the reason for non-attendance on the log and replace with field nurses from the "Qualified-Not Selected" folder. Confirm new FN attendance by phone and add name on the Attendance Log and whom he or she is replacing.
Day Before Workshop facility	1. Checks the physical location and set-up of the training 2. Reminds speakers of the time/place of the workshop.
Workshop Day	1. Supervises the sign-in procedure for attendees. 2. Distributes materials and acts as resource person. 3. Conducts sessions. 4. Ensures all participants complete and sign a Memorandum of Agreement. 5. Checks that each participant has provided you with his or her phone number and home address.
After Workshop	1. Ensures that all pertinent FN information is entered on either the RTS or district office tracking system.

Exhibit 8: Contract Field Nurse Evaluation Form

CONTRACT FIELD NURSE EVALUATION FORM

F.N.'s Name: _____

I.W.'s Name: _____

Claim File: _____

Instructions: This evaluation form should be completed when the FN submits the closure report or when the case is assigned to another field nurse or transferred to another district office.

Did the FN: Yes No N/A

1. Respond timely to the request for case referral?
 2. Communicate timely and effectively with IW, AP, EA, SN, CE and other parties?
 3. Identify problems which could affect the RTW promptly and accurately?
 4. Offer good problem-solving techniques and/or offer viable recommendations to OWCP?
 5. Only make commitments based on the written approval and authorization of OWCP?
 6. Provide and coordinate necessary services (e.g., schedule of second opinion exams) without delay?
 7. Follow the directions of the SN and CE?
 8. Submit reports and bills timely and accurately?
-

Chapter 3-0300, Authorizing Examination and Treatment

1. Purpose. An injured employee is entitled to receive all medical services, appliances or supplies which a qualified physician prescribes or recommends and which OWCP considers necessary to treat the work-related injury. The purpose of this chapter is to describe the circumstances under which OWCP or, in some instances the employing agency, may authorize medical services for injured claimants. See 5 U.S.C. 8103.

2. Requests for Authorization. While claims personnel may receive a request for examination and treatment, the majority of such requests are received initially by the Office of Workers' Compensation Programs' (OWCP) designated bill processing agent.

a. Types of Treatment Requested.

(1) Routine Medical Care Routine medical services such as office visits, physical therapy, and requests for durable medical equipment are reviewed by OWCP and its designated bill processing agent to determine whether the treatment is consistent with the accepted work related conditions. If the treatment can be approved, an authorization letter is issued. If the treatment cannot be authorized, the requestor may submit further medical documentation for consideration.

(a) Any qualified physician or qualified hospital may provide such services, appliances and supplies. Non-physician providers such as physicians' assistants, nurse practitioners, and physical therapists may also provide authorized services for injured employees to the extent allowed by applicable Federal and State law, but this does not include certification for periods of disability, unless such is provided with the concurrence of a physician. See 20 CFR 10.310.

(b) A clinical psychologist may serve as a physician only within the scope of his or her practice as defined by State law. Therefore, a clinical psychologist may not serve as a physician for conditions that include a physical component unless the applicable State law allows clinical psychologists to treat physical conditions. A clinical psychologist may also perform testing, evaluation and other services under the direction of a qualified physician.

(c) A specialist in the field of occupational medicine can serve as a treating physician and prescribed treatment may be authorized. As a sub-specialty under the Board of Preventive Medicine, occupational medicine physicians are specialists in the field of workplace injuries and illnesses and their causal associations. They also specialize in assessing an employee's ability to work.

(2) Emergency. If an emergency exists, the Claims Examiner (CE), in consultation with a District Medical Advisor (DMA) as needed, may authorize treatment. Otherwise, the requestor should be advised that the physician should submit a written request detailing the type of treatment recommended and the reason it is needed.

Authorization is sometimes requested for a non-emergency procedure scheduled for the immediate future. If the authorization cannot properly be given by the date in question, the requestor should be asked to submit a written request as described above and advised that if the request is approved, payment may be authorized after the fact.

(3) Surgery. Authorization for surgery should be obtained in advance whenever possible in order to ensure payment. Even if surgery is undertaken without OWCP approval, however, the cost may be reimbursed if the procedure is later found to be acceptable. See FECA PM 2-0810 and 3-0400 for a description of the criteria used to determine if surgery should be approved.

(4) Chiropractic Services. Services of chiropractors that may be reimbursed are limited by the Federal Employees' Compensation Act (FECA) to treatment for the correction of spinal subluxation. The costs of tests performed by or required by a chiropractor to diagnose such a subluxation are also payable. A chiropractor may also provide services in the nature of physical therapy, but only under the direction of, and as prescribed by, a qualified physician. See 20 CFR 10.311.

(5) Attendant Services. Attendant services will be considered for payment as long as the personal care services have been determined to be medically necessary and are provided by a home health aide, licensed practical nurse, or similarly trained individual, subject to requirements specified by OWCP. OWCP will pay for the services of an attendant under section 8103 of the Act, instead of section 8111(a). See 20 CFR 10.314. Note that any existing attendant allowance payments made under 5 U.S.C. 8111(a), initiated prior to January 4, 1999, will continue.

b. Contractual Obligation. Authorization by OWCP for medical examination and/or treatment constitutes a contractual agreement to pay for the services if the services are rendered, regardless of whether a compensable injury or condition exists. Moreover, any medical condition resulting from authorized examination or treatment (such as residuals from surgery) may form the basis of a compensation claim for impairment or disability, regardless of the compensability of the original injury. For both of these reasons, great care must be exercised in authorizing medical examination and/or treatment. See *Frederick J. Williams*, 35 ECAB 805 (1984) [Where appellant's official supervisor authorized appellant's examination by the Medical Center on the date of the alleged injury, this created a contractual obligation to pay for the cost of this examination regardless of the ultimate action taken on the claim.]

c. Documentation. A CA-110, Report of Call, or a memorandum to the file must be completed by the CE to document all telephone calls concerning authorization or denial of examination and/or treatment. Usually, however, an authorization letter is issued by OWCP's designated bill processing agent.

Copies of letters of authorization addressed to physicians and medical providers are not usually sent to the employing agency. They may be provided on request to the claimant or representative. A letter of authorization will always be used to arrange for examination of an employee and/or review of the case file by a specialist.

d. Field Nurses. OWCP may also utilize the services of a Field Nurse (FN) in facilitating and coordinating medical care for the injured employee. See FECA PM 2-0811 for more information on Field Nurse services.

3. Form CA-16, Authorization for Examination and/or Treatment. Form CA-16 is the vehicle by which the employing agency authorizes initial examination and/or medical treatment at OWCP expense. It is used to refer an employee who sustains a traumatic injury to a local physician or hospital of the employee's choice. The employer may not authorize examination or medical treatment in any case that OWCP has disallowed.

a. Traumatic Injury.

(1) Period of Authorization. Form CA-16 authorizes treatment for 60 days from the date of injury, unless OWCP terminates the authorization sooner. The Office has a contractual obligation to pay for medical services and instructs physicians to contact the district office for extension of that period. *K.D.*, Docket No. 11-16 (issued August 16, 2011) [While the chiropractor's report was insufficient to establish that the May 5, 2010 MVA caused or aggravated a diagnosed medical condition, the Form CA-16 authorization from the employing establishment created a

contractual obligation to pay for the cost of necessary medical treatment until OWCP terminated the authorization of medical treatment on June 21, 2010.]

(2) Effect of Adjudication. Once a case is accepted, the period of authorization is automatically extended to cover necessary services for the accepted condition, and additional authorization is not necessary unless requested by a provider in a specific case. If a case is denied, however, authorization for further treatment must be revoked even though 60 days have not elapsed.

(3) Emergency Circumstances. Form CA-16 may be used to authorize treatment in cases of a doubtful nature, and in emergencies or unusual circumstances by completing Form CA-16 and checking block 6B of the form.

OWCP may approve payment for medical expenses incurred even if Form CA-16 has not been issued and the claim is subsequently denied. Payment in situations meeting these criteria must be determined on a case-by-case basis (see *Val D. Wynn*, Docket No. 88-1813, issued March 10, 1989). *D.P.*, Docket No. 11-50 (issued October 26, 2011)

(ECAB held that although there was insufficient rationalized medical evidence to establish appellant's claim of injury, OWCP failed to consider whether emergency or otherwise unusual circumstances were present such that reimbursement of medical expenses would be appropriate even though a CA-16 had not been issued in this case.)

For example, if an employee sustains an injury due to a car accident while on travel and a CA-16 is not issued, OWCP should consider whether payment of expenses is appropriate.

b. Occupational Disease. Form CA-16 should not ordinarily be used in occupational disease claims. The employing agency must contact OWCP for instructions on providing treatment in cases where an occupational disease is claimed. Only in exceptional circumstances will OWCP permit the employing agency to issue Form CA-16 for examination and/or treatment in these circumstances.

c. Excluded Providers. If Form CA-16 is inadvertently released to an excluded provider, the bills should be paid, but a letter rescinding the authorization should be released immediately to the claimant and provider.

4. Prohibited Authorizations. No authorization for medical care may be given unless a notice of injury or occupational disease has been or is about to be filed (that is, a notice of injury has been completed and is in possession of the employing agency). The following kinds of authorization are prohibited:

a. Excluded Providers. Although an employee has the right to choose the initial treating physician, no authorization may be given for examination and/or treatment by an excluded physician. For further information regarding excluded providers, see FECA PM 3-0800.

b. Issuance to Oneself. An injured employee does not have the authority to issue a CA-16 on his or her own behalf. For example, if a postmaster sustains an injury, it is expected that

authorization will be secured from the regional office. In an emergency, the services of the nearest physician or hospital may be utilized without prior authorization, with the understanding that the employee will contact the employing agency at the earliest possible time for authorization or instructions.

c. Issuance to Minors. OWCP does not consider any person under the age of 18 to be emancipated. Therefore, permission from the parent or guardian will be needed to authorize treatment of any claimant under 18. If the parent or guardian is not immediately available for signed consent, it may be necessary to arrange for a witnessed telephone call to obtain consent. The information obtained should be documented in a call or memorandum for the file.

d. Issuance to Certain Employees Prior to Separation. Certain groups of claimants are entitled to FECA coverage by virtue of special legislation. They include Peace Corps and VISTA volunteers, as well as Job Corps enrollees. While members of these groups are entitled to medical care for accepted injuries at OWCP expense, authorization for treatment may not be granted until the volunteer or enrollee is separated from the program.

e. Advance or Blanket Authorization. An authorization for treatment at some future time, or as the need arises, is not to be issued. When such authorization is requested, the employee should be advised to contact OWCP and/or its designated billing agent as the need for treatment arises.

f. Fitness-For-Duty Examinations. The FECA statute does not provide for examination to determine the "fitness-for-duty" status of an employee. Such an examination is a function of the employing agency. See generally 20 C.F.R. §10.324.

g. Exposure to Disease. The law does not provide for routine examination of an employee who has been exposed to a co-worker with an infectious disease or to hazards of the workplace. Unless there is reasonable proof that a disease or illness has been sustained by the employee, such examinations are the responsibility of the employing agency (see PM Chapter 3-0400). The decision to authorize examination at OWCP expense in these cases must be made by OWCP. See generally 20 C.F.R. §10.303.

5. Medical Facilities Where Care May Be Authorized. The FECA at 5 U.S.C. 8103 permits the employee an initial choice of physician. Examination and treatment may be given in the following settings:

a. Emergency Medical Facility. Emergency medical care by private physicians, clinics or hospitals may be authorized if such care is warranted. The employee may seek continuing medical care from the physician who provided the initial treatment or select another local physician.

b. Employing Agency Health Units. These facilities are equipped to provide immediate assistance and/or to refer employees to local physicians or emergency care facilities. When indicated, rescue squads or similarly trained and equipped units may be used to move injured persons.

c. Physician's Office. Ordinarily, the physician selected should be located within a reasonable distance of the employee's home or place of employment, and travel should be undertaken by the shortest route, and, if practical, by public conveyance. 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. A reasonable distance of travel up to a roundtrip distance of 100 miles is permitted. See 20 C.F.R. §10.315.

d. Hospital. The attending physician may arrange for care in a local hospital. A private room may be authorized only if the condition is such that the attending physician believes it is medically necessary and the DMA concurs. If a private room is used because of the claimant's personal preference, he or she will be required to pay the difference in cost.

e. Federal Medical Facilities. The medical facilities of the Army, Navy, Air Force, and Department of Veterans' Affairs may be used to provide treatment if practicable. If necessary, arrangements can be made on a case-by-case basis with the director of the hospital or clinic (such arrangements should be documented on a CA-110, Report of Call, or in a memorandum for the file). Use of Federal facilities may not be required to the exclusion of the claimant's choice of physician.

6. Transfer or Termination of Authorization for Medical Care. Any transfer of medical care should be accomplished with due regard for professional ethics and courtesy. No transfer or termination of treatment should be made unless it is in the best interest of the claimant and the government. The following guidelines should be observed:

a. Request by Official Superior. The official superior of an injured employee does not have authority to transfer medical care from one physician to another. If adequate medical care is not available locally, or the employer feels transfer of medical care is advisable for other reasons, the official superior should contact OWCP for instructions.

b. Request by Attending Physician. If the attending physician asks to be relieved of responsibility in a case, the request will be granted. The physician should be asked to provide his or her reasons for the request, report the patient's condition at the time, and state any further medical recommendations.

c. Request by Employee. Employees who want to change attending physicians must explain their reasons in writing, and the CE must review all such requests.

(1) The CE may approve a change on his or her own authority when: the original treating physician refers the claimant to another physician for further treatment; the claimant wants to change from the care of a general practitioner to that of a specialist in the appropriate field, or from the care of one specialist to another in the appropriate field; or the claimant moves beyond 50 miles from the original physician (since OWCP has determined that a reasonable distance of travel is up to a roundtrip distance of 100 miles).

(2) The CE must use discretion in cases where other reasons are presented:

(a) Denial solely on the basis that the claimant did not seek approval of the change before consulting another physician is improper (see *Cybil L. Slade*, 40 ECAB 1029). Rather, the CE must examine the request to determine whether the treatment was reasonable and necessary. (See *Arron G. Marston*, Docket No. 88-1716, issued March 22, 1989). This assessment may require referral of the case to the DMA.

(b) A request to change from the care of a specialist to the care of a non-specialist may not be denied without considering whether the treatment provided by the new physician is reasonable and necessary. However, unless the issue has arisen because care by a specialist is not available, the case should usually be referred for opinion from the DMA.

(c) Likewise, where the claimant wishes to change from the care of a medical doctor to that of a chiropractor, the CE should consult the DMA to determine whether the services of the chiropractor constitutes medical treatment under the Act and, if so, whether it is reasonable and necessary (see *Elizabeth J. Davis-Wright*, 39 ECAB 1232).

(3) Cases involving complex medical issues should be referred for opinion from the DMA.

(4) A second opinion examination may be in order if a claimant requests transfer to another physician at a time when the treating physician is recommending return to employment. If a second opinion is necessary to address issues involving continuing medical care, the selected physician may not become the treating physician.

d. Questions about Treatment. If the employee is under the care of a qualified physician and a question arises concerning the physician's medical management of the case (for instance, the prolonged use of therapeutic measures or the use of measures of questionable value), it is proper to request the physician's comments, and the DMA may request discussion of the medical problem involved. A second opinion may also be necessary.

e. Request for Consultation. OWCP may seek consultation services with experts in specialized fields, either to provide the attending physician with guidelines or to assist in determining a future course of action with regard to medical care.

f. Transfer of Care. When it is determined that a transfer of medical care is needed, the claimant and the previous attending physician (if not already aware) must be notified in writing regarding the change so that the physician may close his or her file and submit a final bill and report. A suitable explanation should also be furnished to the attending physician if he/she was not involved in the transfer of care request. If appropriate, the physician should be assured that OWCP's action is not intended as a criticism of his or her management of the case or professional ability and judgment. The claimant, as well as the physician, should be advised that authorization for treatment is being terminated.

g. Exclusion of Provider. As noted above, OWCP must terminate authorization for treatment with excluded providers. Both the physician and the claimant should be advised immediately that further medical treatment is not authorized, and the claimant should be advised to select another

treating physician. The claimant may continue to receive treatment from the excluded provider at his or her own expense. Exclusion of providers is discussed in Chapter 3-0800.

Chapter 3-0400, Medical Services and Supplies

1. Purpose. Many forms of treatment, including diagnostic procedures, may be authorized by OWCP when prescribed by the attending physician. Similarly, many supplies may be provided at the request of the attending physician or claimant. This chapter describes the circumstances under which such treatments and supplies may be authorized.

2. Statutory Authority. While OWCP generally does not have authority to require an injured employee to undergo treatment against his or her will, it is assumed that employees will seek appropriate treatment to restore health and lessen the severity of impairment. Services and supplies which meet the statutory criteria of being "likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of the monthly compensation" (5 U.S.C. 8103(a)) may be approved.

3. Supplies and Appliances. Specific supplies and appliances and the conditions under which they may be authorized are as follows:

a. Prescription and Non-Prescription Drugs. In general, drugs and medications which are necessary to treat an injury or occupational disease may be purchased at OWCP expense on the recommendation of the attending physician. These include prescription as well as non-prescription medications. Cases requiring prolonged use of narcotic preparations, tranquilizers, or medicinal alcohol must be referred to the DMA for consideration of continued authorization.

b. Home Medical Supplies and Appliances. Items such as rubbing alcohol, thermometers, sun lamps, heating pads, analgesics, antacids, etc., will not be furnished at OWCP expense unless prescribed by the attending physician and justified medically. Accepted conditions which may warrant furnishing such items include such conditions as paraplegia, quadriplegia, coma, and chronic ulcers. The Claims Examiner (CE) does not need to obtain approval for the use of these items but may need to consult the District Medical Adviser (DMA) to determine the frequency with which they are needed.

c. Durable Medical Equipment.

(1) Orthopedic Mattresses or Hospital Beds. These appliances may be authorized when prescribed by the attending physician to relieve orthopedic or other medical conditions, but less costly alternatives such as a bed board should be considered first whenever possible.

(2) Motorized Wheelchairs. The purchase or rental of a motorized wheelchair may be authorized when the condition necessitating it is considered to be permanent. Recommendations for this equipment shall be referred to the DMA for advice regarding authorization.

(3) Other Equipment. Such items as traction apparatus and walkers for home use may be authorized upon the recommendation of the attending physician if their use is warranted by the accepted condition.

d. Prosthetic Devices and Other Personal Appliances.

(1) Glasses and Contact Lenses. Glasses and contact lenses for the correction of refractive error will be furnished for a condition accepted as work-related, and subsequent repair or replacement will be authorized as necessary.

(a) When OWCP accepts a case for loss of vision or loss of an eye, the purchase of glasses or contact lenses will be authorized for correction of refractive error in the uninjured eye.

(b) Prescription sunglasses will be authorized when recommended by a qualified physician in cases following cataract surgery. When recommended for another approved condition, the opinion of the DMA should be obtained prior to acting on the recommendation.

(c) Intraocular implant lenses are imbedded in the eye to correct vision in some older patients when cataract surgery is performed. They may be authorized on recommendation of the attending ophthalmologist.

(2) Hearing Aids. Hearing aids will be authorized when hearing loss has resulted from an accepted injury or disease if the attending physician so recommends. Trial or rental periods should be encouraged as many persons do not find their use satisfactory. Maintenance of hearing aids provided by OWCP, including batteries, repairs, and replacements, may be authorized as needed.

(3) Orthopedic Shoes. If an accepted injury to the foot modifies its structure so that the employee cannot be fitted with ordinary shoes, specially constructed ready-to-wear or custom built shoes may be furnished upon the recommendation of the attending physician. If such shoes will be required permanently, the purchase of two pairs may be authorized. Alterations to stock shoes usually worn by the claimant will also be authorized if needed.

(4) Artificial Limbs and Braces. These devices may be authorized as recommended by the attending physician.

(5) Non-medical Equipment. Items such as waterbeds, saunas, weight-lifting sets, exercise bicycles, etc., may be authorized only if recommended by the attending physician and if OWCP finds that the item is likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation. Procedures for developing and adjudicating requests for such equipment are provided in PM 2-810.15.

(6) House and Vehicle Modifications. Procedures for developing requests for modification of houses and vehicles due to the accepted condition are provided in PM Chapter 2-1800. Requests for items such as home wheelchair ramps, special automobile attachments, and window air conditioning equipment should be handled in accordance with paragraph (5) above.

4. Obtaining Appliances and Arranging for Repairs. Appliances may be either personal or non-personal in nature.

a. Personal Appliances. Devices which are specifically fitted to and worn by the claimant, such as back braces, eyeglasses, and artificial eyes are considered personal rather than government property. Upon the recommendation of the attending physician, such appliances may be repaired or replaced without advance approval when the estimated cost is less than \$500. Repairs or replacements costing more than this amount should be approved in advance by the DMA if possible. The attending physician should check the repaired or replaced item to ensure a proper fit.

b. Non-personal Appliances. Prior to authorizing any item of a non-personal nature, the cost of purchase should be compared to the cost of renting, taking into consideration the prognosis and the estimated duration of need. Generally, the less expensive method will be used. When the item is rented, the Medical Management Assistant (MMA) will place a six-month call-up to assess whether the item is still needed for the accepted condition and if rental is still less costly than purchase.

A purchased item which can be salvaged when no longer required by the employee will be considered government property if its retail value is more than \$5000. Such items as hospital beds and wheelchairs fall into this category, and the employee must be notified in writing at the time of purchase that the property may be recovered by the government at a later date. When the item is no longer needed, the MMA will contact at least one nearby Federal medical facility and offer it for pickup at no expense to OWCP. If the facility does not wish to acquire the item, the MMA will notify the regional office of the General Services Administration that the item is available.

c. Repair and Replacement.

(1) The definition of "injury" at 20 C.F.R. 10.5(a)14 includes:

damage to or destruction of medical braces, artificial limbs, and other prosthetic devices which shall be replaced or repaired; except that eyeglasses and hearing aids shall not be replaced, repaired, or otherwise compensated for, unless the damage or destruction is incident to a personal injury requiring medical services.

(2) Medical braces, artificial limbs, and other prosthetic devices covered under this provision can be repaired or replaced on a one-time basis in the absence of any other medical condition resulting from a work-related incident. OWCP can authorize repair or replacement of property, such as eyeglasses, hearing aids, and artificial teeth, which is damaged or destroyed while in the performance of duty only when the damage or destruction is incident to a personal injury

requiring medical services, or when an accepted condition requires change in a prosthesis used at the time of injury.

(3) When OWCP cannot authorize repair or replacement, the CE should advise the claimant that under 31 U.S.C. 240-243, Federal establishments may settle and pay claims against the United States by its civilian employees for damage to, or loss of, personal property incident to employment. The CE should also advise the claimant to contact his or her supervisor to determine whether a claim may be made under this statute.

5. Medical Services. Services which meet the statutory criteria of being "likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of the monthly compensation" may be authorized. The circumstances under which various kinds of services may be authorized are described below. Any denial of services requested by the claimant or attending physician must address these criteria.

a. Emergency Medical Facility. Emergency medical care by private physicians, clinics or hospitals may be authorized if such care is warranted.

b. Hospital. The attending physician may arrange for care in a local hospital. A private room may be authorized only if the condition is such that the attending physician believes it is medically necessary and the District Medical Advisor (DMA) concurs. If a private room is used because of the claimant's personal preference, he or she will be required to pay the difference in cost. Also, such personal items as television and telephone service must remain the claimant's responsibility.

(1) Surgery. In an elective or non-emergency situation, the file must be reviewed by a specialist prior to authorizing surgery for a back condition, an organ transplant or a destructive procedure. A second opinion examination may be obtained at Office expense prior to authorization for surgery or any invasive procedure (see Chapter 3-500 concerning second opinion requests). In-house review by the consultant should occur within 21 days of receipt of the request for surgery, and any second opinion examination required should be accomplished within 40 days. Plastic surgery for cosmetic reasons may not be authorized unless it is performed for a disfigurement of the face, head or neck which has been accepted by the Office.

(2) Organ Transplants. Organ transplants, except for those which are experimental or not generally accepted by the medical community, may be approved upon the attending physician's recommendation and OWCP's approval consistent with its second opinion procedures. Ancillary treatment such as immunosuppression is also considered compensable.

An organ donor is not considered an "employee" within the meaning of the FECA and is not entitled to compensation for wage loss or permanent impairment, nor is a donor entitled to benefits for any complications resulting from the transplant. Only those medical and related expenses of the donor which are necessary to secure treatment for the employee are allowable.

(3) Destructive and Questionable Measures. Such procedures as rhizotomy, injection treatment for varicose veins, chordotomy, neurectomy, etc., will not normally be authorized solely because of chronicity of a condition. They may be authorized as a measure of last resort, after adequate

consultation with specialists in the appropriate field of medicine. Medical or surgical treatment of a questionable nature will not be authorized without adequate consultations. Second opinion examinations and OWCP approval are required for any such procedure.

(4) Substance Abuse Treatment. Where recommended by the treating physician, the Office may approve a one-time inpatient substance abuse treatment program up to 28 days in length. Such a program may be approved even if the Office has not accepted substance abuse as related to employment in cases where the abuse is hindering the claimant from participating in a rehabilitation program or securing employment. The treatment facility should be located within 25 miles of the claimant's home wherever possible, and a cost comparison between comparable facilities should be made before care is authorized. Any request for a subsequent course of inpatient substance abuse treatment should be forwarded to the National Office for consideration.

Outpatient treatment may be recommended by itself or as a follow-up measure to inpatient care. Such treatment may be authorized when recommended by the attending physician, as may medications prescribed to alleviate the effects of addiction (e.g., Antabuse). Likewise, counseling in a group setting may be undertaken at OWCP expense.

c. Outpatient or Ambulatory Services. In addition to treatment in the physician's office, the following may be authorized:

(1) Nursing Services. See paragraph 6 below.

(2) Physical Therapy. For any orthopedic or neurological condition, physical therapy for a period of 90 days may be authorized if prescribed by the attending physician. Any therapy in excess of 90 days requires additional medical justification. The time limitation does not apply to cases involving brain and spinal cord injuries, extensive second and third degree burns and other conditions which have rendered the claimant bedridden. (See FECA PM 2-810.16 for a detailed discussion of authorization of physical therapy.) Work hardening programs may also be considered on recommendation of the treating physician.

(3) Occupational and Speech Therapy. These services may be authorized when recommended by the attending physician for reasonable periods if improvement or relief of distress is likely to result. Long term therapy without prospect of improvement shall not be authorized. Recommendation for such therapy is usually referred to the DMA for consideration. Occupational or speech therapy may be authorized when performed in recognized facilities or when rendered by private providers as long as it is prescribed by the treating physician and he or she monitors the results.

(4) Lip-Reading Services. On recommendation of the attending physician, the DMA may approve lip reading services if they would likely reduce the extent of disability and aid in rehabilitation.

(5) Pain Clinics. The DMA may authorize pain clinic treatment only if it is appropriate for the accepted condition and the clinic in question is reputable. Whenever possible clinics connected with universities or other teaching institutions should be used.

(6) Palliative Treatment. The DMA may authorize such treatment for prolonged or terminal conditions when the need is adequately supported by consultants. The therapy may consist of surgical procedures (rhizotomy), nerve blocks, large doses of pain medications, and the services of pain clinics or hospices.

(7) Specific Treatments. In addition to the routine diagnostic and therapeutic services provided in an institution or professional office, specific forms of treatment may be authorized as follows:

(a) Acupuncture. Acupuncture may be authorized when recommended by the attending physician to provide relief. Such treatment shall be supervised by the recommending physician, who shall submit periodic reports to show progress or any relief of the symptoms. If the treatment continues beyond six months and/or the results are questionable, the DMA should be asked for an opinion as to whether the treatment should continue.

(b) Chymopapaine Treatment. Serious side effects have been reported from the injection of chymopapaine. Therefore, any request for this form of treatment must be justified by the attending physician and reviewed by the DMA.

(c) Hernia Treatment. Surgery is the usual treatment authorized for a hernia. If surgery is refused or medically contraindicated, the fitting of a truss may be authorized if recommended by an examining physician. Injection treatments are now very rarely used and any such request should be referred to the DMA for opinion.

(d) Substance Abuse Treatment. Such treatment may be authorized on the basis of the attending physician's recommendation. Such a program may be approved even if the Office has not accepted substance abuse as related to employment in cases where the abuse is hindering the claimant from participating in a rehabilitation program or securing employment.

d. Dental Services. The law provides for repair or replacement of injured natural and fixed artificial teeth. Except in dental emergencies, prior approval of OWCP shall be obtained for dental repair or replacement. Before approving dental repair or replacement, an examination including x-ray and prophylaxis should usually be authorized and an estimate of the cost of the proposed dental work must be obtained.

6. Nursing Services. OWCP uses the services of in-house Staff Nurses and contract Field Nurses to coordinate claimants' medical care and aid them in returning to work. The work of the Staff Nurses is discussed briefly in PM 3-200 and more thoroughly in PM 3-201. The following guidelines pertain to requests for clinical nursing services:

a. Licensed or Practical Nurse. The services of these nurses may be authorized when recommended by the attending physician for therapeutic services in the home. The services of a nurse may not be authorized to perform housekeeping duties, however.

(1) Nursing Plans. Nursing agencies routinely develop nursing care plans for home care which are based on the treating physician's instructions. A copy of the plans should be obtained to

verify that the nursing care proposed is related to the accepted condition. Absent such plans, the following questions may be posed to the attending physician:

(a) What are the chronic sequelae of the work-related injury and what form of treatment do they require?

(b) Are there acute and/or recurrent complications of these sequelae? How frequently do they appear? What form of treatment do they require?

(c) Has the claimant required hospitalization for the treatment of any of the chronic sequelae and/or complications? How frequently?

(d) What is the anticipated duration of nursing services?

(2) Special Nurses. The services of special nurses may be authorized when the attending physician certifies that such services are necessary due to the severity of the claimant's condition. In questionable cases, the case file should be referred to the DMA for recommendation. A care plan should be obtained and the approval period tailored to the needs of the claimant in accordance with the physician's recommendation.

b. Services of Relatives. The attending physician must approve the qualifications of a relative acting as a nurse to provide the necessary services.

c. Extended Care Facilities. Care in a convalescent home, skilled nursing facility or hospice may be authorized when the employee does not need acute care but does require services difficult or impossible to arrange in the home setting. The recommendation of the attending physician is required in this situation. OWCP will pay the rates for standard accommodations according to the requirements of the medical condition. The claimant should remain under continuing medical supervision of a physician, who may be asked to justify the continuing need for institutional care every three to six months according to the severity of the claimant's medical condition.

7. Other Modes of Treatment.

a. Preventive (Prophylactic) Treatment. The FECA does not authorize provision of preventive measures such as vaccines and inoculations, and in general, preventive treatment is a responsibility of the employing agency under the provisions of 5 U.S.C. 7901. However, preventive care can be authorized by OWCP for the following:

(1) Complications of preventive measures which are provided or sponsored by the agency, such as adverse reaction to prophylactic immunization.

(2) An injury involving actual or probable exposure to a known contaminant, thereby requiring disease-specific measures against infection. Included among such treatments would be tetanus antitoxin or booster toxoid injections for puncture wounds; administration of rabies vaccine where a bite from a rabid animal, or one whose status was unknown, is involved; or AZT where exposure to HIV virus has occurred.

(3) Periodic examination of the uninjured eye may be authorized where injury to the other eye has resulted in loss of vision, so that possible sympathetic involvement of the uninjured eye may be detected at an early stage. The frequency of these examinations should be determined on the basis of the attending physician's recommendations. If sympathetic involvement of the uninjured eye is found, appropriate medical and surgical treatment for this condition will be authorized.

(4) Conversion of tuberculin reaction from negative to positive. In this situation INH therapy may be authorized. Treatment is limited to the injured employee and cannot be extended to others who may, for example, have been exposed to an infectious agent by the employee.

b. Adjunct and Ancillary Treatment. Upon the recommendation of the attending physician, treatment may be authorized for a concurrent ailment if it appears that such treatment is closely related to the treatment of an injury and would hasten the cure of the accepted condition(s). Requests for such treatments may include such regimes as weight loss programs for claimants with chronic back conditions as well as more traditional therapies such as treatment of concurrent diabetes in claimants with eye or foot conditions. The DMA must review all such requests prior to authorization.

c. Experimental Treatment and Clinical Research. All requests for authorization of the following kinds of treatment or research should be referred to the OWCP Medical Director following appropriate development:

(1) Experimental diagnostic and treatment modalities or those which are not generally accepted. Experimental treatment modalities will be considered if the accepted condition is life-threatening (e.g., cancer or AIDS); established therapy has been tried to no avail; and a significant body of data supports the view that the experimental procedure is indeed beneficial;

(2) Participation in a research protocol;

(3) Administration of questionnaires, particularly of a sociological or psychological nature.

Such requests should not be approved or denied without advice from the National Office.

8. Non-medical Services.

a. Health Club/Spa Membership. Membership in a health club or exercise facility, or treatment at a spa, may be authorized when recommended by the attending physician as likely to cure or give relief. Only the facilities required should be authorized (for example, if swimming is prescribed, the approval should not include use of exercise equipment as well) and the least expensive facility in the area should be used. Procedures for developing and adjudicating requests for health club/spa membership are provided in PM Chapter 2-810.15.

b. Seeing Eye and Hearing Dogs. The OWCP may pay for seeing eye and hearing dogs, as well as for their training and maintenance costs, on prescription of the attending physician if this service is required because of blindness in both eyes or severe deafness (at least 80 percent binaural loss) resulting from factors of the employment.

c. Change in Locality. Where a physician recommends that an injured employee visit or move to another climate to alleviate symptoms of the employment-related condition, the expenses incurred may be authorized if OWCP finds that such a move is likely to cure, give relief, reduce the degree or period of disability, or aid in lessening the amount of monthly compensation. After developing the evidence, the CE should refer the case file to the DMA for opinion concerning the advisability of such a move.

9. Injury or Death While Obtaining Medical Care.

a. Benefits Payable. When an employee is injured while traveling to or obtaining authorized medical care or examination, he or she is entitled to medical benefits just as if the injury had occurred in the performance of duty. If an injured employee dies away from home while receiving medical examination or treatment, the body may be embalmed and transported in a hermetically sealed casket to the employee's home at OWCP expense even if death did not result from an accepted injury. If death resulted from a condition unrelated or questionably related to the accepted condition, authorization for services should include a request for postmortem examination.

b. Pathological and Postmortem Examinations. The DMA may authorize pathological examination of removed tissue at OWCP expense if such examination is necessary to determine the merits of a claim that has been or will be filed. If a postmortem examination has not been ordered by the coroner or local medical examiner, permission for such an examination must be requested in accordance with the appropriate state law.

c. Autopsy. If an autopsy is authorized, the DMA should specify that it be conducted by a pathologist or another physician fully qualified to perform such services and that a complete autopsy protocol must be submitted prior to payment of the bill. Authorization for this procedure may be given by telephone, followed by written confirmation or by telegram (where the medical examiner is overseas). See PM Chapter 2-700 for additional information concerning autopsies.

10. Transportation and Expenses. OWCP will reimburse the cost of transportation needed for treatment or examination of the claimant for the accepted injury, unless transportation is furnished by the government. The transportation costs may include the services of an accompanying nurse or attendant if required (see paragraph 6a(4) above). Incidental expenses may also be reimbursed whether or not transportation is furnished by the Government, but OWCP cannot advance funds to defray travel and incidental expenses except as noted below.

a. Mode of Travel. Travel should be undertaken by the shortest route, and if practical, by public conveyance such as bus or subway. If the medical evidence shows that the employee is unable to use these means of transportation, the CE may authorize travel by taxi or special conveyance.

Transportation by ambulance may also be authorized if required, and if travel by air ambulance is indicated, or air ambulance is found to be more economical and expeditious than ordinary commercial air transportation, approval may be granted for this service. In all such instances the DMA will be consulted for advice, by telephone if indicated.

b. Transportation Expenses. Standard Form 1012 and Form CA-1077 shall be sent to the injured employee whenever examination and/or treatment is authorized. They are used to claim reimbursement for travel expenses when the government does not furnish transportation. When the employee must travel to secure authorized examination and/or treatment and the travel will cost more than one hundred dollars by public transportation, a Government Transportation Request (GTR), Standard Forms 1169 and 1169a, may be issued. The claimant should be instructed to return a GTR which is not used so it can be canceled.

c. Accompaniment While Traveling. If the employee requires a nurse or an attendant to accompany him or her in securing examination and/or treatment, this service and associated transportation and incidental costs may be authorized. Unless a need for other arrangements is demonstrated, he or she should be instructed to make the return trip as soon as possible so that no unnecessary expense will be incurred.

d. Incidental Expenses. Charges for child care, pet care, and home security may be paid when incurred in the course of securing medical services and supplies. In each case, the record must contain a memorandum discussing the need for the incidental expenditure and the reasonableness of the amount claimed.

(1) Necessity and Reasonableness. Incidental expenses shall be paid to the extent that they are necessary and reasonable. For example, in a household consisting of the claimant, a child, and a semi-invalid parent where the claimant must pay for care of the child and parent while hospitalized, reasonable family care expenses would be paid. Should additional expenses be claimed, such as a kennel for the family dog, reasonable kennel charges would be paid only if it were determined that other arrangements could not be made, such as pet care by the person staying with the family.

(2) Timing of Expense. Incidental expenses are allowable only when incurred in the course of securing medical services and supplies. Therefore, it is necessary to distinguish between expenses connected with securing treatment and those incurred following treatment.

Expenses in the latter category, such as housekeeping costs while the claimant convalesces at home, are not payable because they are not required to obtain medical services.

Chapter 3-0500, OWCP Directed Medical Examinations

1. Purpose. This chapter describes the two kinds of OWCP directed medical examinations, second opinion and impartial referee medical examinations, and the steps involved in scheduling these examinations.

Other Federal Employees' Compensation Act (FECA) Procedure Manual chapters also have relevant guidance pertaining to medical examinations and should be consulted.

Chapter 2-0810, Developing and Evaluating Medical Evidence, discusses the Claims Examiner's (CE's) function in evaluating medical evidence and authorizing treatment. It has specific sections devoted to the decision-making process for obtaining second opinion and referee examinations.

Chapter 3-0300, Authorizing Examination and Treatment, discusses the circumstances under which OWCP or, in some instances, the employing agency may authorize medical services and treatment for injured claimants.

Chapter 3-0600, Requirements for Medical Reports, outlines the information that should be included in all medical reports.

2. Statutory Requirements. The authority to schedule second opinion and referee examinations is specifically noted in the FECA in §8123, which states:

An employee shall submit to examination by a medical officer of the United States, or by a physician designated or approved by the Secretary of Labor, after the injury and as frequently and at the times and places as may be reasonably required. The employee may have a physician designated and paid by him present to participate in the examination. If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.

3. Second Opinion Examinations. The attending physician (AP) is the primary source of medical evidence in most cases, and the AP is expected to provide a rationalized medical opinion based on a complete medical and factual background in order to resolve any pending issues in a case. In certain circumstances, such as where the AP's report does not meet the needs of the OWCP, OWCP may schedule a second opinion examination (SECOP).

a. Determining the Need for Examination. The decision to refer a case for a second opinion examination rests with the CE, though such an exam may be recommended by a Field Nurse (FN) or District Medical Advisor (DMA), or requested by the employing agency. A complete discussion of when a CE should refer a case for a second opinion examination is found in PM 2-0810-9 and 2-810-10.

Also, OWCP may send a case file for second opinion review where actual examination is not needed, or where the employee is deceased.

b. Selection of SECOP Physician.

(1) Physicians selected to perform second opinion examinations should be administratively qualified in the appropriate branch of medicine.

(a) Where an emotional condition is the only work-related condition known to be present, a referral can be made to a psychiatrist or a clinical psychologist (as long as the file contains no indication that medication for a psychological condition is being used). Referral to a clinical psychologist may be made even if the attending physician is a psychiatrist, but not where psychogenic overlay is felt to be present, as these cases presuppose a connection between the psychological condition and its physical manifestation which can best be addressed by a psychiatrist.

(b) If the issue for determination is the causal relationship between a workplace injury/factor and a claimed condition or a claimant's ability to perform the date of injury position or some other type of modified work, a referral can be made to a specialist in occupational medicine, even if the attending physician is an orthopedist, neurologist or some other specialty. As a sub-specialty under the Board of Preventive Medicine, occupational medicine physicians are specialists in the field of workplace injuries and illnesses and their causal associations. They also specialize in assessing fitness for duty relevant to the employee's work environment.

(2) Second opinion examinations are generally conducted by a physician selected by a medical referral group that has contracted with OWCP to provide second opinion medical referrals. The method for selecting second opinion physicians is more flexible, since a strict rotation of physicians is not required for this type of examination.

(3) If the medical referral group is unable to schedule the necessary appointment in accordance with the needs of OWCP, OWCP can use the Medical Management application for this purpose (see paragraph 5 below).

c. Information Sent to Second Opinion Physician. The physician should be provided with the following:

(1) A statement of accepted facts (SOAF);

(2) A list of pertinent questions or issues to be addressed;

(3) Copies of medical records from the case file based on the age of the case and/or the nature of the referral as follows:

(a) For unadjudicated case referrals and all referrals for medical management, disability management or surgery:

(i) All operative reports regardless of age;

(ii) All diagnostic tests regardless of age; and

(iii) All medical records from any qualified physician as defined in 5 U.S.C. 8101(2) authored within three years of the date of the second opinion referral.

(b) For schedule award referrals:

- (i) All operative reports regardless of age;
- (ii) All diagnostic tests regardless of age;
- (iii) All medical records from any qualified physician as defined in 5 U.S.C. 8101(2) that address permanent partial impairment and maximum medical improvement; and
- (iv) The most current comprehensive medical narrative report from a qualified physician as defined in 5 U.S.C. 8101(2).

If the CE determines in the exercise of his or her judgment that the unique circumstances of a case file require deviation from these requirements in order to assist the physician in rendering a rationalized medical opinion based on an adequate medical background, the CE should document such circumstances and the specific deviations/changes in a Memorandum to the File to be made part of the case record. An example of a situation where inclusion of additional medicals might be appropriate would be in a complex catastrophic case with numerous accepted conditions.

(4) If a medical report has been excluded from the case record, it should be omitted from the medical evidence sent to the second opinion specialist. See PM 2-0810.12.

d. Information Sent to Claimant and the Properly Authorized Designated Representative. Once the appointment has been scheduled, the claimant/representative should be notified. See *Donald J. Knight*, 47 ECAB 706 (1996) (where ECAB held that OWCP's failure to notify appellant's authorized representative of the referral to a second opinion physician effectively denied appellant's statutory right to have a physician designated and paid by him to be present and participate in the examination pursuant to 5 U.S.C. 8123). This may be done by OWCP, or by the contractor on OWCP's behalf. The claimant and his or her designated representative should be provided with the following information:

(1) The name and address of the physician to whom he or she is being referred, as well as the date and time of the appointment.

(2) The claimant's right, under section 5 U.S.C. 8123 of the FECA, to have a physician paid by him or her present during a second opinion examination. 20 C.F.R. § 10.320; *Esther Velasquez*, 45 ECAB 249 (1993) (ECAB held that by misinforming the claimant of the purpose of the medical referral, OWCP effectively denied her the right granted by the FECA, and that OWCP was precluded from relying on the resulting medical report "before affording appellant the opportunity to exercise this statutory right.")

Because a claimant has a right under the statute to have such a physician attend a second opinion examination, OWCP may not re-characterize an impartial examination as a second opinion examination in the event it determines there was no conflict in the medical evidence; however, the report need not be excluded and may be considered for its intrinsic value.

(3) A warning that benefits may be suspended pursuant to 5 U.S.C. 8123(d) for failure to report for examination.

(4) Information on how to claim travel expenses.

e. The employee is not entitled to have anyone present at the examination (other than the physician identified in d(2) above), unless the case file or other rationalized medical evidence establishes the need for someone else in the room, or OWCP decides that exceptional circumstances exist. However, where an employee requires an accommodation, such as where a hearing-impaired employee needs an interpreter, the presence of an interpreter or other individual will be allowed. *Anthony H. Jackson*, 53 ECAB 529 (2002) (ECAB held that a claimant is not entitled to have anyone other than a qualified physician in attendance at a referral medical examination unless OWCP decides that exceptional circumstances exist); *Ida L. Townsen*, 45 ECAB 750, 757 (1994) (finding that interference by appellant's representative in insisting that he be present for a medical examination constituted obstruction under section 8123 and supported suspension of appellant's benefits).

f. Follow-up Action. Using the SOAF (See FECA PM 2-0809 regarding SOAF requirements) as the framework for his or her opinion, the second opinion physician should provide a report which contains a clinical history, results of the examination, results of any testing performed, and a reasoned opinion in response to the questions posed. A report should be expected within 30 days of the examination.

(1) If no medical report is received within 30 days from the date of appointment, the CE or medical scheduler should inquire as to the status with the medical referral group and/or the second opinion physician. The CE or medical scheduler may also follow up soon after the date of the appointment to verify the claimant's attendance at the appointment. For a complete discussion describing the circumstances under which benefits may be suspended under 5 U.S.C. 8123(d) for failure to attend an appointment, see PM 2-0810-13 Suspension of Benefits.

(2) Upon receipt of the report, the CE should review the report to ensure that the physician has adequately addressed the questions posed.

(a) If clarification or additional information is necessary, the CE should write to the specialist to obtain it, either directly or via the medical referral group, as appropriate.

(b) Upon receipt of any clarifying information, the CE should again review the report to ensure that it is complete and responsive to the questions asked.

4. Referee Examinations. Section 8123(a) of the FECA and section 10.321 of the implementing regulations provide for the appointment of a referee physician to examine the claimant and resolve a conflict of medical opinion in a case. This is referred to as an impartial medical examination (IME). Because this method of resolving conflicts is provided in the FECA, the probative value of the referee specialist's report is great and will normally constitute the weight of the medical evidence of record. *Y.A.*, 59 ECAB 701 (2008) (when a case is referred to an impartial medical specialist for the purpose of resolving a conflict in medical opinion, the opinion of such specialist, if sufficiently well rationalized and based on a proper background, must be given special weight).

a. Determining the Need for Examination. A difference in medical opinion sufficient to be considered a conflict occurs when two reports of virtually equal weight and rationale reach opposing conclusions. See *James P. Roberts*, 31 ECAB 1010 (1980). The CE makes this determination after weighing the opinions. See PM 2-0810-6 for an extended discussion on weighing medical evidence. A complete discussion of when a CE should refer a case for a referee examination is found in PM 2-0810-11. 20 CFR § 10.321(a).

b. Selection of IME Physician. Unlike selection of second opinion examining physicians, selection of referee physicians is made on a strict rotational basis.

(1) OWCP will select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case.

(2) The Employees' Compensation Appeals Board has placed great importance on the appearance as well as the fact of impartiality, and only if the selection procedures which were designed to achieve this result are carefully followed may the selected physician carry the special weight accorded to an "impartial specialist."

In *Leonard W. Waggoner*, 37 ECAB 676 (1986), ECAB remanded the case because the physician who examined the claimant was an associate of the physician to whom the claimant had been referred. Since the claimant was told to report to one physician but was ultimately examined by another, he had no opportunity to object to the choice of examiner. ECAB did not find that the specialist in this case was in fact biased, or would have been ineligible on any particular ground. Rather, it found that to give special weight to a physician not selected in accordance with procedures would "undermine the appearance of impartiality or would appear to compromise the integrity of the system for selecting impartial specialists." ECAB found that the physician was not entitled to the special weight accorded to a referee specialist because the procedures designed to provide adequate safeguards against any possible appearance of bias were not followed.

(3) Physicians in certain roles may not be chosen to act as referees in specific cases. When a physician is asked to act as a referee specialist, the medical scheduler should inquire as to the nature of any previous association with the claimant or the claimant's employing agency. Physicians who may not be used as referees include:

(a) Those employed by, under contract to, or regularly associated with Federal agencies. See *George W. Coast*, 36 ECAB 600 (1985) (ECAB held that although there was no direct evidence of record substantiating that the physician was previously connected with the claimant's case, the selection of a physician involved with fitness-for-duty examinations on behalf of the employing establishment undermined the appearance of impartiality).

(b) Physicians previously connected with the claim or the claimant, or physicians in partnership with those already so connected (see *Raymond E. Heathcock*, 32 ECAB 2004 (1981) (ECAB held that OWCP could not use the report of one physician to resolve a conflict in medical evidence because he was an associate of another physician previously connected with the case, and therefore was not completely independent)).

(c) Physicians who have acted as a medical consultant to OWCP (see *John Clement*, 35 ECAB 959 (1984)).

Note: The mere fact that a physician has conducted a second opinion examination in connection with the FECA program does not eliminate that physician from serving as an impartial referee physician in another case.

(4) In a case involving only a mental condition where a conflict exists between two psychologists or between a psychologist and a physician who does not specialize in treatment of mental disorders, the referee specialist chosen to resolve the case may be either a psychiatrist or clinical psychologist (as long as the file contains no indication that medication for a psychological condition is being used). In those cases, however, where a conflict has arisen between a psychologist and a psychiatrist or between two psychiatrists, the Office will obtain a referee examination from a psychiatrist. This practice will ensure that the referee physician carries sufficient weight in cases where a medical doctor has been involved in creating the conflict, and should also ensure that the full range of issues is addressed.

(5) In a case involving a physical condition where a conflict exists with regard to the causal relationship between a workplace injury/factor and a claimed condition or a claimant's ability to perform the date of injury position or some other type of modified work, a referee examination may be scheduled with an occupational medicine physician, even if one or both of the physicians with conflicting opinions is not an occupational medicine physician. As a sub-specialty under the Board of Preventive Medicine, occupational medicine physicians are specialists in the field of workplace injuries and illnesses and their causal associations, and they also specialize in assessing fitness for duty relevant to the employee's work environment, they are qualified to provide an opinion on these issues and may be afforded the special weight provided to referee physicians.

(6) The selection of a physician to perform a referee medical examination is done by the district office using the Medical Management application within the Integrated Federal Employees' Compensation System (iFECS). This selection process is described in detail in paragraph 5 of this chapter.

(a) The Medical Management application contains the names of physicians who are Board-certified in certain specialties. The database of Board-certified physicians used for referee examinations contains over 30 specialties, including: cardiovascular disease, dermatology, gastroenterology, internal medicine, neurology, occupational medicine, osteopathy, orthopedic surgery, physical medicine and others.

(b) The services of all available and qualified Board-certified specialists will be used as far as possible to eliminate any inference of bias or partiality. This is accomplished by selecting physicians (in the designated specialty in the appropriate geographic area) in alphabetical order as listed in the roster and repeating the process until the list is exhausted.

(c) A physician can be added to the Medical Management application, and thereby the rotation, by the District Director, or his/her designee after verifying that the physician meets the board-certification requirements for a particular specialty.

(d) A physician may be eliminated from the rotation for the following reasons, which include, but are not limited to: he or she is not willing to perform examinations for OWCP; reports have shown a predictable pattern amounting to bias; he or she chronically submits inadequate reports in the face of acceptable questions; reports are consistently submitted late; or he or she has a signed agreement with OWCP to perform case file reviews.

OWCP may discontinue the use of a physician by properly updating the Medical Management application and citing instances (dates, specific case files, etc.) in which bias or inadequacies are demonstrated. The District Director, or his/her designee, is authorized to suspend or permanently remove a physician.

(e) Excluded providers are disqualified from serving as referee physicians (see Chapter 3-0800).

(f) A physician who is not Board-certified may be used if he or she has special qualifications for performing the examination, but the scheduler must document the reasons for the selection in the case record.

(7) Sometimes examination by more than one kind of specialist is required in order to fully address work-related injuries and any complications that may be associated with the injuries. If the CE has identified the need for examination by two kinds of specialists, for instance an orthopedist and a psychiatrist or clinical psychologist, the scheduler will arrange two separate examinations without asking either physician to coordinate the results.

On the other hand, a referral physician who needs to obtain information from another provider is authorized to make subsidiary referrals as necessary (for instance, a psychiatrist may refer a claimant to a clinical psychologist for testing). In this case, the referral physician should submit a summary report discussing any discrepancies among the physicians' viewpoints so that questions posed by OWCP are fully answered.

In extremely complex cases, a panel of physicians may be asked to examine the claimant and render a collective opinion. The services of such panels are most easily arranged through medical schools and hospitals, as these institutions employ specialists in many fields of medicine. Such referrals are rare.

c. Information Sent to Physician. The physician should be provided with the following:

(1) Description of the reason(s) for requesting the examination, including an indication of the conflict and a list of questions to be resolved, along with a blank Form OWCP-5 if appropriate.

(2) Statement of Accepted Facts (SOAF).

(3) Copy of the complete case file, either in paper or electronic form.

(4) Notice that he or she is the only individual authorized to perform the requested examination and provide the required report.

(5) Prompt payment billing information, including the code for referee medical examination or case review.

d. Information Sent to Claimant and Properly Authorized Designated Representative. Once the appointment has been scheduled, the claimant/representative should be notified. See *Rosita Mahana*, 50 ECAB 331 (1999) (ECAB held that by not notifying appellant and her attorney of the identity of the impartial medical specialist, OWCP deprived her of an opportunity to present any objections to the selection of Dr. Schwarz as the impartial medical specialist; and, accordingly, Dr. Schwarz was not properly selected as an impartial medical specialist and her report could not be used to resolve the conflict of medical opinion). The claimant and his or her duly appointed representative should be provided with the following information:

(1) Notice of the existence of a conflict in the medical evidence and the specific nature of the conflict. Notification should also be included that the examination is being arranged under the provisions of 5 U.S.C. 8123, which provides the claimant an opportunity to raise any objection to the selected physician prior to the examination.

(2) The name and address of the physician to whom he or she is being referred, as well as the date and time of the appointment.

(3) A warning that benefits may be suspended pursuant to 5 U.S.C. 8123(d) for failure to report for examination.

(4) Information on how to claim travel expenses.

e. The employee is not entitled to have anyone present at the examination unless OWCP decides that exceptional circumstances exist. For example, an interpreter may be allowed if a claimant is hearing-impaired. The law does not provide for participation by a physician of the claimant's choice in a referee examination (unlike second opinion examinations). 20 C.F.R. § 10.321(b).

f. A claimant who asks to participate in selecting the referee physician or who objects to the selected physician should be requested to provide his or her reason for doing so. The CE is responsible for evaluating the explanation offered. See *Miguel A. Munitz*, 54 ECAB 217, 221 (2002) (ECAB held that OWCP properly denied appellant's request to participate in the selection of the impartial medical specialist: "appellant's representative merely requested to participate in the selection of the referee examiner, in an 'attempt to assure that the claimant receives an impartial evaluation concerning this schedule award claim.' The Board finds that he did not provide a valid reason for participating in the selection and did not raise a specific objection to the selected physician."); *Terrance R. Stath*, 45 ECAB 412 (1994) (ECAB has recognized that under the OWCP's procedures, a claimant is entitled to participation in the selection of an impartial specialist; however, the claimant does not possess an unqualified right to participate. The claimant must provide a valid reason for request for participation at the time the conflict of medical opinion is found.).

(1) Examples of circumstances under which the claimant may participate in the selection include (but are not limited to):

- (a) Documented bias by the selected physician;
 - (b) Documented unprofessional conduct by the selected physician;
 - (c) A female claimant who requests a female physician when a gynecological examination is required; or
 - (d) A claimant with a medically documented inability to travel to the arranged appointment when an appropriate specialist may be located closer. For instance, if the orthopedic specialist chosen through the Medical Management application in iFECS is three hours by automobile from the claimant's home, but an orthopedic specialist in the nearest large city is only one hour away by airplane, the latter physician may be chosen if the attending physician documents that the claimant can not travel for three hours by automobile.
 - (e) Simple preference for examination in a particular location will not be considered a valid reason. See *S.W.*, Docket No. 09-1110 (issued February 19, 2010) (ECAB held that appellant did not present any evidence establishing that the impartial selection was improper: "Although appellant's attorney noted that the Office of the impartial medical examiner was approximately 281 miles from appellant's residence, the Office indicated that it would reimburse travel expenses, including the cost of an overnight stay, if necessary. A simple preference for examination in a particular location is not considered a valid reason for objecting to an impartial medical examiner.").
- (2) If the reason is considered acceptable, the scheduler will prepare a list of three specialists available through the Medical Management application in iFECS, including a candidate from a minority group if indicated, and ask the claimant to choose one. This is the extent of the intervention allowed by the claimant in the process of selection or examination.
- (3) If the reason offered is not considered valid, a formal denial on the claimant's request, including appeal rights, may be issued if requested.

g. Follow-up Action. Using the SOAF as the framework for his or her opinion, the referee physician should provide a report which contains a clinical history, results of the examination, results of any testing performed, and a reasoned opinion in response to the questions posed sufficient to resolve the conflict. A report should be expected within 30 days of the examination.

(1) If no medical report is received within 30 days from the date of appointment, the CE or medical scheduler should inquire as to the status with the referee physician's office. The CE or medical scheduler may also follow up soon after the date of the appointment to verify the claimant's attendance at the appointment. For a complete discussion describing the circumstances under which benefits may be suspended under 5 U.S.C. 8123(d) for failure to attend an appointment, see PM 2-0810-13 Suspension of Benefits.

(2) The CE must refrain from verbal contact to discuss any substantive issue in the case with a physician who has been engaged to provide a referee opinion. All such communication regarding these issues should be in writing.

If a referee medical report is obtained through such substantive telephone contact with the physician or submitted as a result of such contact, the referee report must be excluded. See PM 2-0810-12 for further details regarding exclusion of medical evidence.

The CE may only verify attendance at the appointment and inquire as to the status of the submission of the report, and should document that verification with a CA-110.

(3) Upon receipt of the report, the CE should review the specialist's report to ensure that it meets the requirements for a referee examination and that it addresses all issues posed.

(a) If someone other than the selected physician examined the claimant, the report cannot be used to resolve a conflict in medical opinion and cannot be afforded special weight. It should be annotated accordingly, and another referee examination must be arranged. Moreover, any indication of interference by the employing agency or claimant's representative will be considered sufficient to bias the report, which will then not be considered probative evidence.

(b) If clarification or additional information is necessary, the CE should write to the specialist to obtain it. Under no circumstances, however, should the CE telephone the specialist for elaboration of the report as information obtained in this manner cannot be considered probative medical evidence and bias may be inferred as a result, leading to exclusion of the report. See PM 2-0810-12 for further details regarding exclusion of medical evidence.

(c) Upon receipt of any clarifying information, the CE should again review the report to ensure that it is complete and pertinent to the questions asked. When the referee's report is considered adequate, the CE will take action without review by the DMA, except where a referee examination was arranged to resolve a schedule award issue. See PM 2-810-8.k. for further details regarding DMA review of referee reports relating to schedule award determinations.

5. Medical Management Application. The Medical Management application in iFECS, which replaced the Physician Directory System (PDS), allows users access to a database of Board-certified specialist physicians and is used to schedule referee examinations. On rare occasions, the Medical Management application will be used to locate qualified second opinion examiners if a second opinion examiner within the second opinion contract for the District Office cannot be utilized; the rotational requirement does not apply to second opinion examiners. The Medical Management application contains an automatic and strict rotational scheduling feature. This application provides for consistent rotation among physicians and records the information needed to document the selection of the physician.

a. In 2000, an updated version of the PDS stand-alone software was placed into the FECS system, replacing the previous PDS system. The directory of medical specialists contains physicians from the American Board of Medical Specialties (ABMS). The ABMS includes the

medical Boards of the American Medical Association (AMA) that certify candidates in their respective fields of specialization.

The OWCP recognizes osteopathic doctors (D.O.) as physicians within the meaning of the Act. As such, the OWCP also accords special weight to their opinions as impartial referee physicians, provided they are Board-certified with the American Osteopathic Association (AOA).

b. Selection of a referee physician should be made only through the use of the Medical Management application (absent exceptional circumstances discussed below), and CEs may not dictate which physician will serve as a referee examiner.

However, where exceptional circumstances exist (such as when an esoteric specialty is required, or the Medical Management application does not contain any physicians of the required specialty within a 200-mile radius of the claimant's home zip code), scheduling outside of the Medical Management application may be appropriate. If this occurs, the scheduler should consult an appropriate directory of Board-certified medical specialists to obtain names of suitable physicians for referral. Documentation outlining the rationale for this decision must be placed in the case file, and the decision must be approved by a Supervisory Claims Examiner or higher level authority.

If an examination needs to be rescheduled with a prior referee examiner in accordance with a remand order or when a follow-up examination is necessary, scheduling outside of the strict rotational guidelines may also be necessary. In these more obvious instances, documentation must still be placed in the case file, but approval by a Supervisory Claims Examiner or higher level authority is not required.

c. When the medical scheduler inputs a claim number, the claimant's home zip code is automatically loaded. The medical scheduler then chooses the type of examination (generally referee) and the appropriate specialty. Information regarding the next physician on the roster, based on primary medical specialty and zip code, appears on the screen and remains on the screen only until the appointment is scheduled or until the physician is bypassed.

The entire roster of physicians is invisible to the medical scheduler, as he or she can only see and update appointment information pertaining to any particular physician while an attempt to schedule an examination with that physician is being made. See paragraph 6 of this chapter for a complete discussion on the reasons for bypassing a physician.

d. The universe of physicians included in the search and available for second opinion or referee scheduling is based on the primary specialty chosen and the claimant's home zip code.

e. Presentation of Physicians.

(1) The Medical Management application uses zip code clusters (the first three digits of the zip code) to select physicians for the initial rotation. For example, if the claimant's home zip code is 12345, the Medical Management application will select physicians of the appropriate specialty who have "123" as the first three digits in their zip codes.

(a) From the universe of physicians in this zip cluster, the Medical Management application separates them into essentially two groups – physicians who have previously had an appointment scheduled within the Medical Management application, and those who have not.

(b) The physicians who have not had a previous appointment scheduled in the Medical Management application are presented to the scheduler first. These physicians are presented in alphabetical order.

(c) If all of these physicians must be bypassed, then the Medical Management application presents the physicians who have had previous appointments scheduled. These physicians are presented in order such that the physician who had an appointment scheduled most recently will be at the bottom of the list based on the date that the last appointment was scheduled. The physician who had an appointment scheduled furthest in the past will be the first physician presented (after those who have never had a previous appointment scheduled).

Note that the order is based on the date on which the last appointment was scheduled (not the date of the actual appointment).

(2) If every physician in the initial zip cluster must be bypassed, the Medical Management application will then select physicians outside of the zip cluster that are within a 50-mile range of the claimant's home zip code. Physicians are presented in the same order as the initial zip cluster (first those who have never previously had an appointment scheduled within the Medical Management application, and then those that have had a previous appointment scheduled). See 5e(1) above.

If every physician in the 50-mile range outside of the zip cluster must be bypassed, the Medical Management application then extends to a 75-mile range, and continues to expand in 25-mile increments until the 200-mile range is reached.

(3) The Medical Management application sets 200 miles as the maximum limit for a zip code range.

(a) Once the 200-mile range (using the claimant's home zip code) has been exhausted, a "Zip Code Exhausted" report will be automatically generated for the file showing all of the physicians that have been bypassed during that search.

(b) If the scheduler reaches the 200-mile limit and still cannot locate an appropriate physician, the scheduler will then need to use an alternative method for scheduling the examination as outlined in 5b of this chapter. Alternatively, it may be appropriate to choose a different zip code, other than the claimant's home zip code, in order to continue the search. A different zip code may be used, for instance, if the claimant lives in a very remote area and will need to travel to a larger city in order to attend a scheduled examination. In this instance, the scheduler will enter the zip code of the city to which the claimant will be traveling.

(c) An alternative search with a different zip code should only be pursued if the 200-mile range (using the claimant's home zip code) has been exhausted. The reason for the alternative zip code search should be documented in the file.

(4) The Medical Management application calculates "distance" based upon the approximate number of miles between the claimant's home zip code and the physician's zip code. This "distance" is not a precise determination based upon a calculation from the claimant's specific address to the physician's specific address, since the capability to calculate that precise distance does not exist within iFECS.

Note that the "distance" need only be within the specified incremental range and does not affect the order in which the physicians are listed as described in 5e(1) above.

f. The medical scheduler will contact each physician presented by the Medical Management application to ascertain whether the necessary appointment can be scheduled in a timely manner.

g. If an appointment cannot be scheduled in a timely manner (or cannot be scheduled for some other reason such as a conflict, the physician is of the wrong specialty, etc.), the scheduler will update the application with an appropriate bypass code. Upon entering a bypass code, the Medical Management application will select the next physician in the rotation (as outlined in 5e above). See paragraph 6 of this chapter for more explicit information pertaining to the use of bypass codes.

h. If the physician agrees to schedule the appointment, the scheduler inputs the appointment date and time into the Medical Management application. The application saves the appointment information and prompts the scheduler to generate the ME023, Appointment Notification Report, for imaging into the case file.

i. The ME023, Appointment Notification Report, can only be generated through the Medical Management application and serves as documentary evidence that the appointment was scheduled through the use of the rotational system in the Medical Management application. The medical scheduler should image a copy of the ME023 report into the case file to substantiate that the rotational system was used to select the physician. In the event that the ME023 report is not imaged into the case file at the time the appointment was scheduled, and an issue is subsequently raised concerning the physician selection (such as in an appeal process), a copy of the original ME023 report may be reproduced at a later date.

Note, however, that the updated version of the ME023 report (described below) can only be generated for new appointments created on and after December 17, 2012. It cannot be accurately generated for appointments made prior to December 17, 2012, and the prior version of the ME023 report (without bypass information) can no longer be duplicated.

As of December 17, 2012, the ME023 report contains the following information:

(1) For the physician selected, the following information will be available on page 1 of the report: the claimant's name, case number, and home zip code; the name, address, phone number,

and specialty of the physician selected for the appointment; the date, time, and type of appointment; and the user ID of the individual who generated the report.

If physicians were bypassed prior to the selection of this physician, the selected physician's information will also be listed at the end of the report in a section that denotes the physician that was selected for the appointment. The date on which the appointment was scheduled will also be listed here. (This is not the same as the date of the actual appointment.)

(2) For each physician bypassed, the report will show the following information on subsequent pages of the report:

(a) The name, specialty, state, and zip code based upon the information in the Medical Management application.

(b) A distance based on the approximate number of miles between the claimant's home zip code and that physician's zip code. See 5e(4) for more detail on the calculation of the distance.

(c) The date on which the last appointment was scheduled with that physician based upon the information in the Medical Management application. (This is not the same as the date of the actual appointment.) If there is no record of any previously scheduled appointment, the report will list "none."

(d) The date and time the physician was bypassed, along with the bypass code (and bypass note, if any). See paragraph 6 of this chapter for a more detailed discussion of bypass codes.

(3) Every page of the ME023 report (other than the first page) has a certification statement on the bottom verifying that the report is evidence that the appointment was scheduled using the Medical Management application in iFECS.

(4) The ME023 report is separated into sections based on the various search ranges (Initial Zip Cluster Match, 50-Mile Range Outside of Zip Cluster, 75-Mile Range Outside of Zip Cluster, etc.). If no physicians were found within a particular range, the report shows this result.

j. If a scheduled appointment has to be cancelled or rescheduled for any reason, the file should be appropriately and clearly documented.

6. Medical Management Codes. The Medical Management application has numerous codes to display the disposition of physicians and appointments.

If a physician cannot or will not schedule an examination, he or she must be bypassed in the Medical Management application so that the next physician in the rotation is available for scheduling. Various codes are used to document the reasons for not scheduling an examination with a physician in the rotation.

Most codes are stand-alone codes and do not require any rationale beyond their meaning as outlined in this chapter. However, three codes, code B (Busy), code L (Location), and code O

(Other), do require a note explaining the reason for entry of the code. The note is entered directly into the Medical Management application, without any requirement that the imaged file be documented. Bypass notes entered must be sufficiently detailed to explain the reason the physician was bypassed (e.g. a note like "pass" is not sufficient), and the use of local abbreviations should be avoided. Finally, while notes are not mandatory for all codes, if the scheduler enters a note, it should be applicable and germane to the bypass code used.

Code A - Appointment Cancelled. This code is used when an appointment has been cancelled by either the physician or OWCP. This code is not a bypass code option but can be used in other portions of the Medical Management application.

Code B - Busy. This code is used when the physician cannot schedule an appointment in a reasonable amount of time (usually within 60 days) or is on extended leave or a leave of absence. A note is required to further explain usage of this code, e.g. "physician is on medical leave of absence - unknown return date." This code should NOT be used if the telephone line is busy or if the medical receptionist indicates the physician is too busy at the moment to take the call.

If a physician will be on a defined period for a leave of absence longer than 60 days, the user should annotate the physician's record in the Medical Management application in iFECS as appropriate. This will ensure that the physician does not appear in the rotation for the leave of absence period but will again appear in rotation once the leave of absence has ended.

Code C - Conflict. This code is used if the physician, or his/her associate, has a previous connection with the claim. This also includes physicians performing fitness for duty exams for the employing agency.

Code D - Physician does not accept DOL patients. This code is used if the physician will not accept any Department of Labor (DOL) cases, will not do IMEs, will not accept workers' compensation cases, or is not willing to perform examinations for OWCP.

If a physician will not accept DOL or OWCP cases for medical examinations, the physician's record in the Medical Management application in iFECS should be updated so that the physician no longer appears in the rotation.

Code E - Excluded/Lost license. This code is used if a physician is an excluded provider or has lost required licensing. This code is not a bypass code option but can be used in other portions of the Medical Management application.

Code L - Location is too far for claimant. This code is used when the physician's office is too far for the employee to travel, or the claimant may be medically unable to travel long distances to report for examination. A note is required to further explain usage of this code, since distance to travel is accounted for in the rotational presentation of physicians in the Medical Management application.

Code M - Physician moved out of zip code area. This code is used when the physician is no longer at the address shown in our database. The medical scheduler should attempt to obtain

current contact information to update the physician address in the Medical Management application. If the physician is still within the same zip code as the address in the Medical Management application, the address can be updated and the appointment scheduled.

Code O - Other. This code is used when none of the other bypass reasons are applicable. This code is appropriate to use when no one answers the phone (e.g. "phone rings continuously with no answer") or the phone number has been disconnected (e.g. "phone disconnected/no other contact number noted"). A note is required to explain usage of this code, and code O should not be used if there is another appropriate code.

Code O is also appropriate if the medical scheduler must leave a message. If a message must be left, the medical scheduler should note the name of the person who was contacted or that a message was left on a voice mail. While waiting for a return call, the appointment with that particular physician should be put into a "pending" status. The scheduler should allow the physician's office a minimum of two business hours for a return call (as determined by usual physician business hours). If the physician's office does not call back within this period of time, the physician can be bypassed with the O code and another physician can be contacted. When the scheduler removes the "pending" status, the bypass note should be updated with an annotation that no call back was received. If a call back was received, and it was determined that the appointment could not be scheduled for some other reason (related to another bypass code), the record should be updated accordingly.

If a physician previously bypassed as non-responsive contacts the OWCP medical scheduler prior to the scheduler finalizing an appointment with another physician, continued efforts to arrange an examination with the second physician should cease and the appointment should be scheduled with the previously bypassed physician, as he or she was actually earlier in the rotation of physicians. If this occurs, the note should be updated accordingly when the appointment is scheduled.

Code S - Subspecialty. This code is used if the case requires a different subspecialty, or if the physician does not evaluate the specific body part or extremity. For instance, the physician will only perform exams for back conditions but the claimant has an upper extremity injury.

Code U - Physician in use by another user. This code is used when the physician is in use by another user. It is not available as a bypass option; rather, it is automatically updated by the Medical Management application when the next physician in the rotation is currently in use or in pending status (being contacted for an appointment) by another user.

Chapter 3-0600, Requirements for Medical Reports

1. Purpose. The Office relies on written medical reports to justify awards for compensation, support payment of medical expenses, and monitor the quality of care being provided. This

chapter will detail the type of information needed to render proper determinations for the medical issues in each case.

2. Reports of Disability and Impairment. Reports are submitted by attending physicians, consultant (second opinion) specialists, and referee physicians. Each report may address one or more topics pertaining to the claimant's medical status. Whatever the format or source of a report, the information provided in it must be sufficiently clear and detailed so that claims and medical reviewers are certain of the physician's findings, conclusions, and opinions.

Under the FECA, impairment is defined as the anatomical or functional loss or reduction of a function of an organ of the body in reference to the activities of normal life; it pertains solely to the claimant's medical condition. Disability is defined, on the other hand, in terms of the claimant's ability to perform the duties of his or her job.

3. Statement of Accepted Facts (SOAF). Where a medical opinion is needed to resolve an issue in a case, the file is referred to the Medical Unit with a list of questions (see paragraph 4 below). An SOAF usually accompanies the case and provides the factual background for the physician's opinion. Only where the Claims Examiner (CE) needs general information, for instance about the course of a disease, will an SOAF not be included.

a. Contents. All SOAFs should include the information listed in items (1) through (6); depending on the issue to be resolved, the information shown in items (7) through (10) will be included as well:

- (1) The claimant's name and age;
- (2) The employer and the job held at the time of injury;
- (3) Mechanism of injury;
- (4) Conditions claimed or accepted;
- (5) Work history since the injury, including the date the claimant stopped work and returned to either light or regular duty;
- (6) A description of medical treatment since the injury, including dates of treatment and names of physicians, and if relevant what diagnostic tests were conducted (physicians' findings and conclusions should not, however, be discussed in the SOAF);
- (7) Relevant medical history;
- (8) Specific description of injury or exposure factors, particularly in cases involving occupational disease;
- (9) The claimant's hobbies or activities outside of work;

(10) Physical or mental demands of claimant's regular or light duty job, or of light duty job offered.

Detailed instructions for CEs concerning the preparation of SOAFs are contained in PM Chapter 2-809.

The CE is responsible for ensuring that the SOAF is correct, complete, unequivocal, and specific. When the DMA, second opinion specialist or referee physician renders a medical opinion based on an SOAF which is incomplete or inaccurate or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether.

4. Questions for Response. Files referred to the Medical Unit will contain a list of question composed by the CE for response by the physician (DMA, second opinion or referee) to answer. In reviewing case files, the DMA should ensure that he or she addresses each of the questions posed, preferably in the order given, and that the response is:

- a. Complete and accurate in addressing all of the questions posed and in addressing them thoroughly. In some instances the DMA may identify medical issues which the CE has not addressed. It is perfectly appropriate to discuss such issues and provide information in addition to what the CE has requested as long as medical rather than adjudicatory questions are the subject of the discussion.
- b. Responsive to the material provided in the SOAF. If the physician whose reports are under review has based his or her opinion on other factual material, the DMA should take account of this in reaching an opinion.
- c. Well rationalized in discussing the opinion reached. Because the quality of the Office's adjudicatory functions depends heavily on well reasoned medical evidence, it is very important to provide clear rationale for the opinion given.
- d. Neutral with respect to adjudicatory issues. It is not appropriate for the DMA to offer opinions as to whether a case or medical condition should be accepted. Doing so may adversely affect the outcome of the case since it may suggest bias to a later reviewer.

5. Form of Medical Reports. The DMA will be expected to review, interpret, or evaluate a variety of medical reports ranging from simple form reports to detailed narrative reports (it should be noted that the use of an OWCP form is never required in making reports). Descriptions of OWCP forms are as follows:

- a. Form CA-16, Form CA-20, and Form CA-20a, Attending Physician's Report. An initial or preliminary report may be submitted on either Form CA-16 (Exhibit 1, Chapter 3-300 ([Link to Image](#))) or Form CA-20 (Exhibit 1 Pages 1-2([Link to Image](#)); Page 3 ([Link to Image](#))), while a supplementary report may be submitted on Form CA-20a (Exhibit 2 ([Link to Image](#))). A completed Form CA-16 or CA-20 represents sufficient medical evidence for adjudication of

most traumatic injury claims, although additional evidence in narrative form may be required to justify payment of continuing benefits.

b. Form CA-17, Duty Status Report. The CA-17 (Exhibit 3 ([Link to Image](#))) is used by the employing agency to obtain information from the attending physician about the claimant's work restrictions. A copy of the form may be sent to OWCP to aid in evaluating the extent of disability remaining. Reports submitted by the employing agency generally do not address all pertinent issues such as the causal relationship between current disability and factors of Federal employment. Therefore, these reports are usually considered as supplemental information although some narrative fitness-for-duty reports may be sufficiently probative in and of themselves.

c. Narrative Report. A narrative medical report may be required if disability continues or complex issues such as a pre-existing medical condition are present. In addition, narrative reports are necessary in almost all occupational disease cases. In any case where the injury causes disability for work for an extended period or requires lengthy treatment, reports describing the clinical course, prognosis, and recommendations for further medical care must be furnished as

6. Content of Medical Report. Regardless of the form a medical report takes, the following information will usually be required:

- a. Dates of examination or treatment;
- b. Clinical history given to the physician;
- c. Detailed description of physical findings;
- d. Results of any x-ray or laboratory tests;
- e. Diagnosis;
- f. Prognosis;
- g. Description of impairment, if any;
- h. Specific limitations for work;
- i. Clinical course of treatment followed;
- j. The physician's reasoned opinion as to the relationship between the condition found and factors of Federal employment. (Causal relationship is discussed in PM Chapter 2-805.)

In addition, a detailed description of the employee's work tolerance limitations is required in any case where the issue is the claimant's ability to return to duty, and a detailed description of anatomical impairment in accordance with the AMA Guides is required in any claim for schedule award.

7. Criteria. Guidelines for weighing the value of medical reports are provided in PM Chapter 2-810. The Office uses the following criteria in evaluating medical opinions:

- (1) Physician's Qualifications. The opinion of a specialist in the appropriate field of medicine often carries greater weight than the opinion of a non-specialist or a specialist in an unrelated field. The opinion of a Board-certified specialist or a specialist of professorial rank will carry added weight.
- (2) Medical Rationale. Opinion supported by a medical explanation is required in most cases.
- (3) Accuracy and Completeness. The factual and medical background reflected in the report must be correct and complete in accordance with the facts of the case and the medical information reflected in other reports in file.
- (4) Comprehensiveness. A comprehensive report is one which reflects that all testing and analysis necessary to support the physician's conclusions have been performed.
- (5) Consistency. The physical findings must substantiate the medical opinion.
- (6) Decisiveness. Opinions containing unclear or vague language can be characterized as equivocal, speculative or conjectural. Terms such as "could", "may", or "might be" indicate speculation and/or equivocation and are assigned less probative value than positively expressed medical opinions. The term "probably" is considered less speculative than the above terms and therefore has greater probative value.

The DMA should render his or her opinion using the Statement of Accepted Facts (SOAF), which the CE prepares (see Chapter 3-500 for a discussion of the SOAF). The opinion should be based on the medical evidence of record (except for any reports annotated with the word "excluded" because the evidence which they contain was improperly obtained.) The DMA should avoid commenting on legal issues when rendering a medical opinion. If the DMA disagrees with the opinion of the treating physician, a clear and thorough medical explanation must be included.

8. Specific Conditions. OWCP has developed checklists for use by claimants and their official superiors in order to better identify and gather the information required to support a claim for occupational disease. These checklists address the following conditions: hearing loss, asbestos, coronary/vascular conditions, skin diseases, pulmonary disease other than asbestos, psychiatric illness, and carpal tunnel syndrome. A general checklist is also available for use in claims for occupational diseases not enumerated above.

Occupational disease claims in general are discussed in PM Chapter 2-806. The following guidance is provided with respect to specific medical conditions encountered in OWCP claims:

- a. Hearing Loss. Refer to "Medical Management of Claims under the FECA" for a discussion of development of such cases. It is generally accepted that hearing loss may result from prolonged

exposure to noise levels above 85 decibels. Acoustic trauma may, however, result from decibel levels below 85 decibels if exposure is sufficiently prolonged. OWCP therefore does not require that the claimant show exposure to injurious noise in excess of 85 decibels as a condition to approval of the claim.

(1) After obtaining all pertinent factual evidence, the CE will prepare a Statement of Accepted Facts. Unless the case file already contains a reliable medical report which fully meets OWCP requirements, the CE should refer the claimant for audiological evaluation and otological examination which addresses the relationship of any hearing loss to the employment and the degree of any permanent impairment.

The audiological evaluation and the otological examination are to be performed by different individuals as a method of evaluating the reliability of the findings through independent observations. If possible, the two consultations should occur on the same day. The usual information sent to consultants, as outlined in PM 3-500.3c, should be forwarded to both the audiologist and otolaryngologist.

(2) The audiological testing is to be performed by persons possessing certification in audiology from the American Speech-Language-Hearing Association (ASHA), or State licensure as an audiologist. The audiological testing should precede the visit to the otolaryngologist since the latter should have the audiological findings at the time of the examination. The audiological examination should be conducted in accordance with OWCP requirements, which are described in Form CA-1087 (Exhibit 4).

(3) The medical examination should be performed by an otolaryngologist certified (or eligible for certification) by the American Board of Otolaryngology. The physician should be instructed to conduct additional tests or retests in those cases where the initial tests were inadequate or there is reason to believe the claimant is malingering. Form CA-1331 and Form CA-1332 can be used to obtain the required report.(Exhibit 5) Pages 1-2 ([Link to Image](#)); Pages 3-4 ([Link to Image](#)))

(4) Audiological equipment used for testing must meet the calibration protocol embodied in the Professional Services Board Manual of the ASHA (see Exhibit 6). Each audiologist or physician who conducts hearing tests must certify that at the time of examination the equipment used for testing met the standards for accreditation of an audiological facility by ASHA (ANSI S 3.6 (1969) and 3.1 (1977), respectively).

(5) Where the employee is deceased, the following procedures are to be followed according to the stage of development of the medical evidence:

(a) Where an audiogram meeting the requirements set forth in Form CA-1087, either alone or in conjunction with audiograms that do not meet OWCP requirements, appears in the file, the audiogram may be used as the basis of an award if it is medically determined to be internally consistent (the various measurements of the components of hearing are in substantial agreement) and the evidence shows a causal relationship between the hearing loss and employment.

(b) Where no audiogram meets the requirements of Form CA-1087, an audiologist should review all audiograms in the case to ascertain whether they are internally consistent with each other and whether the hearing loss was causally related to employment. If so, an appropriate audiogram should be selected as the basis for an award. If not, every effort should be made to determine an equitable award. Where an award is made based on evidence which does not fully meet the OWCP's requirements, the CE should prepare a detailed memorandum to the file which explains how the award was determined. Such decisions should be signed at the level of the Senior CE or above.

(6) The DMA calculates the percentage of hearing loss using Form CA-51 (see Exhibit 3 of PM 3-700 (Link to Image,)) if a schedule award is at issue. The DMA provides opinion regarding the causal relationship between any hearing loss and the employment and verifies the calculations of the audiologist.

b. Asbestos-Related Diseases. Refer to "Medical Management of Claims under the FECA" for a discussion of development of such cases. It is accepted that asbestos-related disease may result from occupational exposure in excess of two fibers/cc (moderate or heavy) during the course of Federal employment, or the presence of asbestos dust on work surfaces, even if invisible.

(1) After obtaining all pertinent factual evidence, the CE should consider referral to a pulmonary specialist.

(a) If the level of exposure indicated above has been met and a medical report indicates the possible existence of an asbestos-related abnormality, such as X-ray report of pleural or parenchymal abnormality or report of pulmonary fibrosis, the CE should prepare a Statement of Accepted Facts and arrange for referral of the claimant to a pulmonary specialist for complete evaluation in accordance with the requirements shown in Exhibit 7, OWCP Medical Examination Requirements in Asbestos Disease Cases.

(b) If the level of exposure indicated above has been met but no medical report indicates the possible existence of an asbestos-related abnormality, the claimant shall be instructed to arrange for submission of a current medical report from his or her treating physician which meets all of the requirements shown in Exhibit 7, OWCP Medical Examination Requirements for Asbestos Disease Cases. If the submitted report satisfies OWCP requirements and the case is accepted, the cost of the examination is reimbursable.

In addition to the usual materials sent to consultants (see PM 3-500.3), the physician selected should be sent copies of Form CM-933 (Exhibit 8, Page 1 ([Link to Image](#)), Page 2 ([Link to Image](#))) and the job description.

(2) Where the employee is deceased, the CE should evaluate the available medical evidence for completeness and refer the file for medical evaluation (with Statement of Accepted Facts) to a pulmonary specialist.

(3) The DMA or consultant acting in that capacity, preferably a Board-certified pulmonary specialist, should review the report once the CE determines that it is complete. The medical specialist should be asked to consider the following issues:

- (a) Diagnosis. Are the laboratory and physical findings adequately supportive?
- (b) Work-Relatedness. Has Federal occupational exposure contributed to development of diagnosed conditions by direct cause, aggravation, acceleration or precipitation?
- (c) Impairment. With reference to the AMA Guides, what percent of pulmonary impairment is indicated?
- (d) Disability. Is the evidence sufficient to allow a determination of the extent and degree of disability for normal work (current or last) as a result of the diagnosed condition? Is the disability partial or total, temporary or permanent?
- (e) Treatment. Is the recommended treatment appropriate?
- (f) Follow-up. When should the next pulmonary evaluation be performed?
- (g) Employment. If the claimant is still employed and exposed to asbestos, should employment continue based on current medical findings, medical knowledge, and documented working conditions?

c. Carpal Tunnel Syndrome. This condition involves the compression of the medial nerve between the longitudinal tendons of the wrist musculature and the transverse superficial carpal ligament along the palmar aspect of the wrist (see Exhibit 9 ([Link to Image](#))). Symptoms resulting from this compression include pain, numbness, tingling, and weakness of the affected hand (usually the dominant one, though bilateral involvement does occur). Causes which may be work-related include constant exertion and/or repetitive motion with the wrist flexed or extended against resistance, and acute trauma. The medical report should contain clear evidence that the disease is present. Among the clinical findings are:

- (1) Phalen's Sign. This test is positive if maintenance of forced hyperflexion for one minute precipitates pain and paresthesia.
- (2) Tinel's Sign. This test is positive if tapping over the medial nerve at the wrist produces pain.
- (3) Neurological Abnormalities. These include decreased sensation over the palmar aspect of the end joints of the same three and one half digits and atrophy of the thenar eminence in severe cases.
- (4) Decreased nerve conduction velocity (NCV) as measured during nerve conduction test. The test results should include an evaluation as to whether the velocities obtained are normal or not.

(5) Decreased muscle motor activity as measured by electromyography (EMG). The test results should clearly indicate whether the results are within normal limits or are abnormal. An opinion as to the cause of the abnormality may also be present.

9. Partial Disability. When employment-related injury or disease permanently prevents a return to regular duties, the Office and the employing agency work together to reemploy the claimant within his or her work restrictions if possible. If not, OWCP will offer rehabilitation services to the employee with the goal of reemployment in the general work force.

a. Loss of Wage-Earning Capacity (LWEC). The CE monitors medical reports to determine the extent of disability resulting from an employment-related injury or disease. When an attending physician's report indicates the claimant is no longer totally disabled for all work, the physician is sent Form CA-1302, Request for Medical Progress Report (or narrative equivalent) and/or Form OWCP-5, Work Tolerance limitations. When this information is received, the DMA will review it in conjunction with the description of the position under consideration in order to determine the claimant's ability to perform the duties involved, if that position has been identified by using the Dictionary of Occupational Titles (that is, the position is not one which has actually been offered to the claimant).

Occasionally the DMA will be asked to complete the Form OWCP-5 based on the examining physician's findings. In doing so, the DMA should consider any disability which existed prior to the injury as well as any disability resulting from the employment injury. Subsequently acquired conditions unrelated to the injury are excluded from consideration in determining the claimant's LWEC but are included when considering suitability of an offered position.

b. End of Schedule Awards. As with disability, permanent impairment does not always result in a loss of wage-earning capacity. In some cases, however, the claimant cannot return to the kind of work performed at the time of injury, and when this happens, compensation may be awarded based on the claimant's LWEC. Prior to the expiration of the schedule award, the CE may request a current medical report to determine whether a claimant has any LWEC due to the employment injury. To make a proper determination, the DMA must review the claimant's job description, including its physical requirements, and compare the claimant's current work tolerance limitations with the position description.

Exhibit 1: Attending Physician's Report, Form CA-20

Page 1-2 ([Link to Image](#))

Page 3 ([Link to Image](#))

Exhibit 2: Attending Physician's Supplemental Report, Form CA-20a

Pages 1-2 ([Link to Image](#))

Exhibit 3: Duty Status Report, Form CA-17 ([Link to Image](#))

Exhibit 4: OWCP Hearing Loss Medical RequirementsOWCP HEARING LOSS MEDICAL REQUIREMENTS

Each employee should be seen for audiological and otological examination. The audiological testing should precede the visit to the otologist; the otologist should have the audiological findings at the time of the examination; and, to the extent possible, these two consultations should occur on the same day. It is also required that the audiological and otological examinations be performed by different individuals.

Any tests administered as part of an audiological battery must be conducted by a person possessing certification in audiology from the American Speech-Language-Hearing Association (ASHA) or State licensure as an audiologist. The medical examination must be performed by an otolaryngologist certified (or eligible for certification) by the American Academy of Otolaryngology. All tests comprising the battery administered in the audiological evaluation must be performed in an environment meeting the specifications of ANSI S3.1 (1977). Facilities which are accredited by the Professional Service Board of the ASHA meet this requirement. Testing equipment must be calibrated in accordance with the protocol contained in the accreditation manual of ASHA's Professional Service Board (ANSI S3.6-1969).

Audiometric tests must include the following:

1. Pure-tone air conduction thresholds should be obtained for each ear at 500, 1000, 2000, 3000, 4000, 6000 and 8000 Hz. Bone conduction thresholds should be obtained for the specified frequencies from 500 to 4000 Hz, inclusive. Appropriate masking should be employed as necessary and the use of masking should be denoted on the audiogram. The symbols used in recording thresholds should be in accordance with the most recent ASHA recommendations.
2. Impedance audiometry should be done on both ears as a means of determining the reliability of air-bone conduction threshold relationships and for any contribution it might otherwise make to differential diagnosis by the physician.
3. Speech reception thresholds for each ear should be established, using test procedures and spondaic words which conform to guidelines (ASHA Committee on Audiometric Evaluation, 1979). Standardized recorded materials should be used rather than live voices.
4. Monaural discrimination scores should be obtained; masking should be used when necessary. Standardized recorded word lists should serve as the stimuli and the discrimination scores for the full list should be reported for each ear.

Reports must include, as appropriate:

1. Date and hour of examination.

2. Date and hour of employee's last exposure to loud noise. (If the employee was exposed to noise within the last 16 hours, do not proceed with testing.)
3. History of injury.
4. The physician's rationalized medical opinion regarding the relation of the hearing loss to employment-related noise exposure.
5. The physician's recommendation for treatment.
6. A certification must accompany each audiological battery indicating that instrument calibration and the environment in which the tests were conducted met the accreditation standards of the Professional Services Board of ASHA (ANSI S3.6 (1969) and S3.1 (1977), respectively). A copy of the calibration standards are attached for your convenience.
7. A statement commenting on the reliability of the tests.

Exhibit 5: Outline for Otologic Evaluation, Form CA-1332

Pages 1-2 ([Link to Image](#))

Pages 3-4 ([Link to Image](#))

Exhibit 6: Calibration Requirements for Accreditation of an Audiological Facility by the Professional Services Board

CALIBRATION REQUIREMENTS FOR ACCREDITATION OF AN
AUDIOLOGICAL FACILITY BY THE PROFESSIONAL SERVICES BOARD

7.3.4. Calibration: The program shall establish and follow

- 7.3.4.1. The program shall keep an accurate record of all audiometric calibrations performed. The record shall include at least:
 - a. Type of calibration--biological, electroacoustic,.
 - b. Date performed.
 - c. All measurements obtained.
 - d. Name of observer.
 - e. Equipment calibrated (make, model,serial#).
 - f. Calibration equipment used (make, model, serial#).
- 7.3.4.2. Diagnostic audiometers and/or audiometers used in fixed locations shall meet ANSI S3.6-1969 specifications for wide-range audiometers and shall be calibrated according to the following schedule:
 - a. Daily: A brief biological check of the audiometer to ensure proper operating order shall be made each day the audiometer is in use.
 - b. Monthly:

(1) A detailed biological check of the audiometer which includes a careful listening test of earphones and bone vibrator shall be performed to ensure that the audiometer displays no evidence of:

- (i) Cross talk.
- (ii) Signal distortion.
- (iii) Abnormal noise.

(2) An electroacoustic calibration check of non-solid-state audiometers shall be made once a month which includes at least the following measurements:

- (i) The accuracy of the sound pressure levels for all pure tones in both earphones.
- (ii) The accuracy of the sound pressure levels for all masking noises in both earphones.
- (iii) The accuracy of the sound pressure levels for speech signals in both earphones.
- (iv) The accuracy of the sound pressure levels for speech signals in all sound field loudspeakers.

c. Quarterly: An electroacoustic calibration check of solid-state audiometers shall be made once every three months which includes at least the measurements specified in section 7.3.4.2.(2)(i)through (iv).

d. Annually: An electroacoustic calibration check of all audiometer shall be made every 12 months which includes at least the following measurements:

- (1) The accuracy of output levels for all pure tones in bone vibrator(s).
- (2) The accuracy of the frequency calibration for pure tones.
- (3) The accuracy of rise/decay time for all pure tones.
- (4) Harmonic distortion for pure tones.
- (5) Signal-to-noise ratio for all outputs.
- (6) Accuracy of attenuator linearity.
- (7) Accuracy of signal parameters utilized in special diagnostic tests, including impedance/admittance.
- (8) Freedom from shock hazard.

Exhibit 7: OWCP Medical Examination Requirements in Asbestos Disease Cases

OWCP MEDICAL EXAMINATION REQUIREMENTS IN ASBESTOS DISEASE CASES

1. Occupational History. Chronological summary of the individual's job history which includes a description of the frequency, degree, and duration of occupational exposures to asbestos with emphasis on exposure in Federal civilian employment, but which includes exposure in non-Federal employment. Include other dusts or toxins and any non-occupational exposure.

2. Medical History. Chronological summary which includes references to any previous injuries or illnesses, pulmonary problems and the development of pulmonary symptoms. Summary of pulmonary symptoms. Complete smoking history. Family medical history.

3. Physical Examination. To include description of all the following:

- a. General appearance and performance.
- b. Sex, age, height and weight.
- c. General examination denoting the presence or absence of cyanosis, clubbing, nicotine stains, edema, hepatomegaly, ascites and other signs ascribable to the pulmonary and cardiovascular systems.
- d. The pattern and rate of claimant's breathing (presence and degree of dyspnea, etc.); the presence of any exertional changes.
- e. Results of cardiac examination.
- f. The results of chest examination, including configuration, findings on percussion and auscultation (i.e., the presence or absence of rales and/or other abnormal sounds).

4. Chest X-rays and CAT Scans. Minimum of AP, lateral and R and L oblique views. A full size x-ray shall be taken under the supervision of a Board-certified radiologist and read by either a Board-certified radiologist or pulmonary specialist. This reading must include a description of the quality of the film and all radiographic findings. The examining physician will also review the film for these same purposes.

The x-ray interpretation must include a description of any abnormality or pathology present with special attention given to evidence of pulmonary hypertension, fibrosis, carcinoma, or mesothelioma. If any abnormality or pathology is present, the description must include the following information:

- a. Presence or absence of opacities described by type, size, shape, distribution and profusion.
- b. Presence or absence of plural thickening, plaques or calcification, with description of site and extent.
- c. Presence or absence of ill-defined diaphragmatic or cardiac outlines with description of extent.
- d. Any other pertinent findings of a chronic or acute nature.

X-rays should be kept available for review but should not be sent to this Office unless requested. Additional views may be obtained at the discretion of the physician.

In lieu of x-rays, the physician may elect to perform computerized axial tomography (CAT scan) of the thorax, which can provide a more definitive view of the lungs and the presence or absence of asbestosis.

5. Pulmonary Function Studies. To include measurement of the following functions (the report of the results of the FVC, FEV(1), and diffusing capacity must include actual recorded values, the percent of predicted normal, and identification of the normal standard applied for tests conducted before and/or after the use of bronchodilators). These studies should be performed under the supervision or direction of a Board-certified pulmonary specialist.

a. Forced Vital Capacity (FVC) and Forced Expiratory Volume in One Second (FEV(1)) measured in liters and representing the best of three efforts and the FEV(1)/FVC Ratio (FEV(1)%) computed from these results. Also include total lung capacity (TLC). Report of the results of these tests must include:

- (1) Date and time of the test.
- (2) Name, file number, sex, age, weight, and height of the patient.
- (3) The names of the technician performing and the physician supervising the test, if different from the referring physician.
- (4) A description of the patient's ability to understand and follow instructions and the degree of cooperation in performing the test.
- (5) The paper speed (if applicable) and the name of the instrument used.
- (6) The date of last calibration of the instrument.
- (7) Whether and why a bronchodilator was used and its impact on test results.

The report must be accompanied by appropriately labeled spirometric tracings (for all tests) showing distance per second on the abscissa and distance per liter on the ordinate.

b. Carbon Monoxide Diffusing Capacity (Single Breath Method). The results must be reported in ml/mm/mmHg. The report of the test must include estimated alveolar volume (based on measured FRC), the barometric pressure at the time of the test, the name of the technician performing the test and the instrument used, and the date of last calibration.

c. Arterial Blood Gas Study, administered at rest. A blood gas study may be done during exercise only if not medically contraindicated and if, in the opinion of the examining physician, it is necessary for diagnostic purposes. Report of the ABG study must include recorded values for pCO(2), pO(2), and pH collected simultaneously; the date and time of the test; the altitude and barometric pressure at which the test was conducted; the name of the technician and supervising physician; the pulse rate at the time the blood sample was drawn; the time elapsed between drawing and analysis of the sample and whether the specimen was iced; the duration and time of

exercise (if appropriate); and a statement indicating that the equipment was calibrated before and after each test.

6. Electrocardiogram results submitted with tracings.

7. Complete Blood Count.

8. Medical Impression and Opinion which includes:

a. Diagnosis of all pulmonary conditions present.

b. Diagnosis of any other relevant disease condition present.

c. Recommendations regarding indicated course of treatment to improve the level of pulmonary function.

d. A discussion of the findings regarding the indicated degree of pulmonary impairment and exertional limitations (with reference to the enclosed job description).

e. Discussion of work-relatedness, including a detailed discussion of other possible etiological factors for each of the diagnosed conditions.

Exhibit 8: Roentgenographic Interpretation

Page 1 ([Link to Image](#))

Page 2 ([Link to Image](#))

Exhibit 9: Carpal Tunnel Cross-Sectional View ([Link to Image](#))

Chapter 3-0700, Schedule Awards

1. Purpose. The FECA provides that compensation may be paid for total or partial loss, or loss of use of, certain parts of the body which are specified in the FECA itself and in the regulations. The purpose of this chapter is to describe the procedures involved in medical evaluation of claims for such awards.

2. Definition and Standards for Evaluation. The phrase "permanent disability" in 5 U.S.C. 8107(a) is interpreted to mean "permanent physical impairment." The same standards for evaluating such impairment are applied in all cases. The AMA Guides to the Evaluation of Permanent Impairment is used in order to provide a consistent method of calculating impairment. Exhibit 1 addresses calculations according to the Sixth Edition of the Guides.

Since the Sixth Edition of the Guides is diagnosis based, the main factor in determining impairment is the diagnosis itself. Each diagnosis grid is divided into five classes of impairment severity, ranked from '0' (no impairment) to '4' (very severe). Raters distinguish the level of severity using criteria separated into key factors and non-key factors. These criteria consist of: (1) history of clinical presentation; (2) physical findings; (3) clinical studies or objective test results; and (4) functional history. All of these various factors affect the total amount of impairment awarded to an individual.

3. Determining Schedule Awards. Development of cases for schedule awards is discussed in PM Chapter 2-808. The Claims Examiner (CE) will ask the District Medical Advisor (DMA) to evaluate a case when it appears to be in posture for schedule award determination. The DMA is responsible for reviewing the file, particularly the medical report on which the award is to be based, and then calculating the award. A table showing the number of weeks of compensation payable for various percentages of loss is shown as Exhibit 2.

a. Evaluating the Medical Report. The DMA should review the report of the physician estimating impairment with respect to the following factors:

(1) Maximum Medical Improvement. Before an award may be made, it must be medically determined that no further improvement can be anticipated and the impairment must reach a fixed and permanent state, which is known as Maximum Medical Improvement (MMI).

(a) While additional medical treatment (such as surgery) may be recommended in order to improve the claimant's condition, the claimant is not required to undergo such treatment. See Santo Panzica, 13 ECAB 458 (1964). The Office must calculate the percentage of the award as if no further improvement were possible if the claimant declines such intervention.

(b) It is well settled that maximum medical improvement arises at the point at which an injury has stabilized and will not improve further. This determination is factual in nature and depends primarily on the medical evidence. See Peter C. Belkind, 56 ECAB 580 (2005). Neither temporary nor future impairment may be rated. Impairment should not be rated permanent until

sufficient time has passed for healing and recovery, which may vary substantially depending on the condition and the claimant. Clinical findings must indicate the medical condition has stabilized. See Franklin Armfield, 28 ECAB 445 (1977). A schedule award may be payable based on contemporaneous medical evidence of record showing a peak or plateau in the claimant's recovery status, even if the claimant's condition is likely to deteriorate. Payment of an increased award based on additional impairment may be considered at a later date.

(c) In the absence of evidence to the contrary or a conflict in the medical evidence requiring resolution under 5 U.S.C. 8123, the date of MMI is usually considered to be the date of the attending physician's evaluation that is accepted as definitive by the Office.

(2) Description of Impairment. The attending physician should describe the impairment in sufficient detail to permit clear visualization of the impairment and the restrictions and limitations which have resulted. The description should include the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, disturbance of sensation, or other pertinent description of the impairment. Under the Sixth Edition of the AMA Guides, clinical history is also important in the diagnosis-based grid that ranks impairment within classes of severity.

(3) Percentage of Impairment. Impairment evaluation results are provided in terms of percentage of loss of use to the affected member or function of the body (not the body as a whole, except where impairment to the lungs and other bodily organs is at issue; see paragraph 4 below). The percentage should include those conditions accepted by OWCP as job-related and any pre-existing permanent impairment of the same member or function. If the work-related injury has affected any residual usefulness in whole or in part, a schedule award may be appropriate. There are no provisions for apportionment under the Act. Rated impairment should reflect the total loss as evaluated for the schedule member at the time of the rating exam. See Raymond E. Gwynn, 35 ECAB 247, 253 (1983) [In determining the amount of a schedule award for a member of the body, pre-existing impairments are to be included, citing Larson for the proposition that "the employer takes the employee as he finds him."]

b. Calculation. The DMA should use the method of calculation set forth in the AMA Guides. If it is necessary to deviate from the AMA Guides in calculating an award, the record should reflect the basis for the deviation, particularly when the use of a different table or evaluation materially affects the percentage of the award. The policy of the Office is to round the calculated percentage of impairment to the nearest whole point. Results should be rounded down for figures less than .5 and up for .5 and over.

4. Special Determinations. Following are guidelines under §8107 of the Act for calculating schedule awards for specific conditions:

a. Loss of Digits. While the percentage of impairment to the fingers is generally computed in accordance with the AMA Guides, special computations may be required. In general, loss of more than one digit should be computed in terms of impairment to the whole hand or foot. The impairment computed for loss of two or more digits occasionally exceeds the percentage for the

hand or foot, however, and in such instances the award should reflect the computation most favorable to the claimant.

(1) Loss of Less Than One Phalanx. If less than one-half of a phalanx has been amputated but some loss of bone or bony tuft has occurred, the award shall be one-half of the amount payable for the loss of the first phalanx or for 25 percent of the digit. If more than half of a phalanx is lost, the award shall be for the entire loss of the first phalanx, or for 50 percent of the digit.

Where significant amputation of the soft tissue of the tip of the first phalanx has occurred with no loss of bone or bony tuft, the award shall be one-fourth the amount payable for the loss of the first phalanx or 13 percent of the digit.

If the injury has caused impairment such as loss of flexion or extension, swelling, gross deformity and/or changes in sensation in addition to the amputation, the additional impairment must be considered in the overall determination.

(2) Loss of Two or More Digits of a Hand or Foot. When there is a loss of two or more digits, or one or more phalanges of each of two or more digits, the award is proportional to the loss of use of the hand or foot.

By statute, the loss of one phalanx will be considered equal to 50 percent of the digit and loss of more than one phalanx will be considered equal to 100 percent of the digit. See 5 U.S.C. 8107 (15). The value of each digit lost will then be applied to the hand or foot in accordance with the AMA Guides. If the injury has caused impairment such as nerve or palm involvement in addition to the amputation, such impairment must be considered in the determination. The DMA will calculate the impairment of each digit separately and combine them for a total percentage of loss to the hand or foot. Where the cumulative allowances for the individual digits are greater than the percentage of loss for the entire hand or foot, the higher percentage should be used.

b. Loss of Hearing. After a complete report is received, the percentage of hearing loss is calculated using Form CA-51 (Exhibit 3). The DMA will then verify the calculation and the CE will certify the correctness of the DMA's computations. Adjudications based on just one audiogram should be avoided.

(1) Air vs. Bone Conduction. Air conduction studies provide a complete picture of how well an individual can actually hear, while bone conduction studies show what part of the hearing loss resulted from nerve damage. While it is not unusual for air conduction studies to show a greater hearing loss than bone conduction, the opposite results are medically inconsistent and render the audiogram useless. Therefore, while all audiograms must show test results for bone conduction and pure tone air conduction studies, a schedule award may not be based on the results of bone conduction studies.

(2) Computation. Effective February 24, 1986, hearing loss awards are based on the formula contained in the AMA Guides. (FECA Program Memoranda Nos. 162, 181, and 217 describe the previous frequencies and computation methods.) Awards are computed as follows:

(a) **Monaural Loss.** The average of decibel loss in the frequencies of 500, 1000, 2000 and 3000 cps should first be determined. From this amount 15 decibels should be subtracted if ASA calibration was used and 25 decibels if ISO-ANSI calibration was used. The result should be multiplied by a factor of 1.5 to determine the percentage of loss.

(b) **Binaural Loss.** The monaural loss for each ear should first be computed as described above. The percentage of loss in the better ear should then be multiplied by five and the result added to the percentage of loss in the worse ear. This sum should then be divided by six to determine the percentage of binaural loss. Percentages should not be rounded until the final percent for award purposes is obtained. Fractions should be rounded down from .49 or up from .50.

Between March 7, 1977 and February 23, 1986, the OWCP used only the frequencies of 1000, 2000, and 3000 cps to determine an award for hearing loss.

(3) **Progression.** Noise-induced hearing loss does not typically progress after exposure to noise ceases. A claim with an audiogram showing less than a 25 decibel loss soon after exposure ceases and a second audiogram showing a ratable loss may be denied if the DMA provides a well-reasoned opinion. Other benefits are still payable if any employment related hearing loss exists.

c. **Loss of Vision.** The percentage of impairment continues to be based on best uncorrected vision. See 5 U.S.C. 8107 (19). Loss of binocular vision or for loss of 80 percent or more is the same as for loss of the eye. See 5 U.S.C. 8107 (14).

d. **Loss of Function of Bodily Organs.** The FECA provides for award of compensation due to permanent impairment to the extremities and organs. However, most impairment ratings under the Sixth Edition of the AMA Guides evaluate impairment based on injury or disease. Therefore, special calculations are required to interpret certain ratings completed using the AMA Guides into figures usable under the Act.

(1) **Lung Impairment.** All claims involving impairment of the lungs where exposure occurred during Federal employment on or after September 7, 1974 (see Program Memorandum No. 269) will be evaluated for schedule award purposes. The class of respiratory impairment should first be established, following the AMA Guides as far as possible.

(a) While pulmonary function varies from day to day and from environment to environment, impairment exists for compensation purposes when the pulmonary function testing reveals Class 1 or greater impairment severity as defined by the AMA Guides.

(b) A Class 0 respiratory impairment equates to zero percent impairment of the whole person. An individual in this category would be considered to have no ratable loss and would not be entitled to compensation under the Act.

(c) Awards are based on the loss of use of both lungs, and the percentage for the particular class of whole person respiratory impairment will be multiplied by 312 weeks (twice the award for loss of function of one lung) to obtain the number of weeks payable.

(d) In cases of anatomical loss by traumatic injury or surgery, evaluation will also be based on loss of lung tissue (by weight or volume). If the percentage of loss using this method is higher than the percentage based on loss of respiratory function, the award shall be made on the basis of loss of lung tissue. Anatomical evaluations will be made only with regard to the injured lung and will be based on a 156-week maximum award for each lung. Anatomical loss awards can be made for both lungs if the injury caused loss in both, but each lung must be evaluated separately.

(2) Loss of Function of Other Organs. While the AMA Guides express the impairment of bodily organs in terms of the whole person due to a particular injury or medical condition, a schedule award under the FECA is based on the percentage of impairment of the particular organ.

(a) Whole person impairment measurements can be directly translated into organ ratings in the case of vital organs, such as the lungs, where the total impairment of the organ(s) produces 100% impairment of the whole person. When the maximum whole person rating of the organ is less than 100%, direct translation of the whole person measurement into a percentage of impairment to the organ is not valid. In these cases, to obtain the percentage of impairment to an organ corresponding to a given whole person impairment, the following mathematical ratio should be used:

$$\frac{(A)}{(B)} = \frac{(X)}{100}$$

In this equation:

(A) = Actual whole person impairment of the claimant,

(B) = Maximum whole person impairment for the injury or condition of the organ, and

(X) = Organ rating to be determined.

For example, if the maximum whole person impairment for an injury or disease of an organ is 25% and the actual whole person impairment of the claimant is 10%, then:

$$\frac{10}{25} = \frac{(X)}{100}$$

$$(X) = \frac{1000}{25}$$

(X) = 40% impairment of the organ

(b) For certain schedule organs which have more than one physiologic function, the AMA Guides provide whole person impairment scores for each affected system within that organ. When calculating the impairment of these organs, the DMA must consider all affected organ systems as instructed in the AMA Guides.

In these cases, the maximum whole person impairment ascribed to the particular organ injury or condition (B) is obtained by combining the maximum levels for all functions using the Combined Values Chart in the current edition of the AMA Guides. The actual whole person

impairment (A) is obtained by combining all functional impairments found using the Combined Values Chart in the Guides.

For example, a claimant with an injury to the penis has a Class 3 penile (sexual) whole person impairment amounting to 15%, and Class 2 urethral impairment of 10%. A 15% whole person impairment combined with a 10% whole person impairment results in a whole person impairment of 24%. The maximum whole person impairment for the sexual function is 15% and urethral function is 28%. Using the Combined Values Chart, this amounts to 39% total whole person impairment. Then:

$$\frac{24}{39} = \frac{(X)}{100}$$

$$(X) = \frac{2400}{39}$$

$$(X) = 62\% \text{ impairment of the penis}$$

(c) In addition to the loss of use, the statute compensates for loss of an organ. If there is total loss of a single paired organ (such as a kidney, breast, testicle or ovary), the schedule award is generally based on the loss of the organ. In this situation, it is immaterial whether the remaining organ compensates functionally for the loss.

5. Disfigurement. The FECA [§8107(c)(21)] provides for payment of compensation not to exceed \$3500 for disfigurement of the face, head or neck which is likely to handicap the claimant in securing or maintaining employment. The DMA will be asked to review such claims and to evaluate the employee's disfigurement. If the DMA finds that maximum medical improvement has occurred, the DMA will review the photographs submitted along with the medical evidence of record. The concurrence of the Assistant District Director (ADD) or the District Director (DD) must be obtained. Following the file review, the DMA and ADD or DD will write a memorandum to the file which contains a complete description of the disfigurement. If the DMA does not find that maximum medical improvement has occurred, but has submitted a statement as to whether plastic surgery may improve the appearance and decrease the degree of disfigurement and the claimant is amenable, the DMA should include in his or her statement information concerning arrangements for treatment.

Exhibit 1: USE OF SIXTH EDITION OF AMA GUIDES

Effective May 1, 2009, OWCP began using the Sixth Edition of the AMA Guides. This edition is significantly different from previous editions. There are extensive changes affecting the calculations of schedule awards for FECA claimants.

The biggest adjustment from previous editions involves the rating of permanent impairment based on a specific diagnosis rather than the extremity or organ system. In previous editions an impairment rating may have included multiple diagnoses within an organ or extremity. Under the Sixth Edition most ratings will consider only the diagnosis with the most impact on the rated bodily region. In the Fifth Edition of the Guides impairment ratings relied heavily on loss of

range of motion and strength in comparison to a paired extremity. The Sixth Edition only incorporates these findings as they relate to the specific diagnosis evaluated.

1. The Sixth Edition of the Guides implements a paradigm shift in the way impairment evaluations are conducted. The stated vision of the Sixth Edition is based on five axioms, including: (1) Adoption of terminology and conceptual framework of disablement outlined by the World Health Organization's (WHO's) International Classification of Functioning, Disability, and Health (ICF); (2) Becoming more diagnosis-based and basing the diagnoses in evidence; (3) Optimizing rater reliability through simplicity, ease of application, and following precedent; (4) Rating percentages are functionally based to the fullest extent possible; and (5) Stressing conceptual methodological congruity within and between organ rating systems.

2. The evaluation methodology used in the Sixth Edition substantially revises the methods used in previous editions. The Guides characterize the objective of the new methodology to be consistent, enhance relevancy, promote precision, and standardize the rating process. The foundation of the new methodology is the diagnosis-based grid used for each organ system and chapter. Evaluators will rate impairment according to the diagnosis representing the source of the most impairment in the given bodily region. If there is more than one ratable diagnosis in an affected extremity, the rater should combine all regional impairments for a final impairment at the extremity level.

Each diagnosis grid is divided into five classes of impairment severity, ranked from '0' (no impairment) to '4' (very severe). Within each class are five severity grades categorized 'A' through 'E' (default 'C') with corresponding impairment percentages.

Raters distinguish the level of severity using criteria separated into key factors and non-key factors. These criteria consist of: history of clinical presentation, physical examination or physical findings, clinical studies or objective test results, and functional history. In most organ systems or disease processes, clinical history is the key factor which will determine the impairment class. However, objective test results or physical findings may serve as the key factor in select organ system evaluations. The evaluator will adjust the severity grade based on the results of the remaining criteria. These adjustments cannot exceed the percentage of impairment within the range specified by the designated class.

3. The Sixth Edition of the AMA Guides consists of seventeen chapters, one less than the Fifth Edition. Two cardiovascular chapters in the Fifth Edition are consolidated into one chapter in the Sixth.

4. Musculoskeletal regions in the Sixth Edition of the Guides consist of the upper extremities (Chapter 15), lower extremities (Chapter 16), and the spine and pelvis (Chapter 17). The upper extremity is divided into four separate regions, including digits and hand, wrist, elbow, and shoulder. The lower extremity is divided into three regions consisting of foot and ankle, knee, and hip. The spine and pelvis is divided into four regions, including cervical, thoracic, and lumbar regions, and the pelvis, consisting of the ilium, ischium, pubis, sacrum and coccyx. Diagnosis classes for the upper and lower extremities are broken into the following categories: Soft tissue; muscle and tendon; ligament; and bone and joint. If impairment scores are calculated

in whole person ratings, they should be adjusted to individual extremity or organ system percentages using conversion charts or rates.

5. Impairment to the upper or lower extremities that is caused by a spinal injury should be rated consistent with the article "Rating Spinal Nerve Extremity Impairment Using the Sixth Edition" in the July/August 2009 edition of The Guides Newsletter published by AMA. The Guides Newsletter article (July/August publication by the AMA) titled "Rating Spinal Nerve Extremity Impairment Using the Sixth Edition" is [Exhibit 4](#) in this chapter, and has been reproduced with permission from the AMA.

6. The chapter on impairments due to pain (Chapter 3) has been updated. As with the Fifth Edition, the Sixth Edition allows for a maximum 3% impairment rating for non-specific pain that cannot be attributed to a condition addressed elsewhere in the Guides. According to Section 3.3b:

Patients' responses on functional assessment instruments will act as modifiers of the percentage impairment they are awarded, the awards will, in general, primarily reflect objective factors. This is in keeping with the general strategy of the Guides to consider PRI [Pain-related impairment] but to limit the amount of impairment that is awarded for subjective factors. In no circumstances should the PRIs developed using this chapter be considered as an add-on to impairment determinations based on the criteria listed in Chapters 4 to 17. In essence, the PRIs derived according to this chapter are determined in a stand-alone fashion.

7. Entrapment neuropathy of the upper extremities (e.g. carpal tunnel, cubital tunnel, etc.) (Section 15.4f) must be documented with nerve conduction velocity (NCV) testing in order to consider ratable impairment. If testing was not conducted or does not meet the criteria outlined by the Guides, no ratable impairment may be considered. Only pre-operative testing is used for rating impairment in this section. Optimal rating time following surgical intervention is between nine months and 2 years. When evaluating multiple simultaneous neuropathies, the first (or most impairing) is rated at 100%, the second is rated at 50%, and the third is rated at 0%. If there are more than three neuropathies, the neurology chapter should be used rather than Chapter 15.

8. The Guides stipulate only permanent impairment may be rated, and only after the claimant has reached a point of "maximum medical improvement" (MMI). The Guides do not afford the rating of future impairment. Impairment should not be rated permanent until sufficient time has passed for healing and recovery, which may vary substantially depending on the condition and the claimant's profile. The clinical findings must indicate that the medical condition is stabilized for the claimant to have reached MMI. The Guides define MMI as "a status where patients are as good as they are going to be from the medical and surgical treatment available to them."

In cases where a claimant declines surgery or other curative treatment, an MMI determination may still be reached. The evaluating physician should make a written note in the report discussing the appropriateness of the prescribed treatment and the basis of the claimant's declination. The physician should also indicate that the individual is at MMI in lieu of additional treatment.

Claimants not at MMI, but with potential for future progression of their disease, can be rated for permanent impairment on the current findings; MMI does not preclude the worsening of a condition that is expected with the passage of time or due to the aging process.

Exhibit 2: Percentage Table of Schedule Awards, Form CA-699

PERCENTAGE TABLE OF SCHEDULE AWARDS

(W = weeks; D = days)

MEMBER		01%	02%	03%	04%	05%	10%	15%	20%
Arm	W	3.12	6.24	9.36	12.48	15.60	31.20	46.80	62.40
	D	21.84	43.68	65.52	87.36	109.20	218.40	327.60	436.80
Leg	W	2.88	5.76	8.64	11.52	14.40	28.80	43.20	57.60
	D	20.16	40.32	60.48	80.64	100.80	201.60	302.40	403.20
Hand	W	2.44	4.88	7.32	9.76	12.20	24.40	36.60	48.80
	D	17.08	34.16	51.24	68.32	85.40	170.80	256.20	341.60
Foot/Penis	W	2.05	4.10	6.15	8.20	10.25	20.50	30.75	41.00
	D	14.35	28.70	43.05	57.40	71.75	143.50	215.25	287.00
Vulva/Vagina Uterus/Cervix	W	2.05	4.10	6.15	8.20	10.25	20.50	30.75	41.00
	D	14.35	28.70	43.05	57.40	71.75	143.50	215.25	287.00
Larynx/ Tongue	W	1.60	3.20	4.80	6.40	8.00	16.00	24.00	32.00
	D	11.20	22.40	33.60	44.80	56.00	112.00	168.00	224.00
Eye	W	1.60	3.20	4.80	6.40	8.00	16.00	24.00	32.00
	D	11.20	22.40	33.60	44.80	56.00	112.00	168.00	224.00
Kidney/ Lung	W	1.56	3.12	4.68	6.24	7.80	15.60	23.40	31.20
	D	10.92	21.84	32.76	43.68	54.60	109.20	163.80	218.40
Thumb	W	.75	1.50	2.25	3.00	3.75	7.50	11.25	15.00
	D	5.25	10.50	15.75	21.00	26.25	52.50	78.75	105.00
1st Finger	W	.46	.92	1.38	1.84	2.30	4.60	6.90	9.20
	D	3.22	6.44	9.66	12.88	16.10	32.20	48.30	64.40
Great Toe	W	.38	.76	1.14	1.52	1.90	3.80	5.70	7.60
	D	2.66	5.32	7.98	10.64	13.30	26.60	39.90	53.20

2nd Finger	W	.30	.60	.90	1.20	1.50	3.00	4.50	6.00
	D	2.10	4.20	6.30	8.40	10.50	21.00	31.50	42.00
3rd Finger	W	.25	.50	.75	1.00	1.25	2.50	3.75	5.00
	D	1.75	3.50	5.25	7.00	8.75	17.50	26.25	35.00
Toe other Great Toe	W	.16	.32	.48	.64	.80	1.60	2.40	3.20
	D	1.12	2.24	3.36	4.48	5.60	11.20	16.80	22.40
4th Finger	W	.15	.30	.45	.60	.75	1.50	2.25	3.00
	D	1.05	2.10	3.15	4.20	5.25	10.50	15.75	21.00
Hearing (1 ear)	W	.52	1.04	1.56	2.08	2.60	5.20	7.80	10.40
	D	3.64	7.28	10.92	14.56	18.20	36.40	54.60	72.80
Testicle/ Breast/Ovary*	W	.52	1.04	1.56	2.08	2.60	5.20	7.80	10.40
	D	3.64	7.28	10.92	14.56	18.20	36.40	54.60	72.80
Hearing (Both ears)	W	2.00	4.00	6.00	8.00	10.00	20.00	30.00	40.00
	D	14.00	28.00	42.00	56.00	70.00	140.00	210.00	280.00

* Includes Fallopian tube

(W = weeks; D = days)

MEMBER		25%	30%	35%	40%	45%	50%	55%	60%
Arm	W	78.00	93.60	109.20	124.80	140.40	156.00	171.60	187.20
	D	546.00	655.20	764.40	873.60	982.80	1092.00	1201.20	1310.40
Leg	W	72.00	86.40	100.80	115.20	129.60	144.00	158.40	172.80
	D	504.00	604.80	705.60	806.40	907.20	1008.00	1108.80	1209.60
Hand	W	61.00	73.20	85.40	97.60	109.80	122.00	134.20	146.40
	D	427.00	512.40	597.80	683.20	768.60	854.00	939.40	1024.80
Foot/Penis	W	51.25	61.50	71.75	82.00	92.25	102.50	112.75	123.00
	D	358.75	430.50	502.25	574.00	645.75	717.50	789.25	861.00

Vulva/Vagina Uterus/Cervix	W	51.25	61.50	71.75	82.00	92.25	102.50	112.75	123.00
	D	358.75	430.50	502.25	574.00	645.75	717.50	789.25	861.00
Larynx/ Tongue	W	40.00	48.00	56.00	64.00	72.00	80.00	88.00	96.00
	D	280.00	336.00	392.00	448.00	504.00	560.00	616.00	672.00
Eye	W	40.00	48.00	56.00	64.00	72.00	80.00	88.00	96.00
	D	280.00	336.00	392.00	448.00	504.00	560.00	616.00	672.00
Kidney/Lung	W	39.00	46.80	54.60	62.40	70.20	78.00	85.80	93.60
	D	273.00	327.60	382.20	436.80	491.40	546.00	600.60	655.20
Thumb	W	18.75	22.50	26.25	30.00	33.75	37.50	41.25	45.00
	D	131.25	157.50	183.75	210.00	236.25	262.50	288.75	315.00
1st Finger	W	11.50	13.80	16.10	18.40	20.70	23.00	25.30	27.60
	D	80.50	96.60	112.70	128.80	144.90	161.00	177.10	193.20
Great Toe	W	9.50	11.40	13.30	15.20	17.10	19.00	20.90	22.80
	D	66.50	79.80	93.10	106.40	119.70	133.00	146.30	159.60
2nd Finger	W	7.50	9.00	10.50	12.00	13.50	15.00	16.50	18.00
	D	52.50	63.00	73.50	84.00	94.50	105.00	115.50	126.00
3rd Finger	W	6.25	7.50	8.75	10.00	11.25	12.50	13.75	15.00
	D	43.75	52.50	61.25	70.00	78.75	87.50	96.25	105.00
Toe (No Great Toe)	W	4.00	4.8	5.60	6.40	7.20	8.00	8.80	9.60
	D	28.00	33.60	39.20	44.80	50.40	56.00	61.60	67.20
4th Finger	W	3.75	4.50	5.25	6.00	6.75	7.50	8.25	9.00
	D	26.25	31.50	36.75	42.00	47.25	52.50	57.75	63.00
Hearing (1 ear)	W	13.00	15.60	18.20	20.80	23.40	26.00	28.60	31.20
	D	91.00	109.20	127.40	145.60	163.80	182.00	200.20	218.40
Testicle/ Breast/Ovary*	W	13.00	15.60	18.20	20.80	23.40	26.00	28.60	31.20
	D	91.00	109.20	127.40	145.60	163.80	182.00	200.20	218.40
Hearing (Both ears)	W	50.00	60.00	70.00	80.00	90.00	100.00	110.00	120.00

	D	350.00	420.00	490.00	560.00	630.00	700.00	770.00	840.00

* Includes Fallopian tube

(W = weeks; D = days)

MEMBER		65%	70%	75%	80%	85%	90%	95%	100%
Arm	W	202.80	218.40	234.00	249.60	265.20	280.80	296.40	312.00
	D	1419.60	1528.80	1638.00	1747.20	1856.40	1965.60	2074.80	2184.00
Leg	W	187.20	201.60	216.00	230.40	244.80	259.20	273.60	288.00
	D	1310.40	1411.20	1512.00	1612.80	1713.60	1814.40	1915.20	2016.00
Hand	W	158.60	170.80	183.00	195.20	207.40	219.60	231.80	244.00
	D	1110.20	1195.60	1281.00	1366.40	1451.80	1537.20	1622.60	1708.00
Foot/ Penis	W	133.25	143.50	153.75	164.00	174.25	184.50	194.75	205.00
	D	932.75	1004.50	1076.25	1148.00	1219.75	1291.50	1363.25	1435.00
Vulva/Vagina Uterus/Cervix	W	133.25	143.50	153.75	164.00	174.25	184.50	194.75	205.00
	D	932.75	1004.50	1076.25	1148.00	1219.75	1291.50	1363.25	1435.00
Larynx/ Tongue	W	104.00	112.00	120.00	128.00	136.00	144.00	152.00	160.00
	D	728.00	784.00	840.00	896.00	952.00	1008.00	1064.00	1120.00
Eye	W	104.00	112.00	120.00	160.00	160.00	160.00	160.00	160.00
	D	728.00	784.00	840.00	1120.00	1120.00	1120.00	1120.00	1120.00
Kidney/ Lung	W	101.40	109.20	117.00	124.80	132.60	140.40	148.20	156.00
	D	709.80	764.40	819.00	873.60	928.20	982.80	1037.40	1092.00
Thumb	W	48.75	52.50	56.25	60.00	63.75	67.50	71.25	75.00
	D	341.25	367.50	393.75	420.00	446.25	472.50	498.75	525.00
1st Finger	W	29.90	32.20	34.50	36.80	39.10	41.40	43.70	46.00
	D	209.30	225.40	241.50	257.60	273.70	289.80	305.90	322.00
Great Toe	W	24.70	26.60	28.50	30.40	32.30	34.20	36.10	38.00
	D	172.90	186.20	199.50	212.80	226.10	239.40	252.70	266.00

2nd Finger	W	19.50	21.00	22.50	24.00	25.50	27.00	28.50	30.00
	D	136.50	147.00	157.50	168.00	178.50	189.00	199.50	210.00
3rd Finger	W	16.25	17.50	18.75	20.00	21.25	22.50	23.75	25.00
	D	113.75	122.50	131.25	140.00	148.75	157.50	166.25	175.00
Toe (Not Great Toe)	W	10.40	11.20	12.00	12.80	13.60	14.40	15.20	16.00
	D	72.80	78.40	84.00	89.60	95.20	100.80	106.40	112.00
4th Finger	W	9.75	10.50	11.25	12.00	12.75	13.50	14.25	15.00
	D	68.25	73.50	78.75	84.00	89.25	94.50	99.75	105.00
Hearing (1 ear)	W	33.80	36.40	39.00	41.60	44.20	46.80	49.40	52.00
	D	236.60	254.80	273.00	291.00	309.40	327.60	345.80	364.00
Testicle/ Breast/Ovary*	W	33.80	36.40	39.00	41.60	44.20	46.80	49.40	52.00
	D	236.60	254.80	273.00	291.00	309.40	327.60	345.80	364.00
Hearing (Both ears)	W	130.00	140.00	150.00	160.00	170.00	180.00	190.00	200.00
	D	910.00	980.00	1050.00	1120.00	1190.00	1260.00	1330.00	1400.00

Exhibit 3: Hearing Loss Medical Opinion, Form CA-51 ([Link to Image](#))**HEARING LOSS MEDICAL OPINION, FORM CA-51**

1. Date: _____ 2. File Number: _____
3. In response to memorandum dated: _____
 Yes ☐ No ☐
 Sensorineural Hearing Loss: ☐ Binaural ☐ Monaural
4. Date of Maximum Improvement:
 (same date as audiogram) _____
5. Date audiometer calibrated: _____
6. ASA ☐ ISO ☐ ANSI (Circle Appropriate reading)
7. Right Ear:
 500 cps _____
 1000 cps _____
 2000 cps _____
 3000 cps _____
 Total: _____ $\div 4 =$ _____
 Less Fence: _____ -25
 Balance: _____ $\times 1.5 =$ _____ Monaural loss
8. Left Ear:
 500 cps _____
 1000 cps _____
 2000 cps _____
 3000 cps _____
 Total: _____ $\div 4 =$ _____
 Less Fence: _____ -25
 Balance: _____ $\times 1.5 =$ _____ Monaural loss
9. $\frac{5(\quad) + (\quad)}{6} =$ _____ % binaural loss
10. Hearing Aid Authorized? Yes ☐ No ☐
11. Recommend Examination by Specialist? Yes ☐ No ☐

12. District Medical Director			13. Date
13. Claims Examiner	14. Date	15. Certifier	16. Date

Form Ca-51

Exhibit 4: Use of Sixth Edition of AMA Guides (PLEASE CLICK THE IMAGE BELOW TO ACCESS THE FULL NEWSLETTER)

3-700 Exhibit 4

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The Guides Newsletter

Expert advice, practical information, and current trends on impairment evaluation

July/August 2009

In this issue

Rating Spinal Nerve Extremity Impairment
Degenerative Disk Disease
Pub Med Citations

In upcoming issues

Examinee Reported History
Complex Regional Pain Syndrome Update
Rating by Analogy: Abusing the Guides Fifth Edition: Reflections
Comparison of Two Jurisdictions: California vs Hawaii
Lower Extremity Training Workbook Questions and Answers
Book Review: *Guides to the Evaluation of Disease and Injury*
Observations on the Sixth Edition: Improvement in Impairment Assessment

The Guides, Sixth has been reprinted!

The *Guides to the Evaluation of Permanent Impairment, Sixth Edition*, has been reprinted to incorporate updates to the original edition—all found in the *Clarifications and Corrections* document released in 2008. The reprinted books have been shipping since June 1, 2009, but please e-mail guides6@ama-assn.org with any questions or concerns.



Rating Spinal Nerve Extremity Impairment Using the Sixth Edition

Christopher R. Brigham, MD

The Sixth Edition of the *Guides* did not provide a separate mechanism for rating spinal nerve injuries as extremity impairment; radiculopathy was reflected in the spinal rating process outlined in Chapter 17, The Spine and Pelvis. Certain jurisdictions, such as the Federal Employee Compensation Act (FECA), rate nerve root injury as impairment involving the extremities rather than as part of the spine. For example, a patient may have a spinal injury resulting in a radiculopathy; under FECA, only the impairment resulting from the radiculopathy (ie, the spinal nerve injury) would be rated. The Fifth Edition provided a procedure to assess isolated spinal nerve root impairment, since this was part of the rating system in the range of motion method; however, this was not provided in the Sixth Edition as the range of motion method was discarded. This article presents an approach to rate spinal nerve impairments consistent with the Sixth Edition methodology. This approach should be used only when a jurisdiction mandates ratings for extremities and precludes rating for the spine.

Sixth Edition Rating Process for Peripheral Nerve Injuries

It is helpful to first understand the methodology used in the Sixth Edition to rate for peripheral nerve impairment and how it relates to the Fifth Edition. The clinical assessment process is similar in the two editions; however, the approach to assessing impairment was modified in the Sixth Edition for consistency with the change in methodology. In the Fifth Edition the rating of upper extremity peripheral nerve injuries involved the use of 3 tables. Maximum losses are obtained by using Table 16-15, Maximum Upper Extremity Impairment Due to Unilateral Sensory or Motor Deficits or to Combined 100% Deficits of the Major Peripheral Nerves (5th ed, 492). Sensory deficits are graded by using Table 16-10, Determining Impairment of the Upper Extremity Due to Sensory Deficits or Pain Resulting From Peripheral Nerve Deficits (5th ed, 482). Motor deficits are determined by using Table 16-11, Determining Impairment of the Upper Extremity Due to Motor and Loss-of-Power Deficits Resulting From Peripheral Nerve Disorders Based on Individual Muscle Rating (5th ed, 484).

For example, if a patient had peripheral nerve sensory involvement of the axillary nerve that is assigned according to Table 16-15 (5th ed, 492) a maximum of 5% upper extremity impairment (UEI), and the patient had a grade 3 (moderate) sensory deficit from Table 16-10 (5th ed, 482), which is associated with a 26% to 60% deficit, the impairment could range from 1% UEI (ie, $26\% \times 5\%$ UEI) to 3% UEI (ie, 60%

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Chapter 3-0800, Exclusion of Medical Providers

1. Purpose. Regulations appearing at 20 C.F.R. 10.450-457 furnish the basis for excluding medical providers, including physicians, hospitals, or suppliers of medical support services or appliances, from participation and payment under the FECA for fraud, abuse and other unacceptable practices. The regulations provide a mechanism for initiating and effecting exclusion while ensuring due process for medical providers. They also provide for reinstatement after specified time periods if reasonable assurance exists that the action which led to the exclusion will not recur. The purpose of this chapter is to describe the bases for exclusion and the procedures for excluding and reinstating medical providers. The procedures are shown in diagrammatic form in Exhibit 1 ([Link to Image](#)).

2. Extent of Sanctions. Excluded providers are not authorized to render services and OWCP will not pay their bills. Medical reports from an excluded physician may not be disregarded, but they may be accorded diminished probative value if the reason for exclusion warrants it. A memorandum should appear in the case file showing the reason for exclusion and the rationale for according diminished probative value to the report. The Claims Examiner (CE) should prepare the memorandum unless the reasons for exclusion or the extent to which the probative value is diminished require the expertise of the District Medical Adviser (DMA) to prepare it.

3. Automatic Exclusion. A provider is automatically excluded from participation under the FECA if he or she has been:

- a. Convicted under any criminal statute for fraudulent activities in connection with any Federal or State program for which payments are made to providers for similar medical, surgical, or hospital appliances or supplies; or
- b. Excluded or suspended, or has resigned in lieu of exclusion or suspension, from participation in such a program.

Most automatic exclusions will result from action by Medicare, which is administered by the Health Care Financing Administration (HCFA), but some will result from action by other Federal programs or by state Medicaid programs. (The grounds for exclusion under HCFA include sale and distribution of illegal drugs.) Providers convicted under any criminal statute for fraudulent activities in connection with any Federal or state program for which payments are made for medical services are also automatically excluded by OWCP. District offices should notify the National Office of any convicted providers who are not on the exclusion list. Since such convictions are sometimes overturned on appeal, the district office should not exclude providers under these procedures until documentation of the conviction is obtained by the National Office.

4. Non-Automatic Exclusion. Exclusion for reasons other than those noted above is not automatic and must be initiated in the district office. A provider is subject to exclusion for fraud or abuse if she/he has:

a. 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 (20 C.F.R. 10.450(c)). This provision generally applies to billings for services or supplies which were never furnished.

(1) Unusually Frequent Billings. DMAs, CEs and Benefit Payment Clerks (BPCs) should be alert to instances of unusually frequent office visits or use of prescription drugs or supplies. In such instances the CE should write to the claimant and ask whether the services or supplies in question were actually received and, if so, why the claimant believes they were needed.

(2) Contacting Physicians. If the claimant states that some services or supplies were never furnished and the provider is a physician, the CE will refer the case to the DMA, who should write to the physician, describe the apparent false billing, and request an explanation within 30 days. The DMA should review any reply within the context of the case and prepare a memorandum to the Supervisory Claims Examiner (SCE) concerning possible violation of the regulations. If the physician does not reply within 30 days, the DMA should so advise the SCE.

(3) Contacting Non-Physicians. If the claimant states that some services or supplies were never furnished and the provider is not a physician, the CE will contact him or her to obtain an explanation. If the provider does not reply, or if the reply fails to establish that the billing in question was appropriate, the CE should prepare a memorandum to the Assistant District Director as described in paragraph 9 (a)(1) of PM Chapter 2-402 for possible referral to the Office of the Inspector General.

b. Submitted, or caused to be submitted, three or more bills or requests for payment under the FECA within a twelve-month period containing charges which the Office finds are substantially in excess of the provider's customary charges, unless it is found that there is good cause for the bills or requests containing such charges (20 C.F.R. 450(d)).

(1) Reimbursement. A provider who charges more than the amount allowed by the fee schedule will not be penalized if the amount corresponds to the amount charged other patients. If the claimant has paid the full amount charged prior to notification that the excess is not payable, and then requests reimbursement, the provider will be asked to reimburse the claimant for the amount over and above the allowable fee or submit an explanation to OWCP for the additional charge. Failure of the provider to make such reimbursement within a reasonable time or to provide satisfactory justification will be deemed collection of a fee warranting initiation of the exclusion procedures.

(2) Notification. If the provider is charging FECA claimants a significantly higher price for identical services, appliances, or supplies, the DMA should write to the provider. The letter should state that the Office has found through investigation that it is being billed more than the customary charge for the specific service(s) and invite the provider to give the reason, if any, for

the higher charges. The provider should also be advised that absent such reasons he or she should cease such practice or face possible exclusion.

(3) Response. If the provider replies that the extra charges are made because of special requirements of FECA cases, such as studying files or writing medical reports, he or she should be instructed to show the charge for reports and file review separately.

(4) Advice to RD. Serious or persistent occurrences of excessive billing should be reported to the District Director (DD), and the DMA or DD should telephone the provider to discuss the problem. If the provider fails to cooperate, documentation of the situation should be routed to the Regional Director (RD) for further action. The documentation should include detailed written accounts of all telephone conversations as well as copies of pertinent correspondence.

c. Knowingly failed to timely reimburse claimants for treatment, services, or supplies furnished under the FECA and paid by the Government (20 C.F.R. 10.450(e)).

(1) Dual Payment. If a claimant states that he or she paid for services or supplies which were also paid by the Office without subsequent reimbursement, the SCE should write a letter of warning to the provider, with a copy to the claimant. The letter should bring the dual payment to the provider's attention and ask him or her to reimburse the claimant without delay. The letter should quote the grounds for exclusion and state that initiation of exclusion proceedings will be considered if the claimant is not reimbursed within 30 days.

(2) Follow-up. The SCE or CE should contact the claimant 30 days after release of this letter to ensure that the claimant has received the reimbursement. If not, a copy of all material related to the complaint should be routed to the DD. Serious or persistent offenses should be referred to the RD for consideration of exclusion, and material on such providers should be maintained in the Provider Exclusion File.

d. Failed, neglected, or refused, on three or more occasions during a twelve-month period, to submit full and accurate medical reports, or to respond to requests by the Office for additional reports or information, as required by the FECA and by 20 C.F.R. 10.450 (f)).

(1) No Response. When a third request for a medical report must be made and a response is not received within a reasonable period, the CE will refer the case to the DMA. The DMA will telephone the provider and explain the problem, noting that failure to submit full and accurate reports or to respond to a reasonable request for further information may lead to exclusion from the program.

(2) Inadequate Response. The CE should also refer the case to the DMA when a medical report is incomplete and/or inaccurate and repeated requests for additional information have not received satisfactory response. The DMA should state whether the information is in fact incomplete or inaccurate, and if the request for additional reports or information is reasonable. If so, the DMA should telephone the provider as described above.

(3) Further Action. In intractable cases, the DMA should refer the matter to the DD, who will study the documentation and take further action as indicated, such as additional contact with the provider or referral to the RD for consideration of exclusion.

e. Knowingly furnished treatment, services, or supplies which are substantially in excess of the claimant's needs, or of a quality which fails to meet professionally recognized standards (20 C.F.R. 10.450 (g)).

(1) DMA Advice. CEs and BPCs may ask the DMA if services or supplies are substantially in excess of a claimant's needs or fail to meet professionally recognized standards. The DMA should place a memorandum in the file which addresses the issue and which contains medical rationale for the opinion. The DMA may also identify instances of excessive treatment, services, or supplies in the course of reviewing cases for other reasons. Any question regarding standards or quality should be referred to the DMA for advice and opinion.

(2) Contacting Physicians. The DMA will telephone a provider who is a physician and discuss the issue. If the discussion does not resolve the problem, the DMA will write a letter of warning to the provider which specifies the services or supplies and gives the reason why they are considered excessive or unacceptable and do not meet professionally recognized standards. The letter will also quote the exclusion provision of 20 C.F.R. 10.450 (g).

(3) Contacting Non-Physicians. The SCE will write a letter of warning to a provider who is not a physician, citing the regulations and explaining why the services or supplies are considered to be in violation of them.

(4) Referral to RD. If the DMA finds that a provider is engaging in a medical practice which is life- threatening or harmful, the DMA will refer the matter to the DD with all documentation for routing to the RD.

While non-automatic exclusion may be initiated for any of the practices indicated above, the right to exclude a provider should be exercised with restraint. Every effort should be made to correct unacceptable or deficient practices by letters and telephone calls before taking further action. The RD will initiate exclusion only when it becomes apparent that continued attempts to educate and persuade will not terminate unacceptable activities. Of course, it is not necessary or desirable to attempt to reform a provider who is engaging in harmful medical practices. In such cases exclusion should be undertaken without delay.

5. Formal Notification to Providers. It is essential that the district office act promptly after grounds for exclusion are discovered, since abuses must be curtailed without delay. Cases referred to the SCE and to typing for warning letters should receive priority queuing, and material forwarded to the RD for consideration of exclusion should be designated as "special" and treated as such during all processing in the RD's office.

a. Provider Exclusion File. The RD will maintain a Provider Exclusion File containing copies of evidence, memoranda and letters to reflect action taken by the district office in each instance of

alleged fraud or abuse. When such material is routed to the RD, he or she will review it along with any other material in the file on the same provider.

b. Preliminary Steps. The RD will obtain whatever additional information he or she may deem appropriate and will try to resolve the problem without issuing a letter of intent to exclude. The RD will ensure that thorough and reasonable steps were taken by district office staff to curtail unacceptable provider practices. If feasible, the RD may suggest that a meeting be arranged with the provider and the DMA present in order to achieve compliance. If the provider is amenable to a conference call, it should be arranged.

c. Consultation with Solicitor and National Office. If reasonable educational and persuasive efforts have proven futile, or in the event of a harmful or life-threatening medical practice, the RD should discuss the situation with the Regional Office of the Solicitor. Prior to drafting a letter of intent to exclude, the RD shall telephone the Director for FEC to apprise him or her of the proposed action and the reasons for it. A sample letter of intent meeting the requirements of 20 C.F.R. 10.452 is shown as Exhibit 2.

d. Letter of Intent. The RD may issue a letter of intent to exclude if the provider has engaged in an unacceptable practice in violation of 20 C.F.R. 10.450 (c), (e) or (g). The RD may also issue a letter of intent to exclude for violation of 20 C.F.R. 10.450 (d) or (f) if there have been three instances of violation of either subsection (d) or (f) within any continuous twelve-month period. The instances of excessive charges or deficient reports may have occurred in the same or different cases.

(1) Excessive Charges. In order to be counted as an offense toward violation of 20 C.F.R. 10.450 (d), the excessive charges must be for services or supplies furnished on different dates, not duplicate billings for the same goods or service. Each excessive billing for a service or supply which is furnished on different occasions would constitute a separate and distinct occurrence which should be counted individually. For example, excessive charges for each of three office visits within a continuous twelve-month period will be grounds for exclusion.

(2) Inadequate Reports. Each instance of failure, neglect or refusal to submit a full and accurate medical report in response to a specific request by the district office, or to respond to a request for additional information, will be considered as one offense toward violation of 20 C.F.R. 10.450 (f). An initial inadequate report which is not submitted in response to a specific request from the Office will not count as an offense.

(3) Cumulative Occurrences. The regulations specify three instances of excessive charges or three instances of deficiencies in reports as separate grounds for exclusion. Therefore, two instances of one and one instance of the other will not constitute a basis for exclusion.

e. Information to Provider. The letter to the provider must be sent by certified mail, return receipt requested. Copies of supporting evidence such as deficient medical reports and documentation of billing improprieties may be attached as appropriate. The RD will maintain a five week call-up for the provider's response. A copy of the letter of intent and appropriate documentation should be sent to the Director for FEC.

6. Procedures for Exclusion. The RD will ensure that the provider has a full 30 days to reply to the letter of intent before taking further action.

a. Provider Response.

(1) No Response. If the provider fails to give written response within 30 calendar days, the RD will issue a decision to exclude as described below.

(2) Resignation. If the provider responds by submitting a letter of resignation, the RD will so inform the Director for FEC by telephone and follow up with a brief memorandum giving the provider's name, address and Tax Identification Number (TIN). The reinstatement provisions at 10.457(a) do not apply to those who resign. The RD should therefore write to the provider simply to acknowledge receipt of the resignation. If the provider resigns verbally, the RD should send him or her a letter confirming the resignation for his or her signature and allow 30 days for return of the signed resignation.

(3) Additional Evidence. If the provider responds within 30 calendar days with a request for consideration of additional evidence, the RD will carefully study all the evidence and decide whether or not the provider should be excluded. The RD should maintain liaison with the Solicitor's Office and should keep the Associate Director informed by telephone of the contents of any reply and its effect on the decision.

b. Issuing the Decision.

(1) Contents. The RD will send a letter decision stating the reasons for exclusion to the provider by certified mail, return receipt requested. If no reply was received to the letter of intent, it may be incorporated by reference. If further information was submitted, it must be evaluated in relation to the violations which prompted the letter of intent. The decision must also include the period of exclusion, an explanation of the reinstatement process and the provider's rights to further review of the exclusion. A copy of the decision should be sent to the Director for FEC. A sample decision is shown in Exhibit 3.

(2) Request for Hearing. A decision to exclude takes effect 30 calendar days from the date of the decision. During this period, the provider may file a request for a hearing before an Administrative Law Judge (ALJ) by addressing such request to the RD. The filing of a request for hearing within the 30 calendar day period stays the decision to exclude. Therefore, flagging of the automated provider file and notification of other parties must be held for 30 calendar days pending a request for a hearing.

(3) Further Action. If no request for a hearing is received within 30 calendar days following the RD's letter of decision, the RD shall so notify the Director for FEC in writing. The National Office will add the provider's name to the list of excluded providers distributed to all district offices and will notify state and local licensing agencies.

c. Requests for Hearing.

(1) Forwarding the Request. If a request for a hearing is received within 30 calendar days, the RD will send it to the Office of Administrative Law Judges, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. A copy will be retained in the Provider Exclusion File.

(2) Copies of Request. A copy of the request for hearing will be sent to the Regional Solicitor, with a copy of all information concerning the provider from the Provider Exclusion File. Another copy of the request for hearing will be sent to the Director for FEC.

(3) Late Requests. If a request for a hearing is received later than 30 calendar days from the decision, the RD will advise the provider that it was not timely filed and that the request cannot be honored. A copy of this letter should be sent to the Director for FEC.

(4) ALJ Decision. The decision of the ALJ is effective on the date issued. An ALJ decision affirming exclusion can be stayed only by order of the Director, upon petition for review filed for grounds specified at 20 C.F.R. 10.455(c). Review by the Director is a matter of discretion rather than right. Upon notification of an ALJ's decision affirming exclusion, the district office and National Office will effect the exclusion by notifying interested parties and implementing stop payment flags and related procedures as described below.

d. Reinstatement of an Excluded Provider. An excluded provider may be reinstated after specified time periods, but only when reasonable assurances exist that the basis for the exclusion will not be repeated. Reinstatement is considered in the National Office and each district office will be advised of any reinstated providers.

7. Documentation and Advice to Affected Claimants. The National Office periodically publishes lists of excluded and reinstated providers which are organized by state and distributed to district offices.

a. List of Excluded Providers. Upon receiving the list, the district office should detach and reproduce the section of the list covering physicians within its jurisdiction and distribute it to local Federal agencies. The district office should also compare the list to its Provider Master File to identify any excluded providers who are treating claimants. For any excluded provider identified, the district office will run a Provider Utilization Report without awaiting receipt of the next general list.

b. Notification to Claimant. Form CA-1342 should be sent to each claimant seen by the provider within the past six months. The letter will inform the claimant that the provider has been excluded from furnishing medical services, supplies or appliances under the FECA and that any charges incurred more than 15 days after the date of the letter will not be paid. If the excluded provider is a physician, the claimant will be asked to select another physician and advised that he or she will be responsible for all charges incurred if treatment with the excluded physician is continued.

c. Removal from Roster. The Medical Management Assistant (MMA) will delete the excluded provider, if a physician, from the roster of second opinion and referee physicians. If an

examination with the excluded physician is pending, the MMA will cancel the appointment and arrange to have the claimant examined by another specialist. If the excluded physician has been following a claimant after referral by the Office, care should be transferred to another physician.

d. Claimant Responses. If a claimant who is using the services of an excluded provider asks that the provider continue to be authorized to render services in his or her case and/or that the Office continue to pay for such services, the CE should explain as tactfully as possible the reason the provider has been excluded and why it is in the best interests of the claimant and the Office to use another provider.

e. Formal Decisions. If the claimant persists in submitting bills from the excluded provider, a compensation order should be issued rejecting the claim for services, supplies or appliances furnished by the provider for the reason that the provider has been excluded under 20 C.F.R. 10.450. As in any other adverse decision, the denial should be accompanied by the rights to hearing, reconsideration and appeal.

Exhibit 1: Procedures for Excluding Medical Providers ([Link to Image](#))

Exhibit 2: Sample Letter of Intent To Exclude

Dear NAME OF RECIPIENT:

I am writing to inform you that it is my intention to exclude [you, and/or name of hospital, firm, etc.] from payment and participation as a provider of medical services, medical support services, and/or supplies to injured Federal employees under the Federal Employees' Compensation Act.

This action will be taken because [concisely state the grounds and cite the C.F.R. section, e.g. "you submitted three bills in a twelve month period substantially exceeding your customary charges for these services without good cause, a violation of 20 C.F.R. 10.450(d)." Then summarize the information you relied upon and refer to supporting documentation which will be attached].

Please telephone me at TELEPHONE NUMBER if you wish to inspect the record or obtain copies of any documentation not attached.

If you do not contest this action, you may resign voluntarily from participation in the FECA program without admitting or denying the above-stated grounds for exclusion.

If you do not choose to resign, you may request a decision on exclusion based upon the existing record and any additional documentary information you may wish to provide. You will have the right to request a formal hearing on any adverse decision before an Administrative Law Judge.

Your answer must be received by the undersigned within 30 days. You must state whether (a) you are resigning voluntarily or (b) you are requesting a determination on the existing record and any additional information you are providing. If you chose option (b), the additional information, if any, must be enclosed with your reply.

If you do not reply within 30 days of your receipt of this letter, it will be assumed that the allegations contained above are true, and you will be excluded from the FECA program as proposed.

Sincerely,

REGIONAL DIRECTOR

Exhibit 3: Sample Decision To Exclude

Dear NAME OF RECIPIENT:

Inasmuch as you have not responded to my letter of DATE, wherein I proposed to exclude you as a provider of [medical services, medical support services, supplies] under the Federal Employees' Compensation Act, the allegations stated in that letter are deemed to be true and are hereby incorporated as a part of this letter decision.

OR

I have carefully reviewed the information you submitted in response to my letter dated DATE, wherein I proposed to exclude you as a provider of (medical services, medical support services, supplies) under the Federal Employees' Compensation Act. [Include discussion of findings.]

Based upon these findings, NAME OF PROVIDER is hereby excluded from participation and payment as a provider under the Federal Employees' Compensation Act, for violation of 20 C.F.R. 10.450 [specify c, d, e, f and/or g, whichever applies]. This exclusion is effective 30 days from the date of this letter and shall last for a period of STATE PERIOD.

You may, of course, continue to provide services or supplies for the effects of injuries and occupational diseases under the Federal Employees' Compensation Act, if permitted by your State and local licensing agencies. However, payment is the responsibility of the patient or consumer and will not be reimbursed by this Office.

You may request a hearing on this decision by writing to the undersigned within 30 days of this letter. If such request is timely filed, the decision to exclude will be stayed. No hearing will be scheduled if the request is received after 30 days. Your timely request will be forwarded to the Department's Chief Administrative Law Judge for assignment.

A request for a hearing should contain (1) a concise notice of the issues on which you desire to give evidence at the hearing, (2) any request for a more definite statement by this Office, (3) any request for the presentation of oral argument or evidence, and (4) any request for a certification of questions concerning professional medical standards, medical ethics or medical regulation for

an advisory opinion from a competent recognized professional organization or Federal, State or local regulatory body.

Reinstatement after exclusion is not automatic. You may request reinstatement as a provider after the period of exclusion has expired, or after one year, whichever occurs first. Any request for reinstatement should be addressed to the Director for Federal Employees' Compensation, U.S. Department of Labor, Office of Workers' Compensation Programs, 200 Constitution Avenue, N.W., Room S-3229, Washington, D.C. 20210.

The application for reinstatement should contain a concise statement of the basis for any application and should be accompanied by supporting documents and affidavits. The request for reinstatement may include a request for oral argument, but such argument will be allowed only in unusual circumstances where it will materially aid the decision-making process. The Director will order reinstatement only in instances where such reinstatement is clearly consistent with the ultimate goal of the regulations under which this action is taken, to protect the FECA program against fraud and abuse. To satisfy this requirement, the provider must furnish reasonable assurances that the basis for the exclusion will not be repeated.

Sincerely,

REGIONAL DIRECTOR

Chapter 3-0900, Administrative Matters

1. Purpose. The work of the Medical Unit includes administrative as well as medical aspects. The purpose of this chapter is to describe these administrative considerations and procedures.

2. Obtaining Outside Medical Services. Federal regulations determine the method of compiling the roster of physicians from whom second opinion specialists and case reviewers will be selected. The requirements include public notice or other recruitment methods to advertise OWCP's need for and willingness to purchase certain medical consultation services; broad methods of distribution so that every qualified provider who wishes to participate has an opportunity to do so; and written agreements specifying the nature of services to be performed and the terms of purchase, so that the provider may be held accountable for any failure to provide the service as promised.

a. Recruitment. District offices may use various methods of recruitment, including:

- (1) Writing or telephoning physicians listed in national or local rosters of medical specialists.
- (2) Contacting officers of local medical and hospital associations, departmental chairpersons of medical schools, hospital staffs, and other government agencies which employ physicians. The letters shown in Exhibits 1 and 2 may be used for this purpose.
- (3) Advertising through county medical societies or through publications of other organizations.

The District Medical Director (DMD) is responsible for conducting the district office's outreach function (see Chapter 3-200.3). Form CA-21 (Exhibit 3 ([Link to Image](#))) may be used to provide prospective consultants with general information concerning their role and the program.

b. Insufficient Number of Physicians. If too few physicians respond to recruitment efforts, the list may be expanded by drawing on other sources. For example, the DMD may call or write physicians known to be available in the area on a case-by-case basis. As long as all qualified physicians who express willingness to examine claimants or perform case reviews receive an equitable share of referrals, the Office may freely use other physicians who did not respond to the recruitment or advertisement. Where specialists are scarce, second opinion examiners or case reviewers need not be Board-certified or Board-eligible.

c. Acceptability. The DMD should provide information to the District Director (DD) about the responsiveness and professional qualifications of physicians who apply to provide services and about an appropriate range of fees. The contracting officer (or designee) should interview each physician by telephone or in person to fix a reasonable cost or range of fees per service, and to establish a method whereby the physician will obtain referrals. Physicians who will review case files may obtain them by mail or in person from the district office. The contracting officer should avoid committing the Office to a minimum number of referrals to any one physician. The DMD should, however, be able to provide a verbal estimate of the workload.

If a physician with a demonstrably poor record of timeliness, responsiveness, or completeness of reports asks to provide service, the DMD should contact the physician and explain the program and its requirements, stressing the need for promptness, the standards for reports and the importance of responsiveness to questions. If interest continues, the physician may be asked for an opinion on one or two cases prior to contracting so that his or her understanding of the program and the kinds of issues on which opinions are needed may be demonstrated. Physicians may be advised that the reports are insufficient for the Office's needs, or that the Office has a sufficient number of specialists for present workloads. The district office should, however, avoid writing extensively critical letters to physicians.

d. Written Agreements. All physicians who regularly review cases for the Office should be placed under written agreement. Physicians who complete such agreements should not be asked to perform referee examinations while the contract is in force, and office records should be annotated to show the physicians in this category.

The contracting officer within each region is the Regional Director (RD), who is responsible for ensuring that they procedures are followed. The authority to sign agreements with physicians

may be delegated in writing to the DD, but no further delegation is permitted. Sample agreements are shown in Exhibits 4 and 5.

e. Record-Keeping. The Medical Management Assistant (MMA) should maintain careful records in order to demonstrate compliance with these procedures. The following should be documented:

- (1) Recruitment efforts and responses to them;
- (2) Use of each physician responding, or reasons for not doing so;
- (3) Contractual agreements with all physicians serving as case reviewers.

3. Release of Medical Information. While Federal regulations require the Office to maintain the confidentiality of records under its jurisdiction, they also provide that the claimant may have access to records pertaining to him or her as long as the information released will not be harmful. In most instances the regulations prohibit release of information to others unless the claimant has given written permission to release the records.

a. Release by OWCP. With written consent from the employee, the CE may release medical records to the representative, a private insurance company, a welfare agency, etc. If the CE believes that information contained in the records may be embarrassing or damaging to the claimant, the case will be referred to the DMA for review to determine whether release is advisable. Extreme caution should always be exercised when considering release to any party of medical information containing diagnoses or impressions of sexual deviation, drug addiction, alcoholism, psychotic conditions, or conditions resulting from self-abuse. The DMA may suggest release to the employee's treating physician for interpretation.

(1) Claimant or Representative. The DMA may be asked to render an opinion whether release of medical records would have an adverse effect upon the claimant. If so, the information will normally be released only to the employee's physician for interpretation.

(2) Claimant's Physician. When the claimant's attending physician wishes to study x-rays, electrocardiograms, slides, etc., made by another physician, clinic, or hospital, it is proper to authorize such review. These materials may be sent to the requesting physician by certified mail with the understanding that measures will be taken to avoid loss in transit and to return the materials promptly.

(3) Medical Departments of Other Federal Establishments. It is customary to furnish copies of medical reports of authorized examinations in connection with an injury to medical departments of other Federal establishments upon request.

(4) Office of Personnel Management (OPM). Medical information, usually in the form of copies of pertinent medical records, may be furnished the Office of Personnel Management upon request.

(5) Social Security Administration. Medical information, usually in the form of copies of pertinent medical reports, may be furnished the Social Security Administration upon request.

(6) Attorneys in Third Party Cases. All requests for medical information on third party cases shall be referred to the CE designated to handle such cases.

(7) Insurance Companies. Information may be released to an insurance company when the request is accompanied by a signed release from the employee.

Reports containing confidential information gathered by such agencies as the Federal Bureau of Investigation and the Office of the Inspector General remain the property of those agencies. Neither the reports nor communications concerning them may be disclosed outside OWCP without prior approval. Requests for access or disclosure of such reports or communications should be referred to the agency which generated the report.

Similarly, OWCP should not release reports labeled confidential by their authors. The requestor should be advised to contact the originator of such a report concerning its release.

b. Release of Medical Information by Others. The CE and DMA may be consulted by employing agencies, medical providers and others concerning the propriety of release of information pertaining to FECA claims. The following guidelines pertain to release of such information by parties other than OWCP:

(1) Medical Providers. Physicians providing medical services on OWCP authorization may release medical information to the claimant and his or her representative without OWCP approval, but they may not release such material to other parties, and they are not permitted to use such information for teaching purposes or to abstract it for publication without the specific approval of OWCP. If such release has occurred, the DMA should contact the physician and advise him or her that medical records pertaining to OWCP beneficiaries are privileged and confidential and may not be released to others without the specific approval of OWCP.

(2) Employing Agencies. The regulations state that all records, statements, and reports made in connection with a claim for compensation are the official records of OWCP and are not records of the agency, establishment, or department making or having the care or use of such records. Information needed for the official purposes of any department, agency, or other establishment of the Government may be disclosed if the employing agency certifies that such information will be used exclusively for official purposes.

(3) Federal Facilities. Federal hospitals and clinics may release medical information relating to OWCP beneficiaries from their records to medical officers of other Federal establishments without OWCP approval when requested for assistance in job placement or follow-up medical services. They may also release clinical information without OWCP approval to physicians for their assistance in caring for the patient. In general, Federal medical facilities may release medical information consistent with their responsibilities to safeguard the privacy of employees and protect sensitive information.

Any correspondence concerning medical care and related subjects will be prepared for the signature of the DMA where the district office has a full-time DMA. If the office has only a WAE (when actually employed) physician, correspondence will be prepared for the signature of that physician. The WAE physician will sign the correspondence or may designate the MMA to sign it using the physician's name.

4. Complaints Concerning Medical Care. The DMA may be asked to comment on complaints about the quality of medical care or about medical bias or discrimination. Complaints may range from minor matters such as prolonged waiting periods prior to examination by a particular physician to more serious problems which may potentially lead to malpractice or assault and battery suits. The CE is responsible for answering such complaints, but the DMA's professional expertise may be needed to prepare the response. Complaints Concerning Medical Care:

a. Medical Management. If a question arises concerning the attending physician's medical management of the case, the DMA should request discussion of the medical problem involved.

b. Guidelines for Attending Physician. In response to a complaint, the DMA may wish to seek consultation with experts in specialized fields in order to provide the attending physician with guidelines or to determine a further course of action with regard to medical care. In taking this action, the DMA should not mention any possible transfer of care to the specialist at a later date. Otherwise, the implication of bias may arise. The attending physician must be advised of the contemplated action and told that the findings will be made available to him or her.

Exclusion of medical providers is discussed in Chapter 3-800, while transfer of care to another physician is addressed in Chapter 3-300.

5. Fees for Medical Services. The Office maintains a fee schedule for certain medical services and supplies. The amounts payable are determined by assigning a value to each procedure which represents the relative skill, risk, and time required to perform it and according to whether it is medical, surgical, pathological, or radiological. Each value is then multiplied by a geographical index figure which represents the cost of medical care in the locality where the service is provided. Not all services are covered by the fee schedule, however, and if charges for a service which is not included appear to be unreasonable, the CE or Benefit Payment Clerk (BPC) may refer the case to the DMA for advice.

a. Determining Reasonableness. If the DMA cannot justify the charges on the basis of medical complications or other complexities of the case, either from information of record or through correspondence with the physician, the DMA should consult the local medical society for assistance in assessing the reasonableness of the charges. Fees higher than those charged the general public in the area for similar services will not be allowed without written justification in the case record and may be grounds for excluding the provider (see Chapter 3-800).

b. Services Not Rendered. Payment of medical expenses is made on the basis of services rendered. The law makes no provision for payment of services not rendered or for missed

appointments except where OWCP scheduled the appointment. Payment may, however, be made to a physician for review of a file and preparation of a report.

c. Lost Wages. An employee who loses wages in undergoing examination or treatment authorized by OWCP may be reimbursed for these wages. The employee must submit a statement certified by the employer which shows the exact period of time and the total amount of wages lost. The statement must also furnish information needed to compute the amount of wages lost, such as rate of pay per hour or per day. Lost wages are paid only for the time needed for examination or treatment and travel needed to obtain it.

6. Case Maintenance and Handling.

a. Telephone Conversations and Personal Interviews. A written memorandum which provides a brief resume of the discussion must be prepared with respect to all substantive telephone conversations and personal interviews relating to OWCP claims (though not for brief, simple responses consisting of information about the program or the claim). Form CA-110, Report of Telephone or Office Call, may be used for this purpose. This does not apply to informal discussions with other members of the OWCP staff.

b. Memoranda and Notations by DMA. Material for inclusion in case files will be carefully worded in order to prevent any appearance of bias. Typed memorandums must bear the full signature of the DMA in red ink, unless the MMA signs for the DMA. The DMA's handwritten memorandum and notation will also be signed with red ink.

c. Underscoring. Annotation of medical reports contained in the case file is not permitted as it improperly focuses attention on certain parts of the report at the expense of others and may result in bias. Where the DMA feels such emphasis is necessary, he or she should prepare a memorandum for the file.

d. Order of Pages. Any pages removed for photocopying or other reasons should be replaced in the file in the sequence found. The order of documents numbered for the Employees' Compensation Appeals Board should not be disturbed.

e. Mailing of Case Records. The Branch of Records and Files is responsible for mailing the contents of case files from OWCP. They are to be sent by certified mail.

f. X-rays, Electrocardiograms, and Slides. Reports of x-ray and other kinds of tests are usually sufficient for determining medical issues, and it is rarely necessary to obtain the actual films, tracings, etc. Occasionally, however, the DMA may need to obtain such evidence for proper evaluation of the case. If so, it must be sent and returned by certified mail. All x-rays received in OWCP will promptly be referred to the DMA and returned to the sender as soon as they have served their purpose. If the sender cannot be identified, the x-ray will be referred to the present or latest attending physician and the injured employee notified.

7. Effect of Claims Actions on Entitlement to Medical Benefits.

a. Lump Sum Settlement. The receipt of a lump sum settlement for disability does not bar the claimant from receiving medical examination and treatment at OWCP expense.

b. Third Party Cases. An employee who has made a recovery from a third party is not entitled to treatment at OWCP expense until the remaining credit has been exhausted. Prior to authorizing medical care in such cases, the MMA should check with the designated CE to ensure that the OWCP will pay further medical expenses. When the Office of the Solicitor advises that a court hearing is imminent, all action must be held in abeyance pending the outcome of the suit. If a dire medical emergency exists, the Director for FEC should be contacted for instructions.

8. Time Loss for Routine Medical Appointments. As a rule, no more than four hours of compensation or continuation of pay should be allowed for routine medical appointments. Longer periods of time may be allowed when required by the nature of the medical procedure and/or the need to travel a substantial distance to obtain the medical care.

Exhibit 1: Sample Recruitment Letter and Reply—Second Opinion Examiner

Dear NAME OF PHYSICIAN:

The Federal Employees' Compensation Program is seeking physicians in your area to perform medical evaluations of Federal employees with traumatic injuries or occupational diseases.

As you may know, our program is responsible for providing medical and salary replacement benefits for Federal workers found to have work-related injuries or diseases. It is a non-adversarial system which relies on the medical community, not only for the treatment of our claimants, but also for the evaluation of the medical aspects of our cases. Medical evaluations are used by our claims examiners to adjudicate compensation claims properly and to manage them effectively.

A second opinion evaluation involves the physical examination of the worker, the review of the claim file and the submission of a written medical report answering specific questions posed by the claims examiner. In the report, you will be asked to give your opinion on issues such as the etiology of the condition and its relationship to the workplace, treatment, prognosis, and the assessment of any resulting physical impairment.

The program reimburses these services in full and, because these bills are subject to prompt pay rules, we are committed to process your bill within a short period of time.

Should you be interested in providing these services, please complete and mail the enclosed form. If you desire additional information or have any questions or comments regarding these services, please do not hesitate to call NAME on PHONE NUMBER.

Sincerely,

REGIONAL DIRECTOR

Dear REGIONAL DIRECTOR:

I would like to perform medical evaluations for the Federal Employees' Compensation Program.
I am Board eligible (), Board certified () in _____.

Sincerely,

(Signature)

(Print Name)

Office address(es) _____

Office telephone number(s) _____

Tax identification number _____
(EIN number)

Exhibit 2: Sample Follow-Up Letter—Second Opinion Examiner

Dear NAME OF PHYSICIAN:

Thank you for agreeing to perform medical evaluations for the Federal Employees' Compensation Program.

Please find below some details about our program, its requirements and claims processing system which may be of help to you and your office staff.

A. SCHEDULING

1. A member of our district office staff will call your office to arrange the second opinion examination. Generally, we prefer the actual examination to take place within 15 business days of this initial notification. If the claimant does not keep the appointment, please notify us at once.
2. We rotate medical evaluations among the physicians in the area who agree to perform these services. For this reason, some time may elapse between referrals.

B. BILLING

1. The program reimburses second opinion examinations in full. According to your billing practices, this may include your usual fee for a consultation as well as the time spent in reviewing the claimant's medical file, and any clerical time spent in typing the report. You may wish to itemize these charges in the bill.
2. Our prompt pay rules require that your bill be processed within 30 days. To ensure that your bill is indeed processed within this period of time, please be certain to use the billing form (HCFA-1500) enclosed with the case file. If this form is not used, we may have difficulty identifying your bill as one subject to the prompt pay rules and reimbursement may be delayed.

C. CLAIMANT'S FILE

1. You will receive photocopies of pertinent material from the original case file. These need not be returned to the district office.
2. Our files are arranged in chronological order, with the most recent material at the top of the file. If you need to remove a page from the spindle in order to examine it, please be sure to replace it where originally found. Also, please refrain from making notes in the margins of the reports and underlining any material in the file. We will try to identify the medical material for your attention.

D. MEDICAL REPORT

1. A complete medical report should be submitted to our district office within 15 business days of the actual second opinion examination.
2. The medical report should contain a brief synopsis of the clinical history of the claimant, a description of the physical findings and, most importantly, complete answers to all specific questions posed by the claims examiner. Should you find any question unclear as to wording or purpose, please contact our district office for clarification before answering the particular question. This may minimize the need for additional correspondence from the claims examiner.

3. Answers to the claims examiner's questions, particularly in the areas of etiology and work-relatedness, should be accompanied by an explanation or "rationale"; unsupported, brief (yes or no) answers do not meet the needs of the program. The explanation must be sufficiently clear that other reviewers, including non- medical staff, can see how the medical decision was reached. References from the medical literature may be used as part of the explanation.

4. In answering the claims examiner's questions, please be as definite as the medical findings in the case allow. Expressions such as "reasonable probability" and "likely" are acceptable to the program. In contrast, wording such as "might be due to" or "may have been caused" are too imprecise to support a claims decision.

If, while providing these services, problems or questions arise regarding a particular case or the program as a whole, please do not hesitate to call NAME on PHONE NUMBER. We will be glad to work with you to resolve any issues as they arise. When contacting us to discuss a problem related to a compensation case, please have the claim file number available.

Again, we appreciate your cooperation and look forward to your participation in our program.

Sincerely,

REGIONAL DIRECTOR

Exhibit 3: General Information for Physicians, Form CA-21 ([Link to Image](#))

Exhibit 4: Sample Cover Letter—Case File Reviewer

Dear NAME OF PHYSICIAN:

Thank you for agreeing to perform case file reviews for the Federal Employees' Compensation Program.

Four copies of the Memorandum of Agreement are enclosed. Please sign three copies of the agreement form and return them together with your fee schedule to this office. We will then advise you when evaluations of case files are needed.

All medical opinions must contain detailed supporting rationale, based on actual findings and accepted medical opinion. Unsupported conjecture and speculative judgments cannot be accepted. Evaluations of percentage loss or loss of use of a member or function of the body for schedule award purposes must be made according to the AMA Guides, as far as possible. OWCP will provide further guidance for preparing medical reports as required.

No excerpts may be made from compensation files, and no case histories may be used for publication of any papers or books or in lectures without written permission of the Director, OWCP.

A provider under this agreement is an independent contractor and is not covered under the provisions of the Federal Employees' Compensation Act.

If you are currently providing a second opinion or referee evaluation to this office concerning any claimant, please so advise us, indicating the claimant's name and file number.

Again, we appreciate your cooperation and look forward to your participation in our program. If you have any questions, please contact NAME at TELEPHONE NUMBER.

Sincerely,

REGIONAL DIRECTOR

Enclosure: Memorandum of Agreement

Exhibit 5: Sample Memorandum of Agreement—Case File Reviewer

I. Introduction

This agreement provides for obtaining medical opinions required to determine entitlement to compensation under the Federal Employees' Compensation Act.

Case files reviews and evaluations of medical evidence are needed when the medical evidence of record is not clearly sufficient to support entitlement to benefits being claimed. In such circumstances, the case file is referred to a specialist in the appropriate field for an evaluation of the findings, diagnosis, and conclusions given the medical reports of record.

II. Services to be Provided

The physician shall review the medical reports and test results of record, the Statement of Accepted Facts prepared by OWCP, and any other pertinent information, and shall answer fully and with medical rationale each question posed by the OWCP. If the issue is degree of permanent impairment of a schedule member of the body, the physician shall include the date of maximum improvement and shall show how a percentage of impairment is derived in accordance (as far as possible) with the American Medical Association's Guides to the Evaluation of Permanent Impairment.

III. Reports

A full response to each question posed, with rationalized conclusions, shall be returned with the case file to the OWCP within 15 days after receipt by the reviewer.

IV. Method of Billing and Payment

Billings will be submitted on the form provided in each individual case, together with the physician's report. Fees will be paid in accordance with the negotiated fee schedule.

V. Fee Schedule

The basic fee for review of the file and narrative medical report is \$00.

VI. Termination

This agreement may be canceled by either party upon thirty (30) days' written notice, and return of all OWCP materials.

VII. Security of Files

The physician or medical facility agrees that OWCP files and related material are to be treated in a confidential manner and made available only to individuals who need the files and other material to provide the services described in the agreement. OWCP files and related material will not be reproduced for any reason. When not in actual use, OWCP files and related material will be kept in secure storage under lock and key accessible only to those individuals who have a need for the files and related material for the purpose of providing services under this agreement. OWCP files and related material remain the property of the U.S. Department of Labor. This agreement confers no property rights in OWCP files and related material on the physician or medical facility providing service.

Contracting Officer
U.S. Department of Labor
Washington, D.C. 20210

Physician or Responsible Officer
(Type name and address below)

I am/am not currently providing treatment to beneficiaries of the Federal Employees' Compensation Act to the best of my knowledge. (If yes, provide a list of names.)

Physician's Employer Identification Number, or SSN, if not incorporated. (Show number under which payments should be reported to the Internal Revenue Service.)

State in which licensed: _____

State Board License Number: _____ Expiration Date: _____

FECA Part 4 - Special Case Procedures: Describes the procedures for adjudicating, paying, and managing claims of employees who are covered under the FECA by special legislation.

Chapter 4-0100, Introduction

1. Purpose and Scope. This part of the FECA PM concerns some of the claims issues and functions which are the exclusive jurisdiction of the Cleveland District Office (09). The part provides information necessary for the development, adjudication, payment and monitoring of some of the so-called "Fringe Acts", as well as claims for benefits under the Federal Employees' Compensation Act from foreign nationals.

2. Organization of Material in FECA PM Part 4.

a. Chapter 4-0200 discusses the provisions of 5 U.S.C. 8191 et seq., "Law Enforcement Officers Not Employed by the United States" (LEOs), and the processing of claims for benefits under that subchapter.

b. Chapter 4-0300 outlines the provisions of the War Hazards Compensation Act, 42 U.S.C. 1701 et seq., as well as the procedures to be used in the adjudication and payment of claims under said Act. Individuals who are eligible for coverage under the War Hazards Act include employees of contractors with the United States who sustain injury due to a war-risk hazard or who are detained by a hostile force or person.

c. Chapter 4-0400 concerns claims for benefits under the War Claims Act of 1948. Since the Office of Workers' Compensation Programs administers only certain portions of the War Claims Act, those sections are the focus of the chapter. The majority of claims handled by the Office involve American civilians who were interned by the Japanese Government at Midway, Guam, Wake Island, and the Philippine Islands during World War II.

d. Chapter 4-0500 deals with claims for benefits by volunteer members of the Civil Air Patrol, who were extended coverage under the Federal Employees' Compensation Act by Public Law 89-554, September 6, 1966. Section 8141 includes the provisions of Pub. Law 89-554, as well as Pub. Law 98-94, September 24, 1983, and Pub. Law 103-296, August 15, 1994.

e. Chapter 4-0600 covers claims for benefits by members of and applicants for membership in the Reserve Officers' Training Corps, as outlined in 5 U.S.C. 8140 (Pub. Laws 89-554, September 6, 1966; 100-456, September 29, 1988; and 105-261, October 17, 1998).

f. Chapter 4-0700 concerns the Civilian Conservation Corps and other Federal relief workers.

g. Chapter 4-0801 outlines some the special concerns which must be addressed in the development, adjudication, and payment of claims for benefits by foreign nationals, with more explicit guidance on claims from Philippine and Korean nationals.

h. Chapter 4-0802 provides historical background on claims for benefits from employees of the Panama Canal Commission, as well as procedural guidance.

3. Jurisdiction. All of the claims discussed in this chapter are to be created and adjudicated by the Cleveland District Office (09).

Claims from foreign nationals may be transferred in the manner of any general jurisdiction case where compensation payments do not involve consideration of foreign law, and the claimant has relocated to the United States, except for cases involving employees of the Panama Canal Commission.

See PM 1-0200.3 for a discussion of geographical jurisdiction.

Chapter 4-0200, Non-Federal Law Enforcement Officers

1. Purpose and Scope. This chapter outlines the procedures for developing, adjudicating, paying, and monitoring claims from non-Federal law enforcement officers.

2. Statutory Authority. Public Law 90-291, enacted April 19, 1968, added sections 8191 *et seq.* to the Federal Employees' Compensation Act, and provides compensation coverage for non-Federal law enforcement officers who sustain an injury or disease under circumstances involving a crime against the United States. Coverage is also extended to eligible survivors of officers whose deaths occur under such circumstances. The law was intended to recognize the assistance given to the Federal government by state and local law enforcement officers (LEOs).

3. Regulatory Authority. Regulations governing LEO cases are found in 20 C.F.R., Parts 10.610 through 10.619. Prior to June 1, 1987, no regulations for LEO cases existed.

4. Jurisdiction. All claims from non-Federal law enforcement officers are to be adjudicated and managed in District Office 9 (Cleveland).

5. Claim Forms and Information.

- a. Form CA-721 and Form CA-722 are used for disability and death cases, respectively. No Form CA-7 or Form CA-5 is needed to claim compensation.
- b. Form CA-723 is a poster explaining benefits intended for use by law enforcement agencies.
- c. Form CA-724 is an informational letter designed to be released to agencies, and may be used when information is requested.
- d. Form CA-725 is a more detailed general information letter designed for agencies.
- e. Pamphlet CA-688, "Benefits for Law Enforcement Officers," provides an explanation of conditions of coverage, benefits available, and how to file for benefits.
- f. Requests from city police departments and other law enforcement organizations for multiple copies of forms should be referred to the National Office. A small supply of Forms CA-721 and CA-722 should be maintained by each district office. The supply should be used solely to fill requests for one or two copies of the form in instances where a specific injury, occupational disease, or death has occurred.

6. Conditions of Coverage.

- a. Time. An application for benefits must be made on the appropriate form within five years of the injury or death. Because the claimant's official superior will most likely not be a Federal employee, and because of the wording of the statute, written notice must be received by the Department of Labor within five years, and neither written nor verbal notice to the official superior will suffice. There is no provision for waiver or an exception for medical benefits only.
- b. Civil Employee. Coverage is extended to all non-Federal law enforcement officers who sustain injury or occupational disease while participating in the activities outlined in 5 U.S.C. 8191 (see paragraph 7 below), and to their survivors if the injury results in death. A law enforcement officer is defined in 20 C.F.R., Part 10.610 as an employee of a State or local government, including the governments of U.S. possessions and territories, or an employee of the United States pensioned or pensionable under Sections 521-535 of Title 4, District of Columbia Code, whose functions include one or more of the following:
 - (1) The apprehension of persons sought for the commission of crimes, including those sought by a law enforcement agency for such commission, as well as material witnesses sought in connection with criminal cases; or
 - (2) The protection or guarding of persons held for the commission of crimes or as such material witnesses; or
 - (3) The prevention of the commission of crimes.

Most law enforcement officers who are also Federal employees (for instance, Drug Enforcement Administration agents) must seek compensation for work-related injuries under 5 U.S.C. 8101, not 5 U.S.C. 8191, because they are covered under the Civil Service Retirement System. Law enforcement officers who are members of the Uniformed Divisions of the U.S. Secret Service and the U.S. Park Police and are covered under the D.C. Policemen and Firemen's Retirement and Disability Act (D.C. Retirement Act) are covered under Section 8191 (see paragraph 9 below), rather than 8101, and must meet the definition of a law enforcement officers.

However, 20 C.F.R., Part 10.610 also states, in part:

Members of the Non-Uniformed Division of the United States Secret Service who are covered under the District of Columbia Policemen and Firemen's Disability Act are considered to be engaged in the types of activities specified in 5 U.S.C. 8191 (1)-(3), and are covered by the provisions of 5 U.S.C. 8191-8193 during the performance of all official duties.

Therefore, all employees of the Non-Uniformed Division of the U.S. Secret Service who are covered under the D.C. Retirement Act are covered under 5 U.S.C. 8191-8193, whether they meet the above three criteria for law enforcement officer or not.

In John M. Dolce, 31 ECAB 1787, the Board found that the claimant, a Commissioner for Public Safety, was not a "law enforcement officer" within the meaning of 5 U.S.C. 8191 where he was not considered to be a "Peace Officer" under state law, and where his duties were administrative in nature.

c. Fact of Injury. This element should be considered as in regular FECA claims.

d. Performance of Duty. The same rules concerning performance of duty which apply to regular FECA claims will also apply to LEO claims. Many law enforcement officers are considered to be "on duty" even during off-duty hours, or while "moonlighting" as security guards, so it is important to obtain sufficient information from the claimant and official superior concerning the performance of duty aspects of the particular situation.

e. Causal Relationship. This element should be considered as in regular FECA claims.

7. Criteria to Consider Under Section 8191. A non-Federal law enforcement officer must meet at least one of five criteria outlined in 5 U.S.C. 8191 in order to be eligible for benefits under the FECA. The first three criteria are generally considered together, since they are found in the same subsection of 5 U.S.C. 8191, and all deal with apprehension or attempted apprehension. The criteria are as follows:

a. The officer was engaged on that occasion in the apprehension or attempted apprehension of any person -

(1) for the commission of a crime against the United States, or

(2) who at that time was sought by a law enforcement authority of the United States for the commission of a crime against the United States, or

(3) who at that time was sought as a material witness in a criminal proceeding instituted by the United States.

Apprehension must be in progress, which means that the officer is trying to take someone into custody, or make an arrest.

In Rocco A. Ranaudo, 35 ECAB 689, the claimant was investigating a car sitting idling with the driver apparently asleep at the wheel. When he reached through the window to turn off the ignition, he was grabbed by the driver, who proceeded to accelerate the car, dragging the officer along, and causing him to sustain injury. The claimant was determined not to have been engaged in the "apprehension or attempted apprehension" of an individual under these circumstances.

In Michael McKeon, 28 ECAB 8, where an officer was injured when he picked up a tear gas pen which had been converted to a gun, the Board ruled that his actions did not constitute apprehension.

An officer who is injured when he trips over a tire while conducting an on-site criminal investigation involving Federal offenses is not covered under section 8191 (1) because there is no apprehension (see paragraph 7(c) for a description of the exceptions).

The stimulus for the apprehension or attempted apprehension must be a Federal crime or an integral part of a Federal crime.

In Edward L. Jackson, 31 ECAB 550, the Board found that the officer, who was injured while making an arrest for a local offense, was not brought under coverage simply because he later found that a Federal offense had also been committed. The stimulus for his apprehension was the local matter; his injury occurred prior to the discovery of the Federal offense.

Thus latent discovery of a Federal crime does not bring an officer into the scope of coverage.

After being dragged down the street and injured, the officer in Ranaudo, cited above, arrested the driver for driving while intoxicated and reckless endangerment. The claimant later discovered that the driver was an illegal alien, a violation of Federal law. Since there was no evidence that the apprehension bore any relationship to the Federal violation, coverage was not extended. Later discovery of a Federal crime or potential Federal crime arising out of local activity during which a police officer was injured does not in itself bring the injury within the scope of section 8191.

The latent discovery principle should not be confused with the awareness doctrine, which states that the officer does not need to know at the time of apprehension or attempted apprehension that the violation for which the individual is being arrested is a Federal offense. Thus, the officer who is injured while attempting to apprehend an armed robber will be covered under section 8191 if possession of that particular weapon is a Federal violation, even if the officer didn't know it at

the time of the attempted apprehension. The weapon was an integral part of the stimulus to which the officer was responding.

An officer injured while responding to an alarm of a robbery at a Federally insured bank would be entitled to benefits under section 8191, unless the alarm was false and he was injured after discovering that no crime had been committed. In this situation no Federal crime would have been involved. In most instances, then, there must be an actual Federal crime for there to be coverage (see paragraph 7(c) below for a description of the exceptions).

"Sought by a law enforcement officer of the United States..." means that a Federal warrant must be outstanding, and that the warrant must be at least a part of the reason for the apprehension or attempted apprehension at the time of the encounter. Officers are frequently alerted to the existence of a Federal warrant via police radio.

b. The officer was engaged on that occasion in protecting or guarding a person held for the commission of a crime against the United States or as a material witness in connection with such a crime. This condition of coverage is very rarely encountered.

c. The officer was engaged on that occasion in the lawful prevention of, or lawful attempt to prevent, the commission of a crime against the United States.

The prevention must be an active engagement on the part of the officer. It is not sufficient to argue that all law enforcement officers are engaged in crime prevention while on active duty. The crime being prevented must be specific, and the threat of the crime must be actual and imminent.

In Charles E. Craven, 40 ECAB 447, the Board found that the claimant was engaged in the "lawful prevention of, or lawful attempt to prevent, the commission of a crime against the United States" when he was accidentally shot by a fellow law enforcement officer. He was at the scene with several officers to secure a residence where illegal drug sales were known to be occurring, while a search warrant was being obtained. Because a drug sale had taken place immediately prior, there was every indication that the sale of drugs was about to continue.

In Rocco J. Pascarella, ECAB Docket No. 87-1106, a police officer was injured when he went to investigate a suspicious bag which was sitting outside the entrance to Police Headquarters. He was not extended coverage under Section 8191 even though manufacture of the bomb was a violation of 18 U.S.C. 842(a) because at the time of injury, the crime had already been committed, and he was therefore not in the process of preventing a crime.

In Fred A. Olsen, 40 ECAB 767, the claimant was found to have been engaged in attempting to apprehend a suspect in a Federal crime or prevent the commission of a Federal crime, even though it was later determined that no Federal crime had been committed. The claimant was a local law enforcement officer who responded to a call from the U.S. Coast Guard to assist in apprehending possible drug smugglers. Coverage was extended because the situation presented objective evidence of a potential Federal crime in progress, the claimant had knowledge of this evidence, he had been requested by a Federal agency to assist in apprehending a suspect in a

Federal crime or preventing the commission of such a crime, and he had in fact joined in the pursuit.

Generally, coverage under section 8191 may be extended whenever a local law enforcement officer is requested to provide assistance to a Federal agency in the apprehension of a suspect for, or the prevention of, the commission of a crime against the United States. Officers who are assigned to assist in the protection of the President of the United States are said to be preventing or attempting to prevent a crime against the United States because they are performing Federal law enforcement activities.

In Rodney Aurello, 41 ECAB 450, the Board affirmed the Office's decision to extend coverage to a law enforcement officer who was injured in a helicopter crash while acting as a spotter in a joint Federal-state effort to eradicate illicit cannabis fields. He was found to have been actively engaged in the prevention of a Federal crime, growing of a controlled substance, at the time of his injury.

8. Determinations Under Section 8191.

a. Some of the more common violations of Federal law found in LEO cases include:

- (1) Armed robbery of a Federally insured bank;
- (2) Robbery of a postal worker, vehicle, or office;
- (3) Removal of a serial number from a firearm [26 U.S.C. 5861(g)];
- (4) Possession of a firearm which has crossed state lines [18 U.S.C. 922(h)] by a person convicted or indicted for a crime punishable by imprisonment for a term exceeding one year;
- (5) A stolen firearm has crossed state lines [18 U.S.C. 922(i)];
- (6) A stolen vehicle has crossed state lines;
- (7) Possession or sale of a controlled substance; and
- (8) Manufacture of alcoholic beverages.

Any crime committed in the District of Columbia is considered to be a "crime against the United States" as described in section 8191.

b. Advisory opinions on whether or not a Federal crime is involved in a particular situation may be obtained from the U.S. Department of Justice by forwarding a memorandum outlining the particulars of the situation to the Director for Federal Employees' Compensation.

c. When none of the five criteria are met and a claim must be disallowed, the memorandum must address each of these five factors. It is not sufficient to consider just the one or two factors the

claimant is alleging bring him or her into coverage. Signature level for both the approval and denial of LEO claims is the Senior Claims Examiner. For approvals, only a memorandum outlining the reasons for acceptance and a letter to the claimant(s) explaining the acceptance and asking for information on comparable benefits will be needed.

9. Federal Law Enforcement Officers Covered Under Section 8191.

Members of the Non-Uniformed Division of the Secret Service are covered under section 8191 if they are covered under the D.C. Policemen and Firemen's Disability Act as of the date of injury. Law enforcement officers who are members of the Uniformed Division (formerly called the Executive Protective Service) of the U.S. D.C. Policemen and Firemen's Disability Act are also covered under section 8191. These individuals are not considered employees under section 8101. An individual's retirement plan as of the date of injury determines whether FECA coverage will be under section 8191 or 8101. The Non-Uniformed Division of the Secret Service should provide a statement as to the employee's retirement system as of the date of injury. If a member of the Non-Uniformed Division of the Secret Service sustains a work injury while under the Civil Service Retirement System, but later converts to the D.C. Retirement System and then claims a recurrence of the earlier injury, coverage will be under section 8101. If such an individual applies for and receives D.C. Retirement benefits, and is eligible for FECA benefits under section 8101 for the same period of time, an election of benefits is required under 5 U.S.C. 8116(a). An election between a schedule award of compensation under section 8106 and D.C. Retirement benefits is not required under the FECA. However, section 4-633 of the D.C. Retirement Act prohibits concurrent receipt of FECA benefits under 8101 and D.C. Retirement Benefits for the same injury or death.

a. Members of the Non-Uniformed Division of the Secret Service are covered under section 8191 during the performance of all official duties, and are considered to be engaged in the types of activities specified in section 8191 (1), (2), and (3) during all on-duty time.

b. Law enforcement officers of the Uniformed Division of the Secret Service and U.S. Park Police who are covered under the D.C. Retirement Act must be engaged in specific activities involving crimes against the United States as described in paragraphs 7a through 7c above to qualify for coverage under section 8191.

c. Eligibility for FECA medical benefits for U.S. Park Police and Secret Service employees are as follows:

(1) U. S. Park Police

Pre-retirement: Must use D.C. Clinic if in Washington Metro area. Must use agency-contracted clinics in New York City or California if in those areas. Full FECA if outside D.C., NYC, or CA.

Post-retirement: Full FECA.

(2) Secret Service Uniformed Division

Pre-retirement: D.C. Clinic if in Washington Metro area. Full FECA if outside D.C.

Post-retirement: D.C. Clinic or FECA

(3) Secret Service Non-Uniformed Division

Pre-retirement: Full FECA

Post-retirement: Full FECA

d. Schedule Awards and Leave Buy-Backs are payable. No comparable benefits are deducted during the period of a schedule award (see paragraph 11.b(3) below regarding schedule awards and comparable benefits).

e. Continuation of pay is not payable, even though co-workers who come under the Civil Service Retirement System and who are therefore covered under section 8101 are so entitled.

f. Retirement benefits under the D.C. Retirement System are generally not paid until two days after the hearing with the D.C. Retirement Board has been held, and are not retroactive. Thus full FECA benefits may be paid up through the day after the hearing, after which comparable benefits must be deducted. During the pre-hearing period, deductions for health benefits and optional life insurance must be made, although the enrollment should not be transferred into the office.

10. Details Under the Intergovernmental Personnel Act. Non-Federal law enforcement officers are sometimes detailed to Federal law enforcement agencies (such as the Drug Enforcement Agency) on a long-term basis to assist with the enforcement of Federal laws. These assignments are often made under the provisions of the Intergovernmental Personnel Act (IPA) of 1970, P.L. 91-648, 5 U.S.C. 3371 et seq., issued January 5, 1971. The IPA is not, however, always cited in the agreement between the local law enforcement agency and the Federal agency.

a. To determine whether the claimant may be considered a civil employee of the United States, and thus entitled to coverage under section 8101 instead of 8191, the CE should obtain a copy of the agreement between the local and Federal agencies. The following questions must be considered to determine the civil employee status:

(1) How long has the claimant been assigned to the Federal agency?

(2) How much of the claimant's time is spent working with the Federal agency, as opposed to the local agency?

(3) Who pays the claimant's salary? If paid by the local agency, are they reimbursed by the Federal agency?

(4) Was the claimant issued a Federal agency identification card?

(5) Who is the claimant's immediate superior, and is this individual a Federal employee?

b. Determination of Coverage.

(1) If not found to be an employee under section 8101, the claimant may be instructed to file a claim under section 8191, if appropriate.

(2) If found to be an employee under section 8101, the claimant should be instructed to use Forms CA-1, CA-2, or CA-5 to claim benefits, and the case should be handled in the office with geographical jurisdiction.

(3) If the claimant is entitled to benefits for the same injury or death under both section 8101 of the FECA and a state or local government, sections 3373(d)(1) and 3374(d) of the IPA require that an election of benefits be made within one year after the injury or death. This election is irrevocable.

11. Compensation Benefits. Title 5 U.S.C. 8192 provides that compensation benefits under section 8191 are to be computed as if the officers were employees under section 8101(1). Therefore, the pay rates are determined in accordance with section 8114, and the benefit levels are the same as in other FECA cases. Section 8192 also provides, however, that those benefits may be reduced or adjusted to reflect comparable benefits received by the officer (or survivors) by virtue of his or her employment on the occasion of the injury or death.

a. Comparable Benefits. Any money paid to an officer or survivors by a state or local organization on account of an injury or death which is also covered under 5 U.S.C. 8191 *et seq.* is considered a comparable benefit. The benefit is considered comparable only to the extent that it represents public or state funds. Thus, a benefit which is comprised of both public funds and employee contributions will be only partially comparable.

After a case has been accepted as compensable under section 8191, a letter requesting detailed information on comparable benefits should be released, prior to the payment of compensation benefits. Exhibit 1 shows one example of such a letter.

Types of comparable benefits include the following:

(1) Pension funds. In most cases, the officer has made contributions to the fund, and the formula shown in paragraph 11b must be used to determine the comparable portion. In some death cases, the officer's contribution is repaid to the survivors as a lump sum, and a pension is paid thereafter. The lump sum would not be considered comparable, but the pension paid subsequently would be 100% comparable.

(2) State workers' compensation payments. In almost all cases, state compensation is paid entirely from state funds, and is 100% comparable.

(3) Public Safety Officer Benefit Act (PSOB). The Public Safety Officer Benefit Act, 42 U.S.C. 3796, provides for a \$50,000 lump sum payment to designated survivors of law enforcement officers killed in the line of duty on or after September 29, 1976. The PSOB benefit is 100%

comparable, and it must be completely offset along with any other comparable benefits before FECA compensation is payable.

Effective June 1, 1988, the PSOBA was amended to increase the payment to \$100,000 for eligible survivors, and to provide for cost-of-living increases, effective October 1 of each year. It is therefore necessary to verify the PSOBA amount in each case. Increases to date have been:

October 1, 1988	\$103,890
October 1, 1989	\$109,460
October 1, 1990	\$114,235
October 1, 1991	\$119,894
October 1, 1992	\$123,520
October 1, 1993	\$127,499

If there is more than one eligible survivor, including a widow or widower, 50% of the PSOB benefit is paid on behalf of the widow or widower, and 50% is shared by the remaining beneficiaries. The individual entitlements and comparability offsets must be computed separately.

In practice, because of the large PSOB benefit and the likelihood of other substantial comparable benefits, it may be many years before survivors become eligible for FECA benefits.

Effective November 29, 1990, benefits under the PSOBA of up to \$100,000 were extended to public safety officers who have become permanently and totally disabled as the direct result of a catastrophic personal injury sustained in the line of duty.

Inquiries concerning PSOB should be addressed to:

U.S. Department of Justice
Office of Justice Programs
Bureau of Justice Assistance
633 Indiana Avenue N.W.
Washington, D.C. 20531

(4) State and Local Lump Sums. Many states or localities provide for the payment of a lump sum made up wholly of public funds. As with the PSOBA benefit, these lump sums must be offset in their entirety before FECA compensation will be payable. In the past, lump sum payments were

pro-rated over the projected period of widowhood, based on life expectancy tables. A few of these "pro-rated" cases may remain, and any such case should be left "as is" until the period of the deductions expires.4-0200-11 Compensation Benefits (cont.)

b. Computation of Comparable Benefits. The following formula is generally used to compute the comparable portion of a particular benefit:

a = employer's contribution (may be a monetary amount for the year prior to injury or death, or may be a percentage)

b = employee's contribution expressed in the same terms as "a"

$$\text{comparable benefits} = \frac{a}{a + b}$$

The comparable benefit derived by using this formula will be a decimal (percentage), which must then be multiplied by the total benefit to determine the comparable amount. See Exhibit 2 for an example of the actual calculations.

(1) Percentages of entitlement (i.e., 45% or 50% for widow or widower, 15% for each child, unless there is no widow or widower, etc.) remain the same, even if one survivor is currently ineligible for compensation because of excessive comparable benefits. Prior to August 1, 1982, if one beneficiary was ineligible for compensation, other beneficiaries' entitlement would be computed as if that first beneficiary did not exist. For example, if a widow and one child were entitled to FECA benefits, and the widow's comparable benefits exceeded her entitlement, the child would be paid at 40% instead of 15%, and similarly, if the child's comparable benefits exceeded the FECA entitlement, the widow would be paid at 50%, instead of 45%.

(2) CPI's are applied to the gross compensation benefit before any comparable benefit is deducted. Prior to December 31, 1981 for disability cases and January 1, 1982 for death cases, comparable benefits were first deducted from the gross compensation benefit, then the CPI's were applied. If a computation involves dates prior to December 31, 1981, or January 1, 1982, the method of computation in effect at that time should be used. As with other CPI calculations, disability benefits are rounded to the nearest \$.25 per week, and death benefits to the nearest \$1.00 per month.

(3) During the period of a schedule award, comparable benefits are generally not deducted. One exception would be if an award was made by a state or local organization specifically for loss of or loss of use of the same member for which the FECA award is payable, in which instance, the non-FECA award is considered comparable with the schedule award, but not with any other award payable for loss of wage or loss of wage-earning capacity.

(4) Periodic comparable benefits should be deducted from the FECA entitlement prior to offsetting a lump sum. If the periodic comparable benefits exceed FECA, there will be no lump sum offset.

(5) If there are multiple beneficiaries in a death claim, they may become entitled to FECA benefits on different dates.

When setting up a payment or making a computation in a LEO case, an explanation/breakdown of the computations should usually be provided as an attachment to the CA-24 or CA-25. The attachment should be in sufficient detail that the source of the figures is clear, and it should be certified by the individual certifying the payment. In death cases, each beneficiary's entitlement must be computed separately.

Exhibit 2 provides an example of the calculations which are to be made by the claims examiner in a LEO case.

c. Computing comparable benefits in cases involving employees of the Non-Uniformed Division of the Secret Service. Secret Service employees covered under the D.C. Retirement System contribute 7% of their salary to the retirement system. The Secret Service reimburses D.C. Retirement on a monthly basis to make up the difference between the employee contributions and benefits paid out by the system on behalf of their former employees. To compute the degree to which D.C. Retirement benefits should be offset, the following information should be obtained from the Secret service on a case-by-case basis:

(1) Total Non-Uniformed Division employee contributions to the D.C. Retirement System during the year prior to the effective pay rate date;

(2) The number of employees making those contributions;

(3) The total Secret Service reimbursements to the D.C. Retirement System on behalf of their former (Non-Uniformed Division) employees during the year prior to the effective pay rate date;

(4) The number of former employees on whose behalf those reimbursements were made;

(5) The amount and effective dates of D.C. Retirement benefits, and the amounts and effective dates of any increases. If the case is a death case, each beneficiary's death benefit should be shown separately.

Once this information has been received, the offset amount should be computed as follows:

$$\frac{\begin{array}{r} \text{item} \\ (3) \\ \text{item (4)} \end{array}}{\text{F}} =$$

$$\frac{\text{item (3)}}{\text{item (4)}} + \frac{\text{item (1)}}{\text{item (2)}}$$

F x item (5) = the amount of the D.C. Retirement benefits which must be deducted from the gross FECA benefit.

F will be a decimal, or percentage. If the case is a death case, each beneficiary's benefits must be computed separately. The same percentage will be applicable to each beneficiary. In addition, the D.C. Retirement allows for a \$50,000 lump sum payment to the surviving spouse. This lump sum should be offset at the same rate as the rest of the D.C. Retirement benefits. If a lump sum death payment is also made under the Public Safety Officer's Benefit Act (PSOB), this amount should be offset at 100%, as the employee makes no contribution.

d. Adjustments to comparable benefits. Many state and local benefits programs provide for periodic adjustments, or cost-of-living increases. In addition, they may set limits to the duration of payments, and the ages at which dependent children's benefits cease may be different than under FECA. Each time there is a change in the comparable benefits, it will be necessary to recompute the amount of FECA entitlement. It is thus essential to review cases in which benefits are being paid on a regular basis to ensure that adjustments are made as timely as possible when needed. Reviews at six-month intervals are preferable, and yearly reviews are required. The frequency of review will depend, to a large extent, on the frequency and timing of the changes in the comparable benefits. Exhibit 3 shows a standard status inquiry letter.

e. The student status of children over the age of 18 must be very closely monitored, with a CA-1615 being released at least 45 days prior to the 18th birthday, and a CA-1617 sent each spring to verify that school was attended the entire year and that the child will attend school the following year, and each fall to confirm actual enrollment.

f. An overpayment may occur even though a case is being closely monitored because comparable benefits can change unexpectedly or be made retroactively. All overpayments in LEO cases should be handled in accordance with the overpayment procedures found in Part 9 of this manual.

12. Medical Benefits. Individuals who are eligible for benefits under 5 U.S.C. 8191 et seq. are required to take advantage of any medical benefits which are available to them under other programs prior to seeking FECA medical benefits. In practice, very few LEO cases involve medical expense, because the officers have full coverage under their state or local benefit plans. A state or local government cannot deny medical benefits so that FECA will be responsible for medical bills, if other officers receive medical benefits under that state or local coverage.

13. Other Benefits. Individuals covered under Section 8191 are also entitled to vocational rehabilitation services, attendant allowances, and disfigurement awards. Rehabilitation services

may be provided only while the claimant is in actual receipt of compensation benefits, either for a schedule award or loss of wages. The continuation of pay provisions of Section 8118 do not apply to Section 8191 eligible individuals.

Exhibit 1: Sample Initial Inquiry Letter to an Agency Paying Comparable Benefits

Dear _____,

I am writing in reference to the compensation claim of _____, who was _____ on _____ under circumstances which have been found to be within the purview of the Federal Employees' Compensation Act (FECA). The FECA was extended by Public Law 90-291 to provide compensation for non-Federal law enforcement officers who are injured, sustain disease, or are killed under circumstances involving a crime against the United States. The FECA provides that where local or state compensation benefits for a deceased officer's beneficiaries are less than that payable under FECA, additional compensation may be paid by the Office of Workers' Compensation Programs. Your assistance in furnishing the following information will be appreciated:

- (1) Amount of any regular payments made to the widow and children and the effective dates of any change in payment.
- (2) What events will be legal cause to terminate any benefit?
- (3) What proportion of the award shown in item #1 is paid on behalf of each individual beneficiary?
- (4) What proportion of each award in item #1 represents the amount of state or local government benefits, as opposed to benefits which accrue by reason of the employee's contribution?
- (5) What percentage of pay, or by what other regular method of contribution, did the employee contribute to the benefit fund?
- (6) Did the employer contribute to that fund or any other fund on the employee's behalf? If so, how were the contributions made and how was the amount determined?
- (7) Does the fund have a provision for cost-of-living increases in the future?
- (8) Have there been any lump sum payments made? If yes, please give the amount of the payment, and on whose behalf it was paid.
- (9) If an award has been made in this case, please furnish a copy as well as any letters regarding entitlement.
- (10) To your knowledge, has there been an award made by the Public Safety Officer Benefit Program? Thank you for your assistance in this matter.

Sincerely, Claims Examiner

Exhibit 2: Computation of BenefitsCOMPUTATION OF BENEFITS

The example which follows was chosen specifically because it demonstrates certain principles. The calculations required in an actual case may be more or less complex. Generally speaking, the disability cases will be somewhat easier to compute, because they do not involve PSOB benefits or multiple beneficiaries. A law enforcement officer was killed on February 3, 1986 under circumstances which bring him under the coverage of section 8191. He is survived by a widow and two children. The children's dates of birth are September 10, 1969, and May 6, 1977. The older child has been enrolled in a full-time course of study since turning 18, and student status has been verified satisfactorily. The officer's annual pay as of the date of death was \$35,000. A PSOB benefit of \$50,000 (date of death is prior to the June 1, 1988 PSOB amendments) was paid in a lump sum. In addition, State Worker's Compensation paid a \$10,000 lump sum to the widow, as well as \$2,500 lump sums for each child. The state is also making monthly payments equivalent to \$100.00 per week. These benefits commenced on February 4, 1986, and will continue at the same rate for a period of 10 years without any cost-of-living increases. The widow's share of the benefit is 50%, and each child's share is 25%. Benefits for the children cease when they reach age 18, with no consequent increase in benefits for the widow. The state benefit is 100% comparable. The survivors are also receiving benefits from the local (city) retirement plan of \$600.00 per month as of February 4, 1986. Of this benefit, 60% is paid on behalf of the widow and 20% on behalf of each child. This benefit has increased by 2% each April 1, beginning in 1987. Benefits for the children cease at age 20, regardless of student status, with no resulting increase in the widow's benefit. Because the employee made contributions to this retirement fund during his lifetime, the benefits are only partially comparable. During the year prior to his death, the officer contributed \$1023.50 to the fund, while his employer contributed \$2388.17. Using the comparability formula described in paragraph 11(b) above:

$$\frac{a}{a + b} = \frac{\$2388.17}{\$2388.17 + \$1023.50} = \frac{\$2388.17}{\$3411.67} = .70 \text{ or } 70\%$$

The local benefit is 70% comparable.

Today's date is April 10, 1990.

Monthly FECA pay rate
is

$$\frac{\$35,000}{12}$$

Calculation of Widow's Benefits

<u>FECA:</u>	Widow @ 45% of	\$2916.67 effective 2/4/86	\$1312.50
		.7% CPI effective 3/1/87	\$1322.00
		4.5% CPI effective 3/1/88	\$1381.00
		4.4% CPI effective 3/1/89	\$1442.00
		4.5% CPI effective 3/1/90	\$1507.00

Lump sums: 50% of \$50,000 PSOB payment \$25,000
state \$10,000
total \$35,000

Local benefit: is 70% comparable; 60% of the benefit is the widow's share

\$600.00 x 70% = \$420.00
widow's portion effective \$420.00 x 60% = \$252.00
2/4/86 \$612.00 x 70% = \$428.40
2% increase effective 4/1/87 \$428.40 x 60% = \$257.04
widow's portion \$624.24 x 70% = \$436.97
2% increase effective 4/1/88 \$436.97 x 60% = \$262.18
widow's portion \$636.72 x 70% = \$445.71
2% increase effective 4/1/89 \$445.71 x 60% = \$267.42
widow's portion \$649.45 x 70% = \$454.62
2% increase effective 4/1/90 \$454.62 x 60% = \$272.77
widow's portion

State benefit: \$100 per week = \$433.33 per month ($\frac{\$100 \times 52}{12}$)

widow's portion: \$433.33 x 50% = \$216.67

Net benefits (lump sums yet to be deducted):

2/4/86 - 2/28/87 (12 months and 25 days, or 12.89 months)

FECA	\$1312.50	
less local	\$252.00	
less state	\$216.67	
net	\$843.83 x 12.89 =	\$10876.97

3/1/87 - 3/31/87 (1 month)

FECA	\$1322.00 (.7% CPI)	
less local	\$252.00	
less state	\$216.67	
net	\$853.33 x 1 =	\$853.33

4/1/87 - 2/29/88 (11 months)

FECA	\$1322.00	
less local	\$257.04 (2% increase)	
less state	\$216.67	
net	\$848.29 x 11 =	\$9331.19

3/1/88 - 3/31/88 (1 month)

FECA	\$1381.00 (4.5% CPI)	
less local	\$257.04	\$907.29

less state	<u>\$216.67</u>	
net	\$907.29 x 1 =	

4/1/88 - 2/28/89 (11 months)

FECA	\$1381.00	
less local	\$262.18 (2% increase)	
less state	<u>\$216.67</u>	
net	\$902.15 x 11 =	\$9923.65

3/1/89 - 3/31/89 (1 month)

FECA	\$1442.00 (4.4% CPI)	
less local	\$262.18	
less state	<u>\$216.67</u>	
net	\$963.15 x 1 =	\$963.15

4/1/89 - 2/28/90 (11 months)

FECA	\$1442.00	
less local	\$267.42 (2% increase)	
less state	<u>\$216.67</u>	
net	\$957.91 x 11 =	\$10,537.01

3/1/90 - 3/31/90 (1 month)

FECA	\$1507.00 (4.5% CPI)	
less local	\$267.42	
less state	<u>\$216.67</u>	
net	\$1022.91 x 1 =	\$1022.91

4/1/90 and continuing

FECA	\$1507.00	
less local	\$272.77 (2% increase)	
less state	<u>\$216.67</u>	
net	\$1017.56	

Total entitlement 2/4/86 through 3/31/90:

\$10,876.97 + \$853.33 + \$9331.19 + \$907.29 +	
\$9923.65 + \$963.15 + \$10,537.01 + \$1022.91 =	\$44,415.50

less lump sums	<u>\$35,000.00</u>
balance due	\$ 9,415.50
widow	

Calculation of Child #1's Benefits - Date of Birth 9/10/69

<u>FECA:</u>	Child at 15% of	\$2916.67 effective 2/4/86	\$437.50
		.7% CPI effective 3/1/87	\$441.00
		4.5% CPI effective 3/1/88	\$461.00
		4.4% CPI effective 3/1/89	\$481.00
		4.5% CPI effective 3/1/90	\$503.00

<u>Lump sums:</u> 25% of PSOB payment	\$12,500.00
state	\$2,500.00
total	\$15,000.00

Local benefit: comparable amounts are taken from widow's calculations; the child's share is 20%

Child's portion	effective 2/4/86	\$420.00 x 20% = \$84.00
	effective 4/1/87	\$428.40 x 20% = \$85.68
	effective 4/1/88	\$436.97 x 20% = \$87.39
	effective 4/1/89	\$445.71 x 20% = \$89.14

Benefit stops on 9/9/89, as child turns 20 on 9/10/89.

State benefit: \$433.33 x 25% = \$108.33.

Benefit ceases on 9/9/87, as child turns 18 on 9/10/87

Net benefits (lump sums yet to be deducted):

2/4/86 - 2/28/87 (12.89 months)

FECA	\$437.50
less local	\$ 84.00
less state	<u>\$108.33</u>
net	\$245.17 x 12.89 = \$3160.24

3/1/87 - 3/31/87 (1 month)

FECA	\$441.00 (.7% CPI)
less local	\$ 84.00
less state	\$108.33
net	\$248.67 x 1 = \$248.67

4/1/87 - 9/9/87 (5 months, 9 days, or 5.3 months)

FECA	\$441.00
less local	\$ 85.68 (2% increase)
less state	\$108.33
net	\$246.99 x 5.3 = \$1309.05

9/10/87 - 2/29/88 (5.7 months)

FECA	\$441.00	
less local	\$ 85.68	
net	\$355.32 x 5.7 =	\$2025.32

3/1/88 - 3/31/88 (1 month)

FECA	\$461.00 (4.5% CPI)	
less local	\$ 85.68	
net	\$375.32 x 1 =	\$375.32

4/1/88 - 2/28/89 (11 months)

FECA	\$461.00	
less local	\$ 87.39 (2% increase)	
net	\$373.61 x 11 =	\$4109.71

3/1/89 - 3/31/89 (1 month)

FECA	\$481.00 (4.4% CPI)	
less local	\$ 87.39	
net	\$393.61 x 1 =	\$393.61

4/1/89 - 9/9/89 (5.3 months)

FECA	\$481.00	
less local	\$ 89.14 (2% increase)	
net	\$391.86 x 5.3 =	\$2076.86

Local benefit ceases 9/9/89, as child is 20 on 9/10/89.

9/10/89 - 2/28/90 (5.7 months)

FECA	\$481.00 x 5.7 =	\$2741.00

3/1/90 and continuing: benefit is \$503.00 (4.5% CPI)

Total entitlement 2/4/86 through 3/31/90:

\$3160.24 + \$248.67 + \$1309.05 + \$2025.32 + \$375.32 +	
\$4109.71 + \$393.61 + \$2076.86 + \$2741.00 + \$503.00 =	\$16,942.78
less lump sums	<u>\$15,000.00</u>
balance to child	\$1,942.78
(widow)	

Calculation of Child #2's Benefits - Date of Birth 5/6/77

Basic entitlement is the same as child #1, except:

Local benefit:

Effective 4/1/90,	\$454.62 x 20% =	\$90.92
2/4/86 - 2/28/87	\$3160.24	
3/1/87 - 3/31/87	\$248.67	
4/1/87 - 2/29/88 (11 months)		
\$246.99 x 11 =	\$2716.89	
3/1/88 - 3/31/88 (1 month)		
FECA	\$461.00 (4.5% CPI)	
less local	\$ 85.68	
less state	\$108.33	
net	\$266.99 x 1 =	\$266.99
4/1/88 - 2/28/89 (11 months)		
FECA	\$461.00	
less local	\$ 87.39	
less state	\$108.33	
net	\$265.28 x 11 =	\$2918.08
3/1/89 - 3/31/89 (1 month)		
FECA	\$481.00 (4.4% CPI)	
less local	\$ 87.39	
less state	\$108.33	
net	\$285.28 x 1 =	\$285.28
4/1/89 - 2/28/90 (11 months)		
FECA	\$481.00	
less local	\$ 89.14 (2% increase)	
less state	\$108.33	
net	\$283.53 x 11 =	\$3118.83
3/1/90 - 3/31/90 (1 month)		
FECA	\$503.00 (4.5% increase)	
less local	\$ 89.14	
less state	\$108.33	
net	\$305.53 x 1 =	\$305.53

4/1/90 and continuing

FECA	\$503.00
less local	\$ 90.92 (2% increase)
less state	\$108.33
net	\$303.75

Total entitlement 2/4/86 through 3/31/90:

$$\begin{aligned} &\$3160.24 + \$248.67 + \$2716.89 + \$266.99 + \\ &\$2918.08 + \$285.28 + \$3118.83 + \$305.53 = \quad \$13,020.51 \end{aligned}$$

\$15,000.00 Lump sum payments
less \$13,020.51 Total FECA entitlement 2/4/86 - 3/31/90
\$1,979.49 Balance remaining for offset

At the current rate of payment, \$303.75 per month, the balance of the lump sums will be offset in \$1979.49/\$303.75, or 6.52 months, which will be October 15, 1990.

As of 4/1/90 the monthly benefit will be:

\$1,017.56 (widow's benefit)

\$ 503.00 (child #1's benefit)
\$1,520.56 (total monthly benefit)

$$\frac{\$1520.56 \times 12}{52} = \$350.90 \quad (\text{weekly benefit})$$

For 4/1/90 through 4/7/90 (exactly one week) the widow is due \$350.90.

Total payments due for the period 2/4/86 through 4/7/90 are:

\$9,415.50	(widow's balance due through 3/31/90)
\$1,942.78	(child #1 balance due through 3/31/90)
\$ 350.90	(combined amount due for 4/1 - 4/7/90)
\$ 11,709	18 (total payable to widow)

A narrative Form CA-24 should be prepared for the lump sum payment. A regular Form CA-24 should be prepared to place the widow and first child on the periodic roll as of 4/8/90. This form should be completed as it would be normally, except that:

1. Since the retroactive payment was computed manually, mark item 8 (Has retroactive payment been made from date of death?) "Y" for yes.
2. The current combined four-weekly comparable benefit should be shown in item 16 (Payee code AR). "Total amount due" will be 9999999. The periodic deduction is computed as follows:

$$\begin{array}{r}
 \$272.77 \text{ (widow's local benefit as of 4/1/90)} \\
 + \quad \$216.67 \text{ (widow's state benefit as of 4/1/90)} \\
 \quad \$489.44 \text{ (total monthly comparable benefit)} \\
 \hline
 \$489.44 \times 12 = \$451.79 \text{ (four-weekly comparable benefit)} \\
 13
 \end{array}$$

Enter \$451.79 as the periodic deduction amount. Note that child #1's comparable benefits have terminated.

On October 15, 1990, the second child will become eligible for FECA benefits. A call-up should be set for 10/15/90. In addition, the following dates should be considered intervention points:

- a) 9/9/92, when the first child's eligibility for student benefits under the FECA expires (the child reaches age 23 on 9/10/92; student eligibility may expire sooner if child completes four years of post-high school education prior to age 23);
- b) 3/20/95, when Form CA-1615 should be released to determine the second child's student status, since he/she will be 18 on 5/6/95;
- c) 5/5/95, when the second child's eligibility for state benefits expires at age 18, and when the CA-1615 should have been returned;
- d) 5/5/97, when the second child's local benefit will cease at age 20;
- e) 5/5/2000, when the second child's FECA student eligibility ceases at age 23; and
- f) in March or early April of each year, an adjustment for the local benefits increase will be needed.

Exhibit 3: Sample Status Inquiry Letter to an Agency Paying Comparable Benefits

Dear _____,

I am writing in reference to the compensation claim of _____, a former member of the _____ Police Department, who was _____ on _____, under circumstances which have been found to be within the purview of the Federal Employees' Compensation Act. This Office is currently paying benefits to _____. Periodically, we are required to check on the amount of and changes to comparable benefits (5 USC 8192). The most recent information on file, dated _____, indicates that your agency was paying _____ per month. Please advise if this amount is still correct. If not, please advise the correct amounts, the effective dates of any changes since that time, and the reasons for the changes. If a change is expected in the near future, please advise the expected date and the

amount of the prospective increase or decrease. You may use the bottom or reverse of this letter for your response. The individual furnishing the information should provide his or her name and title. Thank you for your continued assistance.

Sincerely,

CLAIMS EXAMINER

Chapter 4-0300, War Hazards [Chapter Removed]

This chapter has been placed into its own Procedure Manual. There are still a few minor references throughout the Procedure Manual referencing War Hazards that have not yet been updated.

Chapter 4-0400, War Claims

1. Purpose and Scope. This chapter outlines the procedures to be followed in adjudicating and monitoring claims for benefits under Section 5 of the War Claims Act.

2. Statutory Authority. Section 5 of the War Claims Act of July 3, 1948 provides compensation benefits for United States citizens who were captured by or in hiding from the Imperial Japanese Government on or after December 7, 1941, at Midway, Guam, Wake Island, the Philippine Islands, or any territory or possession of the United States attacked or invaded by such government. Benefits are provided for detention, injury, and death. The amendments of August 21, 1954 extended coverage to civilian Americans captured in Korea during hostilities there on or after June 25, 1950. The amendments of June 24, 1970 gave detention coverage to civilian American citizens subsequent to February 27, 1961 for capture during the Vietnam conflict. The following groups are excluded from coverage:

a. A person who at any time voluntarily gave aid to, collaborated with, or in any manner served the Japanese Imperial Government;

- b. Civilian employees covered under the Federal Employees' Compensation Act;
- c. Civilian employees covered under the War Hazards Act;
- d. A person within the purview of the Missing Persons Act of March 7, 1942; or
- e. A regularly appointed, enrolled, enlisted, or inducted member of any military or naval force.

3. Regulations. Regulations concerning "Compensation for Injury, Disability or Death of Civilian American Citizens Incurred while Detained by or Hiding from the Imperial Japanese Government" are found in 20 C.F.R., Chapter 1, Subchapter G, Part 71, and date from 1951.

4. Jurisdiction. All claims for benefits under the War Claims Act are to be adjudicated and maintained in District 9 (Cleveland). War Claims cases are assigned a WC prefix.

5. Claim Forms.

- a. WC-3, "Claim for Injury or Disability Benefits by Civilian American Citizen," is the form used to claim benefits for disability under the War Claims Act.
- b. WC-4, "Claim for Death Benefits by Survivors of Deceased Civilian American Citizens," is the form used to claim death benefits under the War Claims Act.
- c. Neither of these two forms is in print. Photocopies may be used by those individuals who currently wish to claim benefits.

6. Conditions of Coverage.

- a. The time limitations for filing a claim under the War Claims Act are those in effect under the Federal Employees' Compensation Act (FECA) at the time of internment. In most instances, since internment took place during World War II, the 1940 version of the FECA is applicable.
- b. An original claim for compensation must be filed within one year of injury or death. Waiver of the one-year requirements may be made if claim is filed within five years of injury or death, and failure to comply was due to circumstances beyond the control of the individual claiming benefits, or the individual claiming benefits could show sufficient cause for the failure to file within one year, and material prejudice to the interest of the United States did not result from such failure.
- c. Medical treatment may be allowed even if the claim for compensation was not timely if notice of injury was given within one year of the injury, or if the immediate supervisor had actual knowledge of the injury within 48 hours. In War Claims cases, since their eligibility stems from their U.S. citizenship rather than their employment status, the U.S. Government as a whole stands in lieu of a particular employer. Thus, if a War Claims claimant is able to demonstrate that

the U.S. Government had actual knowledge of his or her internment within 48 hours of its ending, the time requirement for the purpose of medical benefits is met. The presence of a claimant's name on a listing of interred civilians which falls within the specified time frames would be an indication of such actual knowledge.

d. In cases of latent disability, time does not begin to run until the potential beneficiary is aware of his or her condition and its possible relationship to internment.

e. By amendment, the time limitation for civilian World War II internees was extended to March 31, 1952.

f. In recent years, the Office has received an increased number of inquiries from individuals seeking benefits under the War Claims Act for conditions arising from internment during World War II. Many of these individuals have existing case files which have been retired and may be recalled, or which were retired so long ago that they have been destroyed. Some claimants filed for detention benefits with the War Claims Commission or the Foreign Claims Settlement Commission, but never filed for disability benefits, so OWCP never created a case. The Foreign Claims Settlement Commission may be a source of information (in addition to the claimant) and may be contacted by writing to:

Foreign Claims Settlement Commission
Room 400
1111 20th Street, N.W.
Washington, D.C. 20579

or by telephoning David Bradley at 659-5883.

g. If the requirements for timely filing are met, the claimant must show that he or she is an American citizen interned under the circumstances outlined in the Act. For World War II internees in the Philippines, the National Operations Office has lists of U.S. citizens interned there.

h. Establishing causal relationship in latent disability cases can be somewhat difficult because of the general lack of knowledge on the part of physicians in this country on the long-term effects of malnutrition and tropical diseases. Therefore, if a claimant submits medical reports which give a modicum of support to the claim, even if unrationalized, the Office will make arrangements for examination of the claimant and/or the record by a second opinion physician who is knowledgeable in the appropriate medical area.

i. For dental conditions, if the claimant provides medical evidence which contains complete diagnostic information and supports causal relationship, even if unrationalized, a presumption will be made that the dental conditions are related to the internment.

7. Computation of Compensation.

- a. The total aggregate compensation for disability is limited to \$7,500 in the case of injury, and \$7,500 in the case of death, exclusive of medical costs and funeral expenses.
- b. Detention benefits of \$60.00 for each calendar month during which the individual interned was at least 18 years of age are payable. The detention benefit for individuals under the age of 18 years is \$25.00 per calendar month.
- c. The weekly pay rate for compensation purposes (disability or death) is deemed to be \$37.50, regardless of employment status.
- d. The compensation rates are as outlined in the War Hazards Compensation Act, which is based on Longshore compensation rates. Thus, the rate payable for total disability is 66 2/3%, and the rates for death are:

<u>Beneficiary</u>	<u>Percentage</u>
Widow/Widower	50%
Widow/Widower and Children	50% plus 16 2/3% for each child, up to a total of 66 2/3% maximum
Child (Rate applicable if widow/widower is dead or remarries)	50%
More than 1 child	plus 16 2/3% for each additional child, up to a total maximum of 66 2/3%
Dependent Parent or Grandparent	25% to each
Dependent Grandchild, Brother or Sister	20% to each

Total compensation paid on account of death may not exceed 66 2/3%.

- e. A funeral expense of up to \$3000.00 is payable in addition to death benefits.

Chapter 4-0500, Civil Air Patrol

1. **Purpose and Scope.** This chapter outlines the procedures to be followed in cases involving Civil Air Patrol volunteers.

2. **Statutory Authority.** Public Law 84-955, approved on August 3, 1956, extended coverage under the Federal Employees' Compensation Act (FECA) to volunteer civilian members of the Civil Air Patrol (CAP). This Public Law is incorporated in the FECA in Section 8141.

3. **Jurisdiction.** All claims by CAP volunteers and their survivors are to be adjudicated and maintained in District Office 9 (Cleveland). These cases are assigned a CP prefix.

4. **Claim Forms.** The usual FECA claim forms may also be used by CAP volunteers.

5. Conditions of Coverage.

a. Civilian CAP volunteers, except for Cadets under the age of 18 years, are covered under the FECA for injury or death sustained while in active service, or while in travel to or from that service.

b. The service must be rendered in performance or support of operational missions of the CAP under direction of the Department of the Air Force and under written authorization by competent authority covering a specific assignment and prescribing a time limit for the assignment.

c. The CAP Wing Commanding Officer and the U.S. Air Force Liaison should submit affidavits confirming that the individual was a volunteer member of the CAP, and that he or she was rendering service in performance or support of the authorized operational mission at the time of injury or death.

d. A copy of the CAP Mission Authorization should be submitted, which will also reflect the prescribed time limit of the assignment or mission. If needed, the USAF Liaison Officer may be asked to verify the scope and time limitations of the assignment.

e. CAP Forms 78, "Notice of Occurrence Form", and 79, "Accident Insurance Form", will describe the circumstances surrounding the injury or death.

6. Eligibility for Benefits.

a. The pay rate for compensation purposes is deemed to be the rate of basic pay for a GS-9, step 1. Compensation for disability is paid as with regular FECA cases. There is no eligibility for Continuation of Pay.

b. The compensation rate in death cases depends on whether or not the deceased individual was fully or currently insured under Subchapter II of Chapter 7 of Title 42 (Social Security Act) at the time of death. Brothers, sisters, grandparents, and grandchildren have no entitlement. Otherwise, the compensation rates are as follows:

For CAP volunteers who are not fully or currently insured under the Social Security Act:

<u>Beneficiary</u>	<u>Percentage</u>
Widow/Widower	50%
Widow/Widower and Children	45% plus 15% for each child, up to a total of 75% maximum
Child	40%
More than 1 child	plus 15% for each additional child, up to a total maximum of 75%
Parents	
One wholly dependent	25%
Other not dependent	
Both wholly dependent	16% to each
One or both partly dependent	Proportionate amount dependent

For CAP volunteers who are fully or currently insured under the Social Security Act:

Widow/Widower	50%
Widow/Widower and Children	45% No additional payments for children while widow/widower is eligible
Child More than 1 child	20% plus 10% for each additional child, 75% maximum
Parents	Same as above

Claims examiners should make an inquiry to the Social Security Administration in death cases, to ask whether the individual was fully or currently insured under Subchapter II of Chapter 7 of Title 42 at the time of death.

c. Prior to September 24, 1983, the pay rate for CAP volunteers was \$300 per month. When the rate was changed to GS-9 as of September 24, 1983, adjustments were made in all of the cases on the rolls at that time to reflect the new rate.

d. The \$800 funeral expense is payable, as are costs of transporting the body. The \$200 amount for the cost of terminating the volunteer's employee status is not payable.

e. Full medical benefits for the accepted conditions are allowed, as are rehabilitation services and attendant allowance.

Chapter 4-0600, Reserve Officers' Training Corps

1. Purpose and Scope. This chapter outlines the procedures to be followed in claims for benefits by members of and applicants for membership in the Reserve Officers' Training Corps (ROTC). These cases have the prefix of TC-.

2. Statutory Authority. Public Law 84-879, enacted August 1, 1956, extended coverage under the Federal Employees' Compensation Act (FECA) to members of or applicants for membership in the Reserve Officers' Training Corps of the Army, Navy or Air Force under

certain conditions. Effective October 1, 1988, the National Defense Authorization Act, Public Law 100-456, made revisions to 5 U.S.C. 8140, which was the encoded portion of P.L. 84-879. These revisions expanded the circumstances under which individuals would be extended coverage under the Federal Employees' Compensation Act.

3. Jurisdiction. All claims for benefits by ROTC cadets or ROTC applicants are to be adjudicated and maintained in District Office 9 (Cleveland).

4. Claim Forms. The usual FECA claim forms are used for ROTC cases.

5. Conditions of Coverage for Injuries Before October 1, 1988.

a. Time. The time limitations for filing notice of injury and claim for compensation are the same for ROTC cases as for other claims under the FECA.

b. Civil Employee/Performance of Duty.

(1) As of August 1, 1956, FECA benefits were extended to members of the ROTC of the Army, Navy, and Air Force who suffered disability or death from an injury incurred in the line of duty while:

(a) engaged in flight instruction under Section 40(a) of the Act of June 3, 1916, Section 22(a) of the Act of March 4, 1925, or Section 3(a) of the Act of August 13, 1946;

(b) attending a training camp under Section 47(a) of the Act of June 3, 1916, a cruise under Section 22(a) of the Act of March 4, 1925, or a cruise or camp prescribed by the Secretary of the Navy under Section 6(a)(1) of the Act of August 13, 1946; or

(c) performing authorized travel to or from a camp or cruise as indicated in item (b) above.

(2) As of October 13, 1964, benefits were expanded to apply to any member of, or applicant for membership in, the ROTC of the Army, Navy, or Air Force who suffers disability or death from an injury incurred in line of duty while:

(a) engaged in a flight or flight instruction under chapter 103 of title 10, U.S.C.; or

(b) performing authorized travel to or from, or while attending, field training or a practice cruise under chapter 103 of title 10, U.S.C.

(3) Benefits for those engaged in flight or flight instruction include disability or death due to traumatic injury only; disability and death benefits for both traumatic injury and occupational disease are payable for those engaged in or traveling to or from field training, or a practice cruise.

(4) For members, and after October 13, 1964, applicants for membership, who were killed while participating in or traveling to or from annual training of more than 14 days' duration, the widow, children, or dependent parents are eligible for benefits with the Department of Veterans Affairs. For other dependents and for deaths in flight instruction situations, benefits are under FECA.

(5) The Military Department concerned is responsible for making a "line of duty" determination, subject to review by OWCP, and should provide the appropriate statutory citation in support of that determination. "Line of duty" determinations made by the military should be accorded great weight. It should be noted that the term, "line of duty," should be interpreted in the military context, and is not synonymous with the term "performance of duty" as usually interpreted under the FECA. There are many circumstances in which a member of the military would be considered to be in the "line of duty," while a civilian federal employee would not be considered in the "performance of duty." One example of this difference would be in the instance of an ROTC cadet who was authorized to take leave from a training exercise for purposes of personal travel, and was injured when returning to the military base. The military would interpret this injury as having occurred in the "line of duty," since the travel was authorized, and took place while travelling to training. A civilian employee under similar circumstances would not be considered to be in the "performance of duty."

c. Fact of Injury will be determined as in other claims.

d. Causal Relationship will also be determined as in other FECA claims.

6. Conditions of Coverage for Injuries On and After October 1, 1988.

a. Time, Fact of Injury, and Causal Relationship will be determined as in other FECA claims.

b. Civil Employee/Performance of Duty.

(1) Coverage extends to members and applicants for membership who sustain injury, occupational disease, or death while participating in a training activity which is prescribed by the Secretary of the military department.

(2) Applicants for membership include students of authorized ROTC courses at education institutions.

(3) The Secretary of the military department (or his or her designee) determines whether or not an injury was incurred in the line of duty. While performance of duty is subject to OWCP review, such review will generally only be reviewed by OWCP in the event of a specific challenge by the employer or subsequently discovered evidence calls into question the coverage determination (See paragraph 5.b.(5) above for further discussion regarding "line of duty" determinations.).

(4) ROTC cases filed by the employer will be considered to have an affirmative "line of duty" determination unless the employer specifically challenges the Performance of Duty element of the claim. For traumatic injury claims, unless the employer challenges "performance of duty" on

the Form CA-1, the claim can be considered for short form closure. (See PM 1-0400 for short form closure criteria.)

7. Benefits.

a. Compensation.

(1) The pay rate for compensation purposes is set by statute at \$150.00 per month, or \$34.62 per week. In disability cases, the claimant will be entitled to 2/3 or 3/4 of this amount, and in death cases, the usual percentages are used. The compensation minimums do not apply, but CPIs do. The compensation payment activity code of "4" should be used, and such an instruction should be included in the payment set-up.

(2) In addition to compensation for total disability and death, compensation for loss of wage-earning capacity or a schedule award may be paid, and an attendant allowance may be authorized.

(3) Disability benefits may not be paid while an individual is on active duty with the armed forces.

b. Medical.

(1) Prior to October 1, 1988, full medical benefits in accordance with FECA were payable, and the military department could be reimbursed for expenses incurred in providing medical treatment, except for treatment received while the claimant was attending field training or a practice cruise.

(2) As of October 1, 1988, full FECA medical benefits are payable, and the military department can be reimbursed for expenses incurred in providing medical treatment, except for care provided by a military department in a facility of a military department.

c. Continuation of pay. ROTC applicants and members are not eligible for continuation of pay as provided by 5 U.S.C. 8118.

8. Benefits Payable by the Department of Veterans Affairs (DVA).

a. The DVA provides dependency and indemnity compensation for members (not applicants for membership) killed while participating in field training or a practice cruise of at least 14 days' duration under 38 U.S.C, or while traveling to or from such training or cruise. Persons eligible for this compensation are not entitled to FECA benefits for the same death.

b. The DVA also provides a death gratuity equal to six months' pay to survivors of ROTC members and applicants for membership who die under the circumstances outlined above. There is no bar to receiving this gratuity payment and FECA benefits for the same death.

c. Public Law 97-306, effective October 1, 1982, extended DVA benefits to ROTC members (not applicants for membership) who are injured during ROTC field training or practice cruises. Public Law 98-233 extended that coverage to members injured prior to October 1, 1982, with benefits retroactive to October 1, 1983.

d. For there to be DVA coverage for disability, permanent disability must result from the injury, and the member must have been discharged from the ROTC due to the injury.

e. DVA medical benefits are prospective from the date of their acceptance of the claim, and compensation benefits for disability are retroactive for up to one year only.

f. If application for FECA benefits is made by an ROTC member, and the injury is one which appears to involve permanent disability which may have resulted or will result in discharge from the ROTC, the claims examiner should inquire as to the application for and receipt of DVA benefits.

g. FECA benefits may be paid up until the date DVA eligibility is established. If paying such benefits results in an overpayment of compensation, no overpayment will be declared if the DVA deducts the amount of FECA benefits paid from the amount of DVA compensation due.

9. Junior ROTC Members. Chapter 102 of Title 10 provides for a "Junior Reserve Officers' Training Corps." Members of and applicants for membership in the Junior ROTC, who are high school students, are not eligible for benefits under the FECA.

10. Army ROTC Regional Headquarters. The four Army Regional Headquarters for ROTC are located as follows:

Region 1 - Fort Bragg, North Carolina

Region 2 - Fort Knox, Kentucky

Region 3 - Fort Riley, Kansas

Region 4 - Fort Lewis, Washington

Chapter 4-0700, Federal Relief Workers

1. Purpose and Scope. This chapter outlines the background and procedures to be used in monitoring claims for a variety of Federal Relief Workers, including Civilian Conservation Corps enrollees (prefix CC-), employees of the Federal Civil Works Administration (prefix CW-), employees of the Federal Emergency Relief Administration (prefix FE-), veterans of World War I and other persons attached to Veterans' Camps Numbers 1, 3, and 5, who were injured or killed as the result of the hurricane of September 2, 1935, at the Florida Keys (prefix FH-), and

persons receiving payments for services rendered under the National Youth Administration (prefix NY-).

2. Statutory Authority. The United States Employees' Compensation Act of 1916, as amended, was extended to provide payment of limited compensation benefits under prescribed circumstances to the classes of employees listed above, by Acts of Congress dated February 15, 1934, June 19, 1934, April 8, 1935, June 22, 1936, June 29, 1936, June 29, 1937, and June 21, 1938.

3. Regulations for claims of these individuals may be found in 20 C.F.R. Parts 21 through 24, published in 1939.

4. Jurisdiction. All claims for benefits from these individuals are under the jurisdiction of District 9 (Cleveland) where the currently active claims are maintained. All of these injuries took place prior to World War II, and thus the number of active claims will decrease over the years. Any inquiries received should be forwarded to the Cleveland District Office.

5. Claim Forms. The claim forms used were the same as for other FECA claims, except that the Civilian Conservation Corps enrollees used a Form CA-2C instead of a CA-1 and CA-2.

6. Conditions of Coverage.

a. Only injury due to accident causing damage or harm to the physical structure of the body is covered, and death resulting from such injury. Diseases are not covered, except as they may naturally result from an injury.

b. Time. A written notice of injury had to be given within one year of the injury. A death claim had to be made within six years of the injury, and within one year of cessation of disability, or if there was no disability, within one year of the injury.

c. Employee. Only the individuals outlined in paragraph 1 above were extended coverage.

d. Performance of Duty. The usual performance of duty rules applied. Injuries which took place while an individual was on authorized leave away from the work place were disallowed, unless the injury took place while riding to or from the work place in a vehicle furnished by the United States government.

e. Fact of Injury and Causal Relationship are considered as in other FECA claims. Because only traumatic injuries are covered, these two considerations are usually very clear-cut.

7. Benefits.

a. Disability Compensation.

(1) Benefits may be paid for temporary total disability, permanent total disability, or permanent partial disability.

(2) Permanent partial disability is paid in accordance with a schedule approved by the President, as found in 20 C.F.R. 25.11.

(3) Total disability benefits are payable at 66 2/3 of the employee's monthly wage, regardless of whether or not the employee has dependents. Initially, the maximum monthly compensation rate was \$25, raised to \$30 per month as of June 30, 1937, and was subject to an aggregate maximum of \$3500, not including medical expenses. As of July 1, 1938, the monthly maximum increased to \$50, and the aggregate maximum to \$4000. As of November 1, 1949, the monthly pay on the basis of which compensation was computed could be no less than \$75, and the maximum aggregate limit was removed in cases of permanent and total disability. On September 13, 1960, the monthly maximum payable was raised to \$150 and the minimum monthly pay on the basis of which compensation for disability or death was computed could be no less than \$150. On July 4, 1966, the pay rate increased to \$450.

(4) No benefits are payable for loss of wage-earning capacity.

b. Death Compensation.

(1) Widow or dependent widower only - 35% of the employee's monthly pay at the time of injury.

(2) Widow or widower and children - 35% for the widow or widower, and an additional 10% for each child, up to a maximum of 66 2/3 of the employee's pay.

(3) To the children, if there is no widow or widower, 25% for one child, and 10% for each additional child, up to a maximum of 66 2/3%, share and share alike.

(4) Benefits were also payable to parents, brothers, sisters, grandparents, and grandchildren for a period of up to eight years from the time of the death.

(5) A funeral expense of \$200 was payable, less any part paid by another agency of the Federal government. In addition, the cost of embalming and transporting the body was payable.

Chapter 4-0801, Foreign National Claims

1. Purpose and Scope. The purpose of this chapter is to provide procedures and general guidance for the adjudication, processing and payment of claims from foreign nationals, except for those individuals covered elsewhere in this part. Because of the great diversity in these claims, this chapter is intended to serve as guidance only, and is not intended to be totally comprehensive.

2. Statutory Authority. Sections 8136, 8137, and 8138 of the Federal Employees' Compensation Act deal specifically with claims from foreign nationals.

3. Regulations. Claims of foreign nationals are addressed in 20 C.F.R. 25.1 through 25.27, "Compensation for Disability and Death of Noncitizen Federal Employees Outside the United States".

4. Definitions.

a. For the purposes of this chapter a foreign national is an employee of the United States who is neither a citizen nor resident of the United States, any territory, or Canada.

b. A third country national is a person who is neither a citizen nor resident of the United States who is hired by the United States in the person's country of citizenship or residence for employment in another foreign country, or in a possession or territory of the United States.

c. A fourth country national is a person who is neither a citizen nor resident of either the country of hire or the place of employment, but otherwise meets the definition of a third country national.

5. Jurisdiction. All claims from foreign nationals will be adjudicated and maintained in District 9 (Cleveland). After the payment level has been established, if the claimant relocates to the United States, the case may be transferred as with any other general jurisdiction case.

6. Claim Forms. For the most part, the claim forms used in the claims of foreign nationals will be the same as other FECA cases, with the exception of cases from Korea. The Korean nationals use bilingual forms 204EK (similar to the CA-1), 203EK (similar to the CA-16), 205EK (similar to the CA-5) and 206EK (similar to the CA-6). Copies of these forms may be found in [Exhibits 1, 2, 3, and 4](#). At times, because of the isolation of some of the reporting offices, the forms used may not be the most current versions.

7. Conditions of Coverage. Conditions of coverage which apply to foreign nationals will be the same as in most other FECA claims, and should be developed in a similar manner.

a. Timely filing - For injuries before September 7, 1974, the one-year filing requirement is usually waived if the claim is filed within 5 years because foreign nationals are not expected to

know or understand American procedures for reporting injuries. For injuries on and after September 7, 1974, time is seldom an issue because of the actual knowledge provision.

b. Civil employee - Contract and non-appropriated fund employees may be found among foreign nationals, and are not civil employees for the purpose of the FECA. Personal services contractors with the Agency for International Development (AID) are considered to be employees under 5 U.S.C. 8101.

Many Department of Defense foreign national employees receive workers' compensation coverage under separate treaty. FECA Program Memos 2, 23, 120, and 126 address treaty coverage for Spanish, Turkish, British, and Australian nationals working for defense agencies. Most NATO countries and Japan also have separate treaty provisions. Individuals who are covered under such treaties are not entitled to benefits under FECA.

c. Fact of injury - Follow the usual procedures.

d. Performance of duty - Consider as with any other claim. Provisions of the local law do not apply to performance of duty issues. Thus, an employee who is injured on his way to work in a country whose law provides workers' compensation coverage for such an injury will not be covered under FECA under most circumstances.

e. Causal relationship - Consider as with any other FECA claim. Medical reports, especially those with rationalized opinions on causal relationship, may be very difficult to obtain, or may require translation.

8. Benefits.

a. With the exception of Canadians and Panamanians, foreign nationals are not entitled to continuation of pay.

b. Medical benefits.

(1) Foreign nationals are entitled to full medical benefits, including a choice of qualified physicians. Often, because of remote or undeveloped locations employees will be treated at a Federal medical facility or may be transported to another country for treatment. Some agencies, the Department of State in particular, expend funds for medical treatment and then apply for reimbursement by OWCP.

(2) Bills received in foreign cases may need to be translated before authorization for payment. Form HCFA-1500 is not required. Claims examiners must be careful to recognize bills as such and not file them down in the case file, but take appropriate action. Bills which have been approved for payment and in which payment is to be made to a foreign address must be forwarded to the National Office (District 50) for manual processing, and should not be processed through the automated system. The original bill with payment authorization and a copy of the CA-800 should be forwarded, and a copy of the bill retained in the file, along with a notation as to when the bill was forwarded for payment. When the bill is paid, a copy of the

payment voucher will be returned to the office with an appropriate entry on the copy of the CA-800. A maintenance adjustment should be performed, an appropriate entry made on the original CA-800, and a notation made on the file copy of the bill.

c. Compensation benefits are paid in accordance with the benefit structure of the local workers' compensation laws, or by special schedule. For further discussion, see paragraphs 9, 10, and 11 below.

9. Computation of Compensation (general).

a. Except for Panamanian, Canadian, Philippine, and Australians nationals, non-resident aliens employed in the Territory of Guam, and direct-hire Japanese seamen employed by the Military Sealift Command in Japan, compensation benefits are paid in accordance with the relevant provisions of the local law, or FECA, whichever is less.

b. Benefits paid should never exceed those which would be payable under FECA. However, when making a comparison of FECA and benefits under the local law, total benefits payable are considered, not just individual portions of the benefits. For example, if in a death claim a local law makes provision for a \$2000 funeral expense (versus \$800 for FECA), but the total benefits payable under the local law are less than under FECA, the \$2000 funeral expense will be paid.

c. The use of a local or FECA benefit structure in a case should remain consistent throughout the case. If benefits are paid initially in accordance with one benefit structure, but it later appears that total benefits under the other benefit structure would be less, the total entitlement should be recomputed based on the lower total benefit structure.

d. Consumer Price Index increases apply only if the claimant is being paid under a FECA benefit structure.

e. There are four basic types of payments which are provided for under local workers' compensation laws:

(1) Lump sum awards for permanent disability or death. The disability awards may be in proportion to impairment of the whole man as medically determined. The AMA Guides to the Evaluation of Permanent Impairment should be used to determine the degree of whole man impairment, when needed.

(2) Pension-type payments. These payments may also be based on whole-man impairment in disability cases. In death cases, the benefit structure may be similar to FECA, although the percentages are usually different.

(3) Payments determined by the local court system or special tribunal. Unless a ruling can be obtained from the court, this type of law is difficult to use. Consideration should be given to making payment under a regular FECA benefit structure.

(4) Laws which combine (1), (2), and (3) above. The portion of the law which fits the particular situation should be applied in any one instance.

f. When adopting the benefit provisions of the local law, procedural provisions, designations of classes of beneficiaries, and limitations (except for those affecting amounts of payments) do not apply.

g. If the local law is not well-defined or does not exist, the law of a nearby country may be used.

h. Third and fourth country nationals are paid benefits applicable to local hires in the country of hire or the place of employment, whichever is greater. Fourth country nationals may be paid in accordance with the laws of their home country, where equitable considerations as determined by the Director so warrant.

i. Non-citizen residents of United States possessions, territories, commonwealths or trust territories are paid full FECA benefits.

j. The Special Schedule, as outlined in 20 C.F.R. 25.11 through 25.13, applies with modifications to local hires in the Philippines, Australia, and the Territory of Guam, and to Japanese seamen, but not to Korean locals. For Korean locals, the Korean Labor Standards Act is used (see paragraph 11 below).

k. Foreign national employees and their survivors are not entitled to the minimum provisions of 5 U.S.C. 8112 and 8133.

l. A CE should work through the employing agency to obtain a translation and when needed, an interpretation of the local law. If an interpretation is needed, this ideally should be secured from an official of the local workers' compensation agency.

m. Some foreign nationals are covered under the Civil Service Retirement System (CSRS). If FECA benefits are being paid under the provisions of the local law, and local law provides for a lump sum payment, no election of benefits between FECA and CSRS is required. If local law provides for pension payments, then an election is required.

n. Exchange rates in effect as of the date of injury, date disability began, or date of recurrence should be used to convert local currencies to United States dollars. The Department of the Treasury is a source for information on exchange rates. In addition, the Fiscal Officer in the National Operations Office keeps records of the exchange rates, and receives quarterly updates.

o. After sufficient information on the local law has been obtained, the claims examiner should prepare a memorandum of computation, comparing the local benefits and FECA, and a CA-24 or CA-25 for the lesser of the two. The computations should be certified by the senior claims examiner or higher authority.

p. If the local law provides benefits for an indefinite period of time, or benefits are being paid under a FECA rate structure, a lump sum settlement should be made.

10. Philippine Nationals.

a. Under an agreement between the United States and the Republic of the Philippines signed on March 10, 1982, the Philippine Medical Care Program and the Employees' Compensation Program were extended to all Philippine national direct-hire employees of the U.S. Military Forces, except for those employees who are not members of the Philippine Social Security System.

(1) Philippine nationals who sustain traumatic injury on or after March 10, 1982, and are eligible for benefits under the Philippine system are not entitled to FECA benefits.

(2) Philippine nationals who sustain occupational disease due to work exposure of which at least a portion occurred on or after September 10, 1982, and who are eligible for Philippine benefits, are not entitled to FECA benefits.

(3) Whenever a claim from a Philippine national who is covered under the local system is received for injury or occupational disease sustained outside of the time frames specified above, the claim should be denied with compensation order, and full appeal rights, on the basis that the claimant is not a civil employee of the United States for purposes of compensation coverage under the FECA.

(4) When a claim for benefits is so disallowed, a copy of the entire submission should be retained, along with the disallowance, and the original submission forwarded with a cover letter to the employing agency for submission to the Philippine Government.

(5) The referenced agreement does not apply to Philippine national employees of U.S. agencies other than the armed forces.

b. For Philippine national employees who are not excluded from FECA coverage by the March 10, 1982 agreement, a modified special schedule of compensation, as described in 20 C.F.R. 25.21 applies for injury or death occurring on or after July 1, 1968.

(1) Temporary total disability benefits are payable at the rate of 66 2/3 percent of the monthly pay, for a maximum of 80 weeks.

(2) Permanent total disability compensation is equal to 400 weeks at two-thirds of the weekly wage rate.

(3) A death benefit equivalent to 400 weeks' compensation at two-thirds of the weekly wage rate is payable, to be shared equally by all eligible survivors in the same class, as follows:

(a) Widow, dependent widower, and unmarried children under 18, or over 18 and totally incapable of self-support;

(b) Dependent parents;

(c) Dependent grandparents;

(d) Dependent grandchildren, brothers, and sisters who are unmarried and under 18, or over 18 and totally incapable of self-support.

(4) Burial allowance is 14 weeks' wages or \$400, whichever is less.

(5) A schedule of awards payable for permanent partial disability, similar to that found in 5 U.S.C. 8107, is outlined in 20 C.F.R. 25.11(c). The durations of the awards are somewhat shorter than those found in section 8107. No provision is made for a disfigurement award. Where the schedule provides no award for a particular disability, the amount payable for permanent total disability may be multiplied by the percentage of the permanent impairment to arrive at an award.

(6) Temporary partial disability payments may be made while the disability persists at a rate which equals two-thirds of the weekly loss of wage-earning capacity, for a maximum of 80 weeks.

(7) Only benefits for temporary disability are paid periodically. All payments for permanent disability or death are paid in full at the time the extent of entitlement is established.

(8) The maximum aggregate compensation payable in any one case for disability or death or both, is \$8000, exclusive of medical costs or burial allowance. The maximum weekly compensation for disability or death is \$35.

11. Korean Nationals.

a. Compensation benefits for Korean Nationals are paid in accordance with the Korean Labour Standards Act (KLSA) or full FECA, whichever is less. The claims examiner should perform a comparison of KLSA and FECA benefits to determine which structure should be used.

b. The basic provisions of the KLSA are as follows:

(1) While the employee is under active medical treatment, benefits are payable at the rate of 60% of the average wage during the period of medical treatment. This compensation is similar in nature to temporary total disability payments. If the active medical treatment continues for more than two years, a full and final payment of 1,340 days' wages is made.

(2) A 14-grade schedule is provided for disability of a permanent nature. Each grade provides an award for a specific number of days, ranging from 50 to 1340. The average daily wage is multiplied by the number of days to arrive at an award amount. A copy of the grading schedule is shown as [Exhibit 5](#).

(3) The KLSA defines "average wage" as the amount derived by dividing the total of three calendar months wages paid by the number of calendar days during that three month period. Thus, the average daily wage amount is a calendar day amount rather than a work day amount.

(4) Death benefits are 1000 days' wages, plus 90 days' wages for funeral expenses.

c. The pay rates of Defense Department Korean Nationals include several supplemental amounts which should be included in the pay rate for compensation purposes, as follows:

(1) Bonuses - several bonuses are paid during the year, which add up to 6 times the monthly base pay, currently. The multiples of the monthly pay and the effective dates have been as follows: 1967 - 1969 -2.5 months' base pay 1970 - 1974 -3 months' base pay 1975 -3.5 months' base pay January 1 - October 31, 1976 -4 months' base pay November 1, 1976 - June 30, 1978 - 4.5 months' base pay July 1, 1978 - August 24, 1988 - 5 months' base pay August 25, 1988 - present - 6 months' base pay

(2) CAP (Consolidated Allowance Payment) - an amount added to the hourly base pay, which is analogous to a consolidation of a variety of allowances provided by companies in the private sector. The rates vary by grade level.

(3) PIK (Allowance for Payments-in-Kind) - an allowance added to the hourly wage for all paid hours, exclusive of overtime.

(4) BA (Benefits Allowance) - an allowance to compensate for various fringe benefits provided by Korean companies and government agencies, but not authorized or authorized at a lower level for U.S. Forces employees. The allowance is a percentage of the base pay, exclusive of overtime. The percentage is revised from time to time.

(5) Occupational premium, remote area allowance, and night differential - these additional amounts are paid less often, but will be seen upon occasion, and should be included in the pay rate for compensation purposes.

The Department of the Army will generally provide the hourly amounts for the base pay, CAP, PIK, BA, and occupational premium (if any), and a prior three-month amount for remote area allowance and night differential if a claim for compensation is made. In addition, they will show the number of hours worked weekly by the employee. This information may be used along with the information on bonuses as shown in item (1) above to compute the daily or weekly rate of pay.

Exhibit 5: KOREAN DISABILITY BENEFIT TABLE

[Pages 1-2 \(Link to Image\)](#)

[Pages 3-4 \(Link to Image\)](#)

[Pages 5-6 \(Link to Image\)](#)

[Pages 7-8 \(Link to Image\)](#)

[Pages 9-10 \(Link to Image\)](#)

Chapter 4-0802, Panama Canal Cases

1. Purpose and Scope. The purpose of this chapter is to outline the procedures to be followed in adjudicating and maintaining cases from the Panama Canal Commission, and to provide a historical background for these cases.

2. Statutory Authority. Section 8146 of the Federal Employees' Compensation Act (FECA) addresses administration of the Panama Canal Commission.

3. Historical Background. Prior to October 1, 1979, all employees of the Panama Canal Company and the Canal Zone government had workers' compensation coverage under the FECA. The Canal Zone government was responsible for administering the Federal Employees' Compensation Act for Panama Canal Company and Canal Zone employees.

The Panama Canal Act of 1979 became law as of October 1, 1979. At that time, the ownership and authority for operating the Panama Canal was placed in the hands of the Panamanian government. With the enactment of the Panama Canal Act, the Canal Zone government ceased to exist, as did the Panama Canal Company. These agencies were combined to form the Panama Canal Commission. Most of the Canal Zone and Panama Canal Company employees became Panama Canal Commission employees, although a few transferred to positions with the Department of Defense and the Smithsonian Institution.

Employees of the Panama Canal Commission hired on and after October 1, 1979, except for U.S. citizens, receive workers' compensation coverage under the social security system of the Republic of Panama. Employees hired prior to that date and U.S. citizens continue to be covered under the FECA.

By Executive Order 12652 of September 19, 1988, effective January 1, 1989, the responsibility for administering FECA benefits in Panama Canal Commission cases was returned to the Department of Labor. All active cases were sent to the then-existent Branch of Special Claims, and inactive cases were maintained in Panama or in the Commission's records center facility.

The Panama Canal Commission followed all FECA and OWCP procedures in handling the FECA cases. Hearings were held locally by an Injury Review Board, and cases in which a decision had been appealed were sent to the Employees' Compensation Appeals Board in Washington, D.C. for action. Because they operated on a basically manual system, a large amount of data entry was required to enter the cases into the FECA system. The file numbers on the existing cases were retained, and consisted of a "C" followed by four or five digits. Cases created on and after January 1, 1989, were assigned an "A50" prefix, along with other cases created in Special Claims. After the merger of Special Claims and District Office 25, new cases were assigned an "A25" prefix.

When a case which was in existence prior to January 1, 1989, is needed for action, but has not been transferred to our data base, the Panama Canal Commission should be asked, either by telephone or in writing, to send the case to District 9 (Cleveland). When the case is transferred in, the original "C" prefix file number should be used.

4. Jurisdiction. All Panama Canal Commission cases must be maintained in District 9 (Cleveland)), including those which begin with a "C" prefix.

5. Eligibility for Benefits. All Panama Canal Commission employees who are covered under FECA, including the foreign nationals, receive full FECA benefits, including Continuation of Pay. The benefit level provided under local law need not be taken into consideration. Minimums do not apply in Panama Canal Commission cases.

6. Special Considerations.

a. The system used by the Panama Canal Commission was primarily a manual system. A record of the compensation and bill payments is contained in the case record. A white card maintained in the file reflects all daily roll payments. A yellow voucher was completed for each bill payment. The Fiscal Unit in the National Operations Office has blue summary sheets for the periodic roll payments.

b. All correspondence and checks for both compensation and bill payments on Panama Canal Commission cases which are being sent to Panama should be sent in care of the Commission at the following address:

Panama Canal Commission
Workers' Compensation Office
APO Miami FL 34011

The employees at the Workers' Compensation office will ensure that the letter or check is delivered to the right person.

c. Some of the information in the cases will be in Spanish. The Commission has agreed to translate any materials which are sent through them prior to forwarding to OWCP. Translations may also be obtained in the usual manner by making a written request through the Office of the Director for OWCP, who will in turn obtain translation from the State Department.

d. Common-law marriages are fairly widespread in Panama. As of 1972, a common-law relationship of five years' duration could receive full civil recognition upon application for a certificate. Prior to 1972, the time requirement was 10 years.

e. Most of the medical bills from Panama are being paid on the bill payment system, rather than being forwarded to National Office for processing. This is possible because payments are being sent in care of the Commission, rather than directly to a Panama street address, and because the mode of exchange is the U.S. dollar.

f. Many of the Commission employees work rotating shifts. To facilitate payment of compensation, the Commission will provide the year prior earnings exclusive of overtime in cases where compensation is claimed.

g. Approximately 50% of the claimant population speaks English.

h. Panama Canal Pilots receive completion assignment bonuses, which should be included in their pay rates for compensation purposes. Because the pilots' base pay is already relatively high, many are restricted to the maximum compensation rate in spite of the inclusion of the bonuses.

i. Specialized medical evaluation and treatment can be somewhat difficult to obtain in Panama. The Commission has and will continue to provide assistance in identifying appropriate physicians for treatment and evaluation. However, it will be necessary at times to refer claimants to physicians in the United States for evaluation and treatment. The Commission will make travel arrangements after receiving authorization from the OWCP, pay for the cost of the travel, then seek reimbursement.

j. Most medical bill payments made on Panama Canal cases prior to the transfer to the Department of Labor will be reflected in the case files. However, because the Meddac Cocosolo Army Clinic, Gorgas Army Hospital and Clinic, and Hospital Santa Fe billed the Commission en masse, their bills will not appear in the file. Thus, if payment information is needed for third party or other purposes, and the claimant was treated during the period the case was under the control of the Commission by one of these facilities, the Commission should be contacted for payment information.

FECA Part 5 - Benefit Payments: Contains the segment of Part 5 which governs adjudication and payment of medical bills under the FECA.

Chapter 5-0100, Introduction

1. Purpose and Scope. Part 5 of the Procedure Manual describes the policies and procedures which pertain to the financial aspects of the Federal Employees' Compensation program. These aspects include processing bills for medical care and related expenses; payment of compensation to beneficiaries in disability and death cases; health benefits and optional life insurance; financial management; financial reports; and the chargeback process.

2. Bill Processing. Bills are processed through the automated Bill Processing System (BPS). The procedures for use of the BPS and related issues are described in FECA PM 5-0200 to 5-0208.

3. Compensation Payments. Entitlement to compensation benefits is determined by the Claims Examiner (CE). Payments are computed based on the period of compensation, rate of pay, and rate of compensation provided by the CE. The procedures for computing payments and use of the Automated Compensation Payment System (ACPS) are described in FECA PM 5-0300 to 5-0309.

4. Health Benefits/Optional Life Insurance. The CE provides the information needed to compute health benefit and optional life insurance deductions under the provisions of the FECA and the regulations of the Bureau of Retirement, Insurance and Occupational Health (BRIOH), Office of Personnel Management. The procedures for computing and making these deductions are described in FECA PM 5-0400.

5. Financial Management. Fiscal personnel are responsible for completing various documents with respect to payments and for maintaining proper control over cash and disbursement activities. General considerations are discussed in FECA PM 5-0500 and 5-0501, while preparation of documents, cash control, and maintenance of the Fund Control Register are described in FECA PM 5-0502 through 5-0504. Procedures relating to recovery of overpayments are discussed in FECA PM 5-0505.

6. Financial Reports. The record-keeping requirements of the program and the major reports which must be completed on a recurring basis are described in FECA PM 5-0600 through 5-0603.

7. Chargeback. The term "chargeback" refers to the process by which OWCP bills employing agencies for their compensation costs, which are calculated on the basis of payments made from the Compensation Fund. By August 15 of each year, OWCP informs each agency of the amount expended on behalf of its employees from the Compensation Fund during the preceding fiscal year (which runs from July to June for chargeback purposes). The agency then either reimburses the Fund in the amount requested or budgets that amount for compensation purposes for the upcoming fiscal year. The process is described in FECA PM 5-0900.

8. Forms and Reference Materials. Forms, charts and tables which are identified as exhibits appear at the end of the applicable chapter. Reference materials include:

- a. Federal Employees' Compensation Act as amended
(5 U.S.C. 8101 et seq.);
- b. Title 20, Code of Federal Regulations (CFR), Chapter 10;
- c. Federal Employee Compensation System (FECS) Users Manual, which also includes the Federal Establishment Code Manual (FECM);
- d. Office of Personnel Management Benefits Administration Letters, formerly the Federal Personnel Manual, letter number 94-202, issued October 19, 1994;
- e. Federal Employees' Health Benefits Act of 1959; and
- f. Retired Employees' Health Act of 1960.

Chapter 5-0101, Security of the Fiscal Operations

1. Purpose and Scope. This chapter describes procedures with implications for the overall security of financial transactions processed under the Federal Employees' Compensation Act. Procedures specific to the security of one type of financial transaction, such as the payment of bills or compensation, are discussed in the applicable chapter.

2. Management Review. The Fiscal Officer, as manager of the Fiscal Section, is responsible for ensuring the security and proper control of financial transactions.

- a. As part of the office-wide management review process, the Fiscal Officer will conduct a periodic review based on the financial sections of the FECA Accountability Review Manual. One of the purposes of the review is to identify problems related to the security of the financial operation and initiate timely corrective action. If a function covered in the review manual is

performed by the Fiscal Officer, management review of that function should be conducted by a higher authority.

b. At the completion of the review, but not later than 10 workdays after the end of the review period, the Fiscal Officer will report the results of the review in writing to the District Director. For each item reviewed, the report should include the sample size (where sampling was involved), a summary of findings, a description of corrective actions taken or planned, and any recommendations for training or other appropriate measures which cannot be taken solely at the unit level.

3. Separation of Functions. Although the size of the Fiscal Section precludes a complete separation of duties in most District Offices, the responsibility for certain fiscal actions should be separated as much as is practical. For reasons of security, the same person should not process payments, receive unidentified cash from the mailroom, record transactions in the automated system, and perform reconciliation procedures. To the extent possible, these duties should be handled by separate persons or rotated among the Fiscal Unit staff.

4. Use and Control of Manual Payments. The use of manual payments must be controlled carefully to eliminate the potential for fraud. Because the automated system is capable of issuing payments in most situations, the use of manual payments should be minimal.

a. Manual payments are permitted in the following situations:

(1) Emergencies. In rare situations where manual payment would be received more quickly than payment through the automated system, and extreme hardship or very unusual circumstances are involved, payment may be made manually using form SF-1166, Voucher and Schedule of Payments. Authorization to issue a manual payment under these circumstances must be provided by the Supervisory Claims Examiner or a higher authority.

(2) Check Recertification. When the disposition of a missing check is unknown (i.e., the confirmed copy of the SF-1184 has not been received from Treasury), the check may be reissued on a manual SF-1166. This should be done only if delay in reissuing the check will cause severe financial hardship. (See FECA PM 5-502.11 concerning procedures for recertification of unavailable checks.)

(3) Erroneous Deposits Unrelated to FECA Cases. When money intended for another account or Federal program is erroneously deposited into the compensation fund via a lockbox depository, the money must be returned to the sender by a manual payment.

(4) Special Payments in District #50. District #50 is responsible for making several types of payments which cannot be made through the automated system. Included among these transactions are payments in foreign currencies, reimbursement to the Panama Canal Commission, and security case payments.

b. Preparation of the SF-1166 is described in FECA PM 5-502.3. The Fiscal Officer must review and certify all manual payments, and must maintain security over the vouchers.

c. Since all payments must be reflected in the history payment file and in the chargeback file, it is necessary to record manual payments in the automated history (see FECA PM 5-0208 and 5-308.4 concerning history updates to BPS and ACPS, respectively). The history should be updated within five days of receipt of the paid SF-1166.

5. FECS Surveillance Reports. District offices receive quarterly surveillance reports to assist in monitoring case payments and detecting unusual provider activity.

a. UTL001, Daily Roll Utilization, lists cases for which more than seven daily roll payments have been made during the quarter, and provides information on the number and amount of the payments. The report should be reviewed to detect inappropriate use of the daily roll, or cases which warrant further investigation to determine whether payments were correctly made.

b. UTL002, Medical Payments on Death Cases, provides information on medical payments made after the date of death. Such payments would normally be made on a one-time basis to a consultant specialist, or to a physician performing an autopsy. Cases with numerous or questionable payments should be reviewed, and additional investigative action taken as needed.

c. UTL003A, Medical Services Without Compensation, and UTL003B, Medical Services Beyond Compensation, are used to identify cases in which frequent bill payments have been made during periods when no compensation was paid.

d. UTL004, Compensation Without Medical Services, provides information about cases in which compensation, but no bill, was paid during the quarter. Long periods of payment without medical service may raise the question of whether disability is supported by medical evidence, or may simply mean that the employee was treated by unreimbursed physicians, such as Army physicians.

e. UTL005A and UTL005B, BPS Surveillance Reports, are designed to assist the offices in identifying unusual patterns of medical provider activity. UTL005A gives provider and payment information for EIN numbers to which payment has been made on more than 20 cases during the quarter. UTL005B provides the same type of information for providers who received more than \$5000 in payments during the quarter. District office personnel who are familiar with the office's frequent providers should review the reports to see if unexpected features or patterns emerge. A Provider Utilization Report by EIN, listing payments to the provider and case file numbers, should be obtained when questionable provider activity is noted. Where necessary, case files should be pulled to examine medical evidence supporting continued or extensive treatment, or to contact the claimant to verify that the treatment was rendered.

f. UTL006A and UTL006B, BPS Surveillance Reports, provide case and payment information for cases with frequent or high cost bill payment activity during the quarter. UTL006A lists cases in which the dollar amount of the bill payments for the quarter exceeded \$5000, and UTL006B

lists cases in which more than 20 bill payments were made during the quarter. Appropriate review and investigation should be undertaken in questionable cases.

g. UTL007, BPS Bypass and Override Utilization Report, provides an analysis of the number and percentage of bills processed with bypass codes and authorizing initials for each district office.

h. UTL008, Override Utilization Report, shows the total number and amounts of ACPS transactions for each office, and the number and percentage of transactions which were made with a gross override.

6. Password Protection. Permissions for use of BPS and ACPS Jobs and Programs is controlled by individual user identifications and passwords. The selection and coding of the passwords occur at the district office. Passwords must be kept confidential. The Systems Manager is responsible for updating and maintaining the passwords.

Chapter 5-0200, Overviews of the BPS

1. Purpose and Scope. This chapter and the following chapter provide information regarding medical payments. This chapter describes the flow of bills through the office, outlines the various types of bills that are processed, and provides an overview of actions required in conjunction with bill processing. Chapter 5-0201 discusses Central Bill Processing (CBP) issues.

Medical bills may be sent to OWCP through the DFEC Central Mailroom (CM) at the address provided below, or they may be filed electronically through the Electronic Data Interchange (EDI). The goals of medical bill processing are to ensure that all proper charges are paid promptly and that charges which cannot be paid are denied promptly with an explanation.

2. Authority.

a. 5 U.S.C., section 8103, provides that an "employee who is injured while in the performance of duty shall be furnished the services, appliances, and supplies prescribed or recommended by a qualified physician which the Secretary of Labor considers likely to cure, give relief, reduce the degree or period of disability, or aid in lessening the amount of monthly compensation." This section also provides that the expense of these services and supplies, as well as necessary and reasonable transportation and other expenses related to obtaining services, shall be paid from the Employees' Compensation Fund.

b. 5 U.S.C., section 8123, provides that an employee "shall submit to examination by a medical officer of the United States, or by a physician designated or approved by the Secretary of Labor, after the injury, and as frequently, and at the times and places as may be reasonably required." If

the employee's physician should disagree with the physician making the examination for the United States, section 8123 provides that the United States shall appoint a referee physician to make an examination. This section also provides for payment from the Employees' Compensation Fund of reasonable expenses incident to any such examination required by OWCP, including transportation and loss of wages incurred.

c. 20 CFR 10.801 and 10.802 outline the requirements for submission of bills for medical services, appliances, and supplies, and for reimbursement of claims for medical expenses, transportation costs, loss of wages, and incidental expenses.

d. 20 CFR 10.803 describes the timeframe in which bills will be considered for payment.

3. Medical Bill Pay Contractor (MBPC). The MBPC provides medical bill payment and medical authorization services. This includes enrolling providers, maintaining the provider file, performing bill resolution, processing adjustments, and issuing payments.

a. Mailing address. Providers and claimants should send all mail for Federal workers' compensation cases to:

U.S. Department of Labor
OWCP/DFEC
PO Box 8300
London, KY 40742-8300

Information concerning electronic data imaging (EDI) is available on the web at <http://www.MBPC-gcro.com/> or by calling the EDI Technical Support line at (800) 987-6717.

b. Contact information for billing inquiries. Providers, claimants, and employing agencies may obtain information on billing or reimbursement online at the [OWCP web bill portal](#). Callers may also choose to speak with an MBPC representative during operating hours (M-F, 8:00 a.m. - 8:00 p.m., EST) by calling (850) 558-1818. This is not a toll-free number. OWCP personnel should direct all billing inquiries to the MBPC.

c. AQS users. Agency Query System (AQS) users may access the MBPC Web Portal to perform queries by selecting the "Bill Inquiry" hyperlink from the AQS Injured Worker Case Query results page.

4. Providers of Medical Services.

a. Definitions. The term "physician" is defined at 5 U.S.C. 8101 to include licensed medical doctors, surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by state law.

(1) "United States Medical Officers and Hospitals" includes medical officers and hospitals of the Army, Navy, Air Force, Department of Veterans Affairs, and United States Public Health

Service, and any other medical officer or hospital designated as a United States medical officer or hospital by the Director of OWCP.

(2) "Medical, Surgical, and Hospital Services and Supplies" includes services and supplies provided or prescribed by physicians and medical facilities defined above within the scope of their practice as defined by state law, except that a chiropractor is considered to be a "physician" only when a subluxation of the spine has been diagnosed by x-ray, and treatment is limited to manual manipulation of the spine. However, if chiropractic treatment is prescribed by a qualified physician, treatment other than manipulation of the spine may be authorized.

b. Excluded Providers. 20 CFR Sections 10.815 – 826 state that certain providers may be excluded from participation in the Federal Employees' Compensation Program, and their services may not be reimbursed from the Employees' Compensation Fund during the period of their exclusion. Providers who are convicted of fraud in connection with any "Federal or State program" for which payments are made for medical services, or who were excluded or suspended from participation in a benefit program, such as Medicare, are automatically excluded.

Other providers may be excluded through an administrative process if they make false statements in support of a claim, have a different schedule of fees for FEC cases than their usual and customary charges, fail to submit accurate and full medical reports, or provide excessive or substandard treatment.

c. Provider enrollment. All medical providers must enroll with the MBPC. All bills submitted by unenrolled providers are returned along with instructions on how to enroll. Providers may contact the MBPC for an enrollment packet or may enroll online at the [OWCP web bill portal](#) through the "Provider" link in the FECA section. All enrolled providers will receive a provider identification (ID) number that is assigned by the MBPC.

d. Provider file updates and Notification of Change reports. The MBPC maintains a provider file. Providers should contact the MBPC for address and account information changes. The Department of Treasury sends Notification of Change reports to the District Office (DO) with information regarding electronic funds transfers (e.g., bank routing numbers or account types). The DO fiscal personnel should fax the reports to the MBPC at (850) 558-1920.

5. Case actions required. The following case actions are required in conjunction with bill processing.

a. Form CA-1 or CA-2 must be filed and a case number assigned by OWCP before a bill for medical expenses may be processed.

b. Form CA-16 (if issued) must be entered into the iFECS system by OWCP. This generally authorizes medical treatment for 60 days in traumatic cases. The date the form was signed by the authorizing official is the "from" date and the system generates the "to" date (60 days later). A CA-16 should not be entered if it has not been signed.

c. Case status/case adjudication codes. After the case is adjudicated, the combination of the assigned case status and case adjudication codes and dates, as described in Part 2 of this manual, determine if medical services and supplies are payable beyond the 60-day period authorized by the CA-16. Before the case is accepted, the status code must reflect that the case is under development (UD). Medical services and supplies acquired using the CA-16 are payable while the case is in UD status.

d. The ICD-9 code of the accepted condition must be entered into the iFECS system. The code should be four or five digits, as appropriate. The CE should also use the appropriate FECA identifier in the sixth position of the code.

The CE should review and update the ICD-9 codes based on the medical evidence of record when needed. In order to process a bill, the ICD-9 code on the bill must fall within a designated range of similar diagnoses related to the accepted condition.

6. Medical bills. All of the following types of medical bills are processed by the MBPC and should be sent to the London, KY address provided above or filed electronically via EDI. Bills must be on the correct form and reflect the OWCP case number in order to be considered for payment. The requirement for forms is as follows:

a. HCFA-1500 or OWCP-1500. Providers must use the HCFA-1500, which is also designated OWCP-1500, to bill for the following types of services: physician, psychologist, chiropractor, therapist, audiologist, radiologist, rural health clinics, laboratory, podiatrist, ambulatory surgery center, home nursing service, acupuncturist, ambulance service, and durable medical equipment.

b. UB-92. All hospital, hospice, and nursing home bills must be on this form.

c. OWCP-957 (Travel Voucher). This form should be used for all medical travel reimbursement and replaces the SF-1012.

d. OWCP-915 (Claim for Medical Reimbursement). The claimant should use this form to request reimbursement for out of pocket injury-related medical expenses. The OWCP-915 replaces Form CA-915.

e. ADA Form J515. This form should be used for all dental bills, including those of oral surgeons.

f. Veterans Administration (VA) bills. VA bills are not subject to the fee schedule. These bills are submitted on the UB-92 (in-patient charges) or the HCFA 1500 (outpatient charges).

g. Field nurse and rehabilitation counselor bills are filed electronically through the MBPC Medical Bill Processing Portal at the [OWCP web bill portal](#).

h. Pharmacy bills may be filed electronically (via EDI) or by completion of the Universal Billing Form (UBF).

7. Information required on bills. Bills for all services and appliances, whether for direct payment to a provider or reimbursement to the claimant, must include the following information to be considered for payment (number placement on HCFA-1500 is indicated in parentheses):

- a. OWCP file number (1a)
- b. Patient's name (2)
- c. Patient's birth date and sex (3)
- d. Patient's address (5)
- e. Other health insurance coverage (9a-d)
- f. Is patient's condition related to: (10 a-c)
- g. Patient's or authorized person's signature (12) "Signature on file" is acceptable.
- h. Insured's or authorized person's signature (13) "Signature on file" is acceptable.
- i. Diagnosis of nature of illness or injury (21)
- j. Dates of service (24a).
- k. Place of service (24b)
- l. Procedure code (24d). This should be in the form of Current Procedure Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, including a modifier, if appropriate.
- m. Diagnosis code (24e). The International Classification of Disease, 9th edition (ICD-9) code should be reflected.
- n. Charges (24f)
- o. Days or units (24g)
- p. Federal Tax ID number (25)
- q. Total charge (28)
- r. Amount paid (29)
- s. Signature of physician (31). "Signature on file" may be used.

t. Name and address of facility where services were rendered (32)

u. Provider's name, address, zip code, telephone number, and provider number (33). The Provider ID number is assigned when the provider enrolls with the MBPC. Using this number facilitates quicker and more accurate processing. All providers must have a MBPC Provider ID number for bills to be paid. The provider number entered in item 33 is where DOL payment is made. It is also used to report DOL payments to the IRS. No provider ID number or Social Security number is required for reimbursement to the claimant for travel, pharmacy, maintenance, or training.

Bills that do not meet the above standards will be returned to the provider by the MBPC.

8. Near-Bills. Bills received that are not submitted on the correct form (invoices, non-HCFA forms, letterhead, etc.) will be returned to the provider by the Central Mailroom. The original bills will be returned with a transmittal letter that explains proper billing procedures.

9. Unique Bills. Bills requiring unique processing procedures are as follows:

a. Foreign bills. Foreign nationals and U.S. citizens receiving medical services in a foreign country are entitled to full medical benefits, including a choice of qualified physicians.

(1) Particular forms are not necessary for payment of foreign bills. They also do not require a provider tax identification number or procedure codes.

(2) When received in the District Office, the responsible claims staff should review the bills prior to submission to the National Office for payment.

(3) The National Office facilitates payment of all bills for which payment is sent to a foreign address or is billed in a foreign currency.

b. Pharmacy. Pharmacies may bill directly via EDI and are encouraged to do so. They may also bill using the Universal Billing Form (UBF). "Real time" pharmacy processing allows pharmacies, through a clearinghouse intermediary, to electronically enter information concerning a pharmacy bill on their point-of-sale device and receive a rapid response as to whether the bill is payable and the amount payable. If the claim is payable, the claim will be processed by the MBPC. If the claim is not payable, the claimant should be advised to contact OWCP.

c. Field nurses and vocational rehabilitation counselors should submit bills via the web portal. The staff nurse and vocational rehabilitation specialists will review and approve the bills and reports. (Field nurses and vocational rehabilitation counselors must enroll as providers and sign a web-billing agreement. Other providers of vocational rehabilitation services and supplies, such as colleges and bookstores, are not required to enroll.)

d. Second Opinion and Impartial Medical Evaluation (SECOP/IMPAR) bills are sent to the District Office for review and approval prior to payment. The DO staff batches the

SECOPI/IMPARI bills, identifies them as prompt pay bills, and sends them to the MBPC for processing. The medical reports are imaged in the DO.

e. The District Medical Advisor (DMA) submits bills to the District Office for review prior to payment. These bills are also sent to the MBPC and are identified as prompt pay bills. The DMA must enroll as a provider with the MBPC in order to have the bills paid. Note: The medical reports are imaged in the DO.

f. 100% wage loss. Payments for 100% wage loss due to the claimant's attendance at an OWCP directed medical examination are processed through the compensation payment system. If the case is under development or denied, the DO personnel should fax a certification memorandum to the National Office Fiscal Officer for payment.

g. If a third party surplus exists on a case, medical payments will not be made until the surplus is absorbed. The CE should use the adjudication status A0 to indicate that a third party surplus exists.

h. Balance forward bills will not be processed. All bills must be submitted in the manner described above for consideration of payment.

i. Travel voucher (OWCP-957). Claimants may request reimbursement for reasonable and necessary transportation costs and expenses incurred to obtain authorized medical services or supplies. Generally, 25 miles from the claimant's work site, residence, or place of injury is considered reasonable. The claimant must complete and sign the OWCP-957, Medical Travel Refund Request. Mileage expenses will be reimbursed at the GSA rate in effect on the date of travel. There will be no reimbursement for meals or lodging when travel is for less than 12 hours in total or fewer than 500 miles round-trip. Lodging must receive prior authorization. Cab fare or hire of special conveyance in excess of \$75 requires prior authorization. Original itemized receipts are required for cabs and other transportation expenses (including parking and tolls), as well as for all lodging and meals for amounts in excess of \$75. Additional instructions for completing the OWCP-957, Medical Travel Refund Request, are shown as [Exhibit 1](#).

j. Common carrier payments. Claimants occasionally travel via common carrier to attend OWCP directed medical examinations due to the geographic dispersion of medical specialists in certain areas. The DO makes the travel arrangements and coordinates payment processing with the NO Fiscal Officer. Once all charges are reconciled, the DO sends the invoice and supporting documents to the NO. The NO issues the payment in accordance with the Debt Collection Improvement Act and the Prompt Pay Act. A confirmation of payment is sent to the MBPC for updating the computer system.

k. Medical Reimbursements. A claimant may request reimbursement for out-of-pocket expenses paid to a provider for a service performed for an accepted condition. A separate request must be submitted for each provider. The claimant should submit:

(1) The completed Form OWCP-915, Claim for Medical Reimbursement.

(2) HCFA-1500 or UB-92 for services provided by a physician or other healthcare provider. The bill must be completed in its entirety as if it were being submitted for direct payment.

(3) The universal billing form (UBF) for prescription medication. The form must include the following information:

- (a) Name, address, and telephone number of the pharmacy;
- (b) Pharmacy provider number;
- (c) Prescription number;
- (d) Claimant's name;
- (e) Date of purchase;
- (f) National Drug Code (NDC);
- (g) New prescription or refill number;
- (h) Quantity of medication; and
- (i) Amount paid by claimant.

l. Over-the-counter (OTC) drugs and supplies prescribed by a physician and paid for by the claimant may be claimed for reimbursement. Form OWCP-915 should be completed as described above. The prescription and proof of payment must be submitted with the OWCP-915.

m. In occupational disease cases, a claimant may have incurred and paid medical expenses for some time before filing a claim. The claimant may be entitled to reimbursement for these expenses and should follow the procedures for medical reimbursements described above.

n. Insurance carriers may learn after having made payment on a claim that it was a workers' compensation claim. They should submit a completed Form NALC-200, Health Insurance Claim Form, Carrier Reimbursement (FECA Program) to the MBPC. This form, when signed by the carrier's representative, requires no further verification of payment.

o. Bills for missed appointments (no-shows). Bills submitted for missed medical appointments (other than OWCP-directed examinations) are not payable. Charges for missed appointments are the responsibility of the claimant.

p. Rehabilitation maintenance benefits. Claimants should complete Form OWCP-17 to claim rehabilitation maintenance benefits. This form must be certified by an official at the rehabilitation facility prior to submission. The form is sent to the Rehabilitation Specialist (RS) in the DO who reviews the form and forwards it to the MBPC for payment.

10. Edit resolution. Most bill resolution is performed by the MBPC. However, DO personnel are required to review bills suspended for claimant eligibility issues related to short form closures, field nurse or vocational rehabilitation bills exceeding authorization time frames and/or dollar limits, and bills over \$50,000.

11. Adjustment requests are used to adjust a previous bill. Most bill resolution is performed by the MBPC. However, DO personnel are required to review bills suspended for claimant eligibility issues related to short form closures, field nurse or vocational rehabilitation bills exceeding authorization time frames and/or dollar limits, and bills over \$50,000.

12. Check tracers. Providers may call the MBPC to obtain the status of checks they have not yet received. MBPC will query Treasury's Pacer system to obtain the check's status and print an image of the check if it has been negotiated. If appropriate, the MBPC will reissue the check.

13. The AchieveHCS System contains five years of bill payment history. It also provides information regarding enrolled providers, claimant eligibility, and medical authorizations.

Exhibit 1: Benefit Payments

**Instructions for Submitting Form
OWCP-957, Medical Travel Refund Request
(For reimbursement of travel and related expenses
under the Federal Employees' Compensation Act)**

**U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs**

Note: Any item not in conformity with the following instructions and not legible will be deducted from the voucher. **Form OWCP-957 MUST be submitted with a valid case file number.**

1. Claim for necessary and reasonable expense incident to travel authorized in accordance with provisions of the Federal Employees Compensation Act may be submitted for consideration on Form OWCP-957. Travel must be by shortest route and, if practicable, by public conveyance (streetcar, bus, boat, or train). Generally, 25 miles from the place of injury, the work site, or the employee's home, is considered a reasonable distance to travel.
2. The Office will promptly reimburse all bills received on the approved form and submitted in a timely manner. However, no bill will be paid for expenses incurred if the bill is submitted more than one year beyond the calendar year in which the expense was incurred or the service/supply was provided, or more than one year beyond the calendar year in which the claim was first accepted by the Office, whichever is later (20 CFR §10.803).
3. Payment will be made for taxicab fare or the hire of special conveyance where streetcars, buses, or other public and regular means of transportation are not available, except where these cannot be used because of the injured employee's disability. If claim is made for payment of expenses for taxicabs in excess of \$75 or hire of special conveyances, prior authorization is required.
4. Reimbursement for transportation by automobile owned by an employee or a member of his/her immediate family or another Government employee may be claimed when no public conveyance is available or where the physical condition of the injured employee requires the use of special conveyance. Mileage expenses will be reimbursed at the GSA rate in effect on the date of travel. Mileage expenses will be reimbursed at the following rates for travel during the following periods:

January 1, 1995 to June 6, 1996	30.0 cents per mile
June 7, 1996 to September 7, 1998	31.0 cents per mile
September 8, 1998 to March 31, 1999	32.5 cents per mile
April 1, 1999 to January 13, 2000	31.0 cents per mile
January 14, 2000 to January 21, 2001	32.5 cents per mile
January 22, 2001 to January 20, 2002	34.5 cents per mile
January 21, 2002 to December 31, 2002	36.5 cents per mile
January 1, 2003 to December 31, 2003	36.0 cents per mile
January 1, 2004 to February 3, 2005	37.5 cents per mile
February 4, 2005 and after	40.5 cents per mile

If mileage expense is claimed prior to January 1, 1995, contact your OWCP district office for rates.

5. Claim may be made for parking fees. If travel must be over a toll route, toll charges may be claimed. The form must show the locations where travel began and ended and mode of travel. List each item of expense separately, showing the date incurred, place and cost of the travel.
6. *There will be no reimbursement for meals or lodging when travel is for less than 12 hours in total or fewer than 500 miles round trip. If the authorized travel was for longer than 12 hours or greater than 500 miles, and a claim for meals or lodging is made, the dates and hours must be shown on the form. Lodging must receive prior authorization. All charges must be reasonable, and will be reimbursed at the per diem rate for the locality of travel. Any stopover or delay en route must receive prior authorization.*
7. If several trips are covered by the same form, list each separately in the spaces provided on the form. Original itemized receipts for amounts in excess of \$75 claimed in 5f, 6f and 7f must be furnished.
8. After a Form OWCP-957 has been completed, it must be signed in ink or indelible pencil in the space provided for the payee.
9. The completed form should be mailed to: U.S. Department of Labor, DFEC Central Mailroom, PO Box 8300, London, KY 40742-8300.
10. The form should not be submitted if there is no expense claimed.



5-0201, BPS FECS001 Programs

1. Purpose and Scope. This chapter summarizes and gives special instructions for certain FECS Sequent BPS programs which are accessed by multiple users through the FECS001 menu.

- a. Payment Input, BILL051. The Payment Input job is used to enter all new bills which have been received in the Office.
- b. Adjustment Input, BILL052. The Adjustment Input job is used occasionally to enter an adjustment to the payment history file so that canceled checks, cash deposits, fund transfers, or manual payments will be reflected appropriately.
- c. Adjustment Correction Input, BILL053. This job is used now and then to correct payment histories for data entry errors made in BILL052 for check cancellations, manual payments, cash receipts and fund transfers.
- d. Suspense Resolution, BILL054. Suspense Resolution is used by bill resolvers to make decisions on bills which have been suspended for review.
- e. Resubmit Duplicate Bills, BILL002. This job allows the user to access bill records which have previously been rejected by the Central system as duplicate, for the purpose of adding bypass codes and eventual retransmitting.
- f. Payee/Case Number Correction Input, BILL004. This job is used infrequently to correct an erroneous Payee EIN/SSN or case file number on a bill record which was previously entered and processed by the system.
- g. Provider Update, BILL005. This job is used to add records to the Provider Master File (v46), or to modify or delete those records.
- h. On-line Payment History, BILL006. This function allows users to obtain on-line information concerning paid and denied bills.
- i. Central Payment History Request, BILL007. The Central Payment History job is used to obtain a report of the Central bill payment history for a specific case. The Central bill payment history contains more information on paid bills than the on-line history, and covers a longer period of time. The Central history does not contain information on denied bills or bills rejected by Central.
- j. Central Provider History Request, BILL008. This job is used to request a Central bill payment history for a specific provider.

k. Provider Inquiry, BILL010. Provider Inquiry is used to determine whether a particular provider is on the Provider Master File (v46).

l. Batch Locator, BILL055. Batch locator is used to determine which batches are open and closed, and shows batches transmitted during the billing cycle. Closed batches which have been edited through the batch edit program are not displayed.

m. Batch Open/Close/Delete. This option is used to open, close, or delete specified batches. The option will not allow these actions to be performed on batches which have already been edited by the BILL552 program.

n. Provider Labels. This option allows the user to print mailing labels for providers.

o. Suspended Bill Query. This option allows the user to view bills on the system which have not been finalized, included suspended, recycled, and newly keyed bills.

p. Zip Code Search. Zip code search is used to determine what state is considered valid by the system for a given zip code.

q. ICD-9 Description. This option allows the user to view ICD-9 codes and descriptions through four different query options.

r. Excluded Provider Query. Queries may be performed by tax identification number or name to determine whether the medical provider has been excluded from participation in the FECA program.

2. Payment Input, BILL051.

a. BILL051 is used to enter information from new bills into the system for processing by BILL552. As each bill is keyed into the system, the data entered is edited for validity, selected data is matched against the corresponding Case Management Record, and data is either extracted from the Case Management Record or the Provider Master File and automatically inserted into the bill payment record. An output file of records is created which will subsequently be edited at the Sequent level by the BILL552 program.

The BILL552 editing will result in bills being approved for payment, denied, partially approved/partially denied, or suspended for manual review. The approved bills are transmitted to the Central computer site, edited further, and checked for possible duplication of payment. If the bill is accepted, a check is issued to the provider or claimant. A explanation of benefits letter (EOB) is produced at the Sequent level by BILL654 to inform the provider or claimant concerning bills which have been denied. The suspended bills are reviewed and resolved by appropriate office personnel using BILL054, Suspended Bill Resolution.

b. Because keying a bill into BILL051 may result in a payment or denial of a payment being made without a manual review, accuracy of keying is critical.

c. For security reasons, individuals who use BILL051 should not have access to either BILL054 (Suspense Resolution), or BILL005 (Provider Update). Generally, contract data entry clerks use BILL051.

d. The mechanics of BILL051 data entry are outlined in detail in the FECS Users' Manual. The following general guidelines supplement that information.

(1) BILL051 is menu item 1 on the Bill Payment Menu.

(2) Bills are entered in groups called batches. A batch will generally consist of 20 to 30 bills, but can consist of as few as one to as many as 999 bills. Batch sizes are determined at each district office.

(3) Each batch is assigned a batch identification number which must remain unique until the payment cycle after the payment cycle in which every bill in the batch is adjudicated. Batch identification numbers are assigned according to the individual office's organizational scheme (see Chapter 5-0200.10), and usually consist of six characters, alpha and/or numeric. Batch numbers may be assigned by mail room, fiscal, or data entry personnel. The batch number should be noted on the CA-D-9, BPS Batch Form, in item 1C. The number of bills in the batch should be shown in item 2A.

(4) To enter bills in BILL051, first enter the batch identification number from item 1C of the CA-D-9.

(5) Next entry is the number of bills in the batch, from item 2A of the CA-D-9.

(6) Enter the case file number. A bill may not be entered in BILL051 without a valid case file number. In addition, if the case has been transferred, loaned, retired, or destroyed, data entry is blocked.

(7) Key the first three letters of the claimant's last name. If the claimant's name does not agree with the name on the data base, further data entry is blocked. Sometimes first and last names are reversed on a bill. If the bill cannot be keyed because of case file number/name disagreement, pull it from the batch and make a note under item 4 on the CA-D-9 that a bill was pulled from the batch because of case file number/name disagreement.

(8) Enter the Direct Payment flag. Direct payment is a payment made directly to a provider or other non-claimant. Payments made to claimants are categorized as reimbursements or non-direct payment. If the bill is for direct payment, key "Y"; if for reimbursement to the claimant, key "N".

Most of bills received in the office are for direct payment. However, travel vouchers, pharmacy receipts, and maintenance reimbursements are usually non-direct payments. The presence of paid receipts or "paid in full" on the bill are also indications of non-direct payment. If the bill is a HCFA-1500, and an "amount paid" is shown in item 29, the bill should be keyed as a non-direct payment. If unable to determine whether the bill is for direct or non-direct payment, key as non-direct, as this will prompt manual review by a bill resolver.

(9) If non-direct payment, enter flag for pharmacy/travel/maintenance/training reimbursement. If the bill is for one of these four types of reimbursement, enter "Y". If not, enter "N". Pharmacy reimbursements usually consist of one or more receipts from the pharmacy. Travel reimbursements are usually submitted on form SF-1012. Maintenance reimbursements are always on form OWCP-17. Training reimbursements should already be marked up with provider type VR on the bill.

If "Y" is entered, the next entry will be provider type. The only provider type codes that should be entered are FR for pharmacy reimbursement, KR for travel reimbursement, QR for maintenance reimbursement, and VR for training reimbursement.

(10) Enter the nine-digit tax identification number of the provider, if bill is for direct payment, or if bill is for claimant reimbursement of anything except pharmacy, travel, maintenance, or training. This number is found at item 25 on the HCFA-1500, or item 6 on the UB-82. This number is not required for reimbursement of pharmacy, travel, maintenance, or training. If that particular identification number is not on the provider file, an error message will be produced. Double check the number keyed and continue if keyed correctly.

(11) Enter provider five-digit zip code. This is required only if a tax identification number has been entered.

(12) Enter provider address sequence number if known. Most of the time, the sequence number will not be known, so press <ENTER> to continue, and the first sequence for that provider tax identification number/zip code combination will be displayed on the screen.

(13) Check the provider name and address on the screen against the one present on the bill. If it matches, respond "Y" to the "Address OK?" prompt. If it does not match, respond "N" to the "Address OK?" prompt, and the next sequence for that tax identification number/zip code combination will be displayed. Continue until a match is found.

(14) If no match is found, it means that the provider is not on the provider file. Keying may continue, or offices may choose to pull a bill from the batch at this point and send for security provider file update. If the bill is pulled from the batch because the provider is not on file, an appropriate notation should be made on the CA-D-9 under item 4.

(15) Enter service state and zip. This data is used to apply the fee schedule. Usually it will be the same as the provider state and zip. However, this is not always true, so if services were rendered at a location other than the provider address state and zip (see item 32 on the HCFA-1500), that information should be entered.

(16) Verify that the claimant address is correct if the bill is for non-direct payment by comparing the claimant name and address on the screen with the name and address on the bill. If they match, respond "Y" to the "Address OK?" prompt. If not, respond "N".

(17) Enter provider type. This entry will be required only on bills which are for reimbursement of pharmacy (FR), travel (KR), maintenance (QR), and training (VR) expenses. For other bills, the provider type is written to the bill record from the provider file record.

(18) Enter the prompt payment flag. Most bills are not subject to prompt payment rules. If the bill is not for prompt payment, enter "N". If it is for prompt payment, press ("Y" already shows on the screen). Prompt payment bills will have already been screened by someone else in the office, and are usually placed in separate batches from the other bills. The following types of bills are always prompt payment:

(a) Bills for direct payment to Rehabilitation Counselors (provider types U, V, and W);

(b) Bills which are stamped "Prompt Payment" and are for direct payment of second opinion (procedure code SECOP), impartial (procedure code IMPAR), consultation (procedure code CNSLT), or medical advisor reviews.

(c) Bills for direct payment to field nurses who are under contract to the office. Their services will be coded using a variety of codes starting with the letter N.

(19) Enter bill number. Entry of a bill number is allowed only if the response to the "prompt payment" question was "Y", or if the payment is for a U.S. Government Transportation Request (GTR), provider type A. For rehabilitation bills, enter the counselor number. For medical and nurse prompt payment bills, enter the prompt payment number which appears on the bill. If there is no prompt payment number on the bill, make an entry consistent with individual district office policy. The system will accept one to 12 digits. For GTR payments, key the Carrier Bill Number.

(20) Enter invoice number or invoice date. The system will ask whether an invoice number (N) or invoice date (D) will be entered. If the response is "N", then an invoice number consisting of up to eight numeric and alpha characters must be entered. If the response is "D", then an invoice date in mm/dd/yyyy format must be entered.

(21) Enter bill receive date. Enter the date the bill was received in mm/dd/yyyy format, from the date stamp that is on the bill. If more than one valid district office date stamp appears on the bill, the oldest date should be used. A date stamp which has been crossed out and marked as returned is invalid. If there is no date stamp on the bill, look for a notation on the bill as to when it was received in the office, and enter that date. If there is no indication on the bill as to date of receipt, enter today's date. (Note: if there is more than a very occasional bill without a date of receipt, notify your supervisor.)

(22) Enter bill total. Key total amount of the bill. No amount in excess of \$999,999.99 may be keyed. If the amount is an even dollar amount, enter the number of dollars and press <ENTER>. If the amount includes cents, use the decimal point, enter cents, and then press <ENTER>.

(23) Key authorizing initials. These will not always be requested, and should be entered only if present on the bill. The authorizing initials will be those of an individual in the office who has

reviewed the bill and has authorized the dollar amount. If there are no initials present on the bill, press <ENTER> to continue.

(24) Enter Line Item Data. The following information must be entered for each line item on the bill. A bill may contain from one to 9999 line items. Continue keying line items until all line items for that bill are entered.

(a) MO: Key the two-digit month treatment or service started for the charge item being keyed.

(b) DA: Key the two-digit day treatment or service started for the charge item being keyed.

(c) YEAR: Key the four-digit year treatment or service started for the charge item being keyed.

(d) The month, day, and year keyed in (a) - (c) above will appear as the to date. If the date is correct, press <ENTER>. If the date is incorrect, type over it.

(e) PROC-CODE: The procedure code is the next entry. Not all bills require procedure codes. Up to eight characters may be entered. The first five characters are for the base procedure code, the next two are for the procedure code modifier, and the final character is for the fee schedule appeals code. Enter five-digit CPT4 code, three-digit RCC code, five-digit HCPCS code, five-digit special DOL code, or five-digit dental code if present on the bill. If a five-digit CPT4 code is followed by a one- or two-digit modifier (this will not occur on a majority of the bills), that should be entered next, followed by a one-digit fee schedule appeals code (this will be present only rarely and will have been written on the bill by other office personnel). If eight characters are entered there is no need to press <ENTER>. RCC, HCPCS, DOL and dental codes should not have modifiers or fee schedule appeal codes.

(f) Unit: If a procedure code is required, the number of units "001" will be automatically generated. If no procedure code is required, no units are required. Key the number of units on the bill for the particular procedure (up to three digits). The user should ensure that the number of units keyed is correct, because errors in the number of units result in misapplication of the fee schedule.

(g) Charge: Key the total amount of the charge item, including the decimal point, and press <ENTER>. The maximum which may be keyed in is \$99,999.99.

(h) BYP-CD: Key the single-digit Bypass Code shown on the bill, if present (it would be written in by other office personnel). If a Bypass Code is not present, press <ENTER>. Valid codes are 1, 2, and 3 for BILL051. Bypass Code 1 may be keyed without being present on the bill if a multi-page bill is keyed as separate bills, and line items appearing on separate pages would be considered as duplicate input by the system (but they are not).

(i) INEL: If an ineligible amount is present, key the ineligible amount, including the decimal point, and press <ENTER>. If an ineligible amount is not present, press <ENTER>.

(j) EXP: If an eligible amount has been keyed, key the one-letter explanation code which is next to the ineligible amount on the bill. Valid codes are A through N.

(25) As line item charges are entered, the bill balance which appears at the bottom of the screen will decrease proportionately. Most of the time, the balance at the bottom of the screen will be 0 when the entire bill has been keyed. If the bill is out of balance, that is, the sum of the line item charges less ineligible amounts does not equal the bill total, a negative or positive amount will appear as the bill balance.

(26) When the entire bill has been keyed, press <F10>. If the bill is in balance, an "OK? (Y/N)" prompt will appear. If the bill is not in balance, the system will produce this message and ask whether or not to continue. After checking to ensure accurate data entry, respond "Y" or "N". If the response is "Y", the system will give a final OK? prompt and then will prompt for the case file number of the next bill. If the response is "N", the cursor returns to the AUTH field of the bill, and the user may <ENTER> through fields or make corrections. At the final "OK" prompt, if the response is "N", the cursor returns to the case file number of the bill being keyed.

3. Adjustment Input, BILL052.

a. Purpose. BILL052 is used to enter data concerning manual bill payments, and to enter adjustments to bills previously paid. There are four types of "adjustments" which may be made using BILL052: Manual Payments (Code "M"), Canceled Checks (Code "C"), Cash Deposits (Code "D"), and Fund Transfers (Code "F"). BILL052 data entry is very similar to BILL051. Detailed data entry instructions may be found in the FECS User's Manual. The following information supplements the User's Manual.

b. Data Entry Procedure.

(1) BILL052 is menu item 2 on the Bill Payment Menu.

(2) Enter batch number. As with BILL051, bills are entered into BILL052 in batches. There may be as few as one bill in a batch. The bill batch identification number must remain unique within the weekly cycle.

(3) Enter case number.

(4) Enter first three letters of the claimant's last name.

(5) Enter direct payment flag. If payment is/was directly to a provider, enter "Y"; if reimbursement to a claimant, enter "N".

(6) If not direct payment, is/was payment reimbursement to the claimant for pharmacy, travel, maintenance or training expenses?

(7) Enter provider information - direct payment bill and non-direct payment for something other than reimbursement of pharmacy, travel, training or maintenance.

(a) EIN: Key the nine-digit tax identification number of the provider.

(b) Zip: Key the provider's zip code.

(c) Bill: Key the Carrier Bill Number if the bill is for payment of a U.S. Government Transportation Request. If the field is not filled completely, press <ENTER>.

(d) Invoice No./Date (N,D): Enter an N followed by the invoice number or a D followed by the invoice date. The invoice date, if present, will be entered as mm/dd/yyyy. If there is no number or date, or if the number does not fill the field completely, press ENTER.

(8) Enter provider information - pharmacy, travel, training, or maintenance reimbursement.

(a) Type: Key the provider code, then an "R".

(b) Invoice No./Date (N,D): Enter an N followed by the invoice number or a D followed by the invoice date. If there is no number or date, or if the number does not fill the field completely, depress <ENTER>.

(9) Enter date received.

(10) Enter authorizing initials present on the bill, if any (not required).

(11) Enter Adjustment/Maintenance Information.

(a) Adj Date: For manual payments, the adjustment date is the date of the check. For other adjustment transactions, the adjustment date is the date of the action by Treasury (check deposit, check cancellation, or fund transfer). Key month, day and year as shown underneath Provider information on bill.

(b) Maint Type: Key maintenance code (M, C, F, or D) as shown underneath Provider information on bill.

(12) Enter Charge Data - All Bills.

(a) MO: Key the two-digit month of the treatment or service for the charge item being keyed.

(b) DA: Key the two-digit day treatment or service started for the charge item being keyed.

(c) YR: Key the four-digit year treatment or service started for the charge item being keyed. If authorization initials are required due to the service date being prior to the history purge date, cursor up to AUTH field.

(d) Charge: Key the total amount of the charge item. If the charge is an even dollar amount, enter the whole dollar amount and press <ENTER>. If cents are involved, enter decimal point and cents and press <ENTER> if the field is not full.

(e) CODE: Key the Bypass Code shown on the bill, to the left of the charge item being keyed. If a Bypass Code is not present, press the space bar or press <ENTER>.

(f) If there is more than one charge item to be keyed, repeat steps b(12)(a) through b(12)(e) for each charge item. (The system will allow up to four charge items per screen format.) The charges must balance with the total.

(g) When all charge lines have been entered for the screen format being keyed, depress <ENTER>.

(h) If the record being keyed is out of balance, review all amounts which have been keyed to determine if there has been a keying error. If there is an entry error, use the up cursor to move to the erroneous amount and make the correction.

(i) There will be a final "OK? Y/N" prompt.

(j) When all adjustments for the batch have been entered, press , and respond to the prompt concerning batch closure.

4. Adjustment Correction Input, BILL053. To adjust an entry to correct payment histories for data entry errors made when entering check cancellations, manual payments, fund transfers and cash receipts, use BILL053. For example, if when entering a cash receipt into BILL052, \$500.00 is entered instead of \$50.00, and the error is not discovered until the records have been transmitted to the central system, BILL053 should be used to enter a transaction which will back out or balance the incorrect transaction. A BILL053 transaction for \$450.00 could be entered, or a BILL053 transaction for \$500.00 and a BILL052 for \$50.00 could be entered. The first entry after the batch number is the adjustment type of the record that is being corrected (manual payment, fund transfer to agency, cash receipt, and check cancellation). After that, data entry is identical to BILL052.

5. Suspense Resolution, BILL054, is covered in detail in PM Chapter 5-0204. Explicit guidance concerning the mechanics of using BILL054 is found in the FECS Users' Guide. BILL054 is used by bill resolvers (either fiscal or claims staff or a combination of the two) to bring bills which have suspended for review from BILL552 to a final disposition.

6. Resubmit Duplicate Bills, BILL002.

a. **Description.** After approved bills are transmitted to the Central system, they are subjected to a variety of processes. One of these is a check against the Central bill history and against bill input for possible duplicate payments. Even though the BILL552 edit process checks for duplicate payments, because the data file BILL552 uses is less complete than the Central bill record file, and because BILL552 does not check against same-day input, it is possible for bills to pass through BILL552 but be rejected by the Central system because of possible duplication. The purpose of BILL002, Resubmit Duplicate Bills, is to allow an office to review records rejected by Central, determine whether the bill is in fact a duplicate of a previously paid item, and if not,

enter a bypass code (as appropriate) and retransmit the bill. BILL002 allows the offices to save time by eliminating the need to rekey and re-resolve rejected bills.

b. The time frame for using BILL002 is limited to 12 days from the date of transmission of the original bill. Bills which have not been corrected within 12 days may no longer be accessible using BILL002, unless another bill in the same batch remains suspended. Thus if a bill has been rejected by Central as a duplicate and it is in fact a duplicate, the office does not need to take any action. If a bill is payable but is not corrected through using BILL002 before the full record is deleted, it must be completely rekeyed.

c. To use BILL002, choose option 16 from the FECS001 Bill Payment Menu, then enter the batch identification number (up to six characters), bill identification number (up to three numbers), and line item number (up to four numbers) of the record which is to be reprocessed. This information is to be obtained from the BP060W report of "Related History and Possible Duplicate Bills Unpaid on yy/mm/dd". If the significant digits for the bill identification number or line item number do not fill up the field, press <ENTER>. For example, if the bill ID number is 002, press 2 and <ENTER>. After entering the batch ID, bill ID, and line item number, if the record is available for resubmission, the bill information will appear on the screen. The user can then enter and verify a blank, or bypass codes 1, 2 or 3.

7. Payee/Case Number Correction Input, BILL004.

a. This job will be used infrequently for purposes of correcting an erroneous Payee EIN/SSN or case file number which was previously entered and processed by the system. Its most frequent use is to transfer bill payments made on a duplicate case to the file number of the case which is to be retained. The payee number correction could be used if a payee was entered in the provider file with an incorrect tax identification number, and a payment was made using the incorrect information. Once the provider file record is corrected, the erroneous bill record can be corrected using BILL004.

b. Using BILL004.

- (1) BILL004 is menu item 4 on the FECS001 Bill Payment menu.
- (2) Enter batch number.
- (3) Indicate whether payee (p) or case (c) number correction is desired.
- (4) Enter authorizing initials (required).
- (5) Enter case file number and do name check (first three initials of last name).
- (6) Enter payee number, service dates, payment date, and payment amount.
- (7) Enter payment type (B, C, M, F, or D).
- (8) Enter new payee (or case) number, then rekey.
- (9) Respond to final "OK? Y/N" prompt.

8. Provider Update, BILL005. This job is used to add, modify, or delete records from the Provider Master File (v46). The Provider Master File contains information on each provider who has submitted bills for payment under the FECA. For each provider, the following information is

present in the file:name, address, including state and zip code, provider type code (see PM Chapter 5-203), an exclusion flag, a payment flag, tax identification number (either Employer Identification Number [EIN] or Social Security Number), sequence number, frequency of payment number, date of last payment, district office information, and date of last change. Payment or denial of payment through the BPS cannot be made unless the provider is on the provider file, except by manual payment.

a. Changes to the provider file may only be made by an individual or individuals who have been authorized to perform this function. The individual who performs the updates must be an employee of the Department of Labor (as opposed to a contract employee) and must not have any other association with processing bills through the BPS. In other words, individuals who key, resolve, authorize, or audit bills should not be given permission to perform updates to the provider file.

b. To perform provider file updates, select option 5 from the FECS001 Bill Payment menu. Detailed instructions for using this option may be found in the FECS Users' Manual.

c. After entering the nine-digit provider identification number, and the zip code, and pressing <ENTER>, the system will display the first provider with that ID number/zip code combination. The user can then modify or delete that record, or may go on to the next record with that ID number/zip code combination.

d. If the particular ID number/zip code combination is not already on the system, or if a new address is to be added for an ID number/zip code combination which is already on the system, the user can add a record.

e. To add a record, in addition to the provider identification number and zip code, the user must enter the full name, street address and city, the two-letter abbreviation for the state, a provider type code (see [Chapter 5-203](#)), a payment flag (Y or N - see below), and district office information (optional). The system assigns a sequence number.

f. Special characters, such as "." ", "#" and "&" may not be entered in the name, address, or city fields. A "/" is allowed in the name or address fields, but not the city field.

g. The payment flag should be "Y" for "yes", unless the district office has excluded the provider from payment under the provisions of 20 C.F.R. 10.450-457, or for some other reason, and the exclusion flag has not been updated by National Office yet. The individual performing provider file updates is responsible for checking the excluded providers report or on-line query before entering a "Y" payment flag for any provider. On occasion, the district office may wish to set the payment flag to "N" for "no" for some other reason, such as the need to manually review all of a provider's bills.

h. When adding providers to the provider file, the user must be careful not to make an addition which varies only insignificantly from a record which is already on the file. For instance, if a record for J H Jones MD, 100 Main Street already exists, another entry for John Howard Jones MD, 100 Main St should not be made.

i. Provider type codes determine the type of editing that will be done on a bill, including application of the fee schedule. The user must therefore be certain to enter a correct provider type code.

9. On-line Payment History, BILL006. This function allows users to obtain immediate information concerning paid and denied bills. The information is displayed for individual case file numbers. The user may narrow the selection of records to be viewed by specifying a provider identification number, provider type, payee zip code, check/EOB date range, and/or service date range. The records are displayed in order of date of service, with the most recent first. The "TOTAL" field just above the "PROVIDER" column shows how many records are in the system for the provider/type/dates combination requested, and the number of the record on which the cursor is presently positioned. Each record displayed represents an individual line item on a bill, rather than the entire bill. If a bill contains several line items, these will not necessarily be displayed sequentially on the screen. The up and down cursors may be used to move from one record to another. As the cursor moves, the display at the bottom of the screen changes. <Page Up> and <Page Down> may be used to move from screen to screen. The following information is displayed on the screen for each record:

- a. Provider/payee ID. This is the tax identification number of the payee. If the payee was a provider, the number will be either the provider's Employer Identification Number (EIN) or Social Security Number. If the payee was a claimant, and the provider type is FR, KR, QR, or VR, the number will be the claimant's Social Security Number. For other types of claimant reimbursements, the provider number is shown. If a provider/payee ID was specified in the selection process, only records which have a matching provider/payee ID will be displayed.
- b. Provider type code. If a provider type code is followed by an "R", the record was processed as a reimbursement to the claimant. If a particular provider type code was specified in the selection process, only 9. records containing that particular provider type code will be displayed. For instance, if "P" is selected, all records with provider type codes of P and PR will be displayed. If "<space>R" is selected, all records processed as reimbursements to the claimant will be displayed.
- c. Dates of service. The "from" and "to" dates of service are displayed in mm/dd/yyyy format. If a date range for the search was specified in the selection process, only the records which contain "from" or "to" dates within that range will be displayed.
- d. Procedure code. The procedure code, including modifier and fee schedule appeals code (if applicable) is shown. If the provider type is one which does not require a procedure code, the space will be blank.
- e. Charge amount. The amount billed for the particular dates of service and procedure is shown.
- f. Paid amount. This is the amount paid for the particular dates of service and procedure code. If this amount is equal to the charge amount, and the check date (see paragraph g below) is blank, the bill has been processed during the current cycle, and the amount of the eventual payment is not yet known. Once payment has been processed by the Central system, the amount will be

updated. If the amount is \$0.00, the bill was denied by the Office, or was rejected by the Central system (see paragraphs g and h below). If the amount is greater than \$0.00, but less than the billed amount, there was either a fee schedule reduction or an ineligible amount.

g. Check date/EOB date. If the bill was paid (paid amount does not equal zero), the date of the check by which it was paid will appear here. If the bill was denied at the Sequent level, the date of the denial will be displayed. If the bill was rejected by Central, a rejection code will be displayed. These codes and their definitions are as follows:

REJDLY - BP010 edit failures
REJWKP - BP020 negative pay amount
REJWKR - Record matched input
REJWKS - Record matched history
REJWKT - Record matched input and history
REJWKU - Record matched input and not history
REJWKV - No match to history

h. Reject date/EOB message. If payment was made, this will be blank. If the bill was denied at the Sequent level, the two highest priority EOB message code numbers will appear (code numbers consist of three numbers). If the record was rejected by the Central system, the date of the rejection will be shown.

i. Record type. The record type reflects the type of record displayed. Bill type B is assigned to all bills created using BILL051 and BILL002. Record types M (manual), C (check cancellation), and D (cash deposit) are for maintenance adjustments keyed using BILL052 or BILL053.

j. A window at the bottom of the screen shows the Provider Zip Code, Sequence Number, District Office issuing Payment, Batch ID, IRS offset flag, and resolver ID for the currently highlighted record. A sequence number of ZZ means that the record was processed as a reimbursement to the claimant.

10. Central Payment History Request, BILL007.

a. Purpose. BILL007 is used to request an overnight Central bill payment history for a particular case. When a history is requested, a report is printed the following work day, if the request was made before history requests were transmitted to the Central system. The history report contains information on bills which have been transmitted and accepted by Central only, including adjustments. Denied bills will not appear on the Central history report, since they are not transmitted to Central. Bills rejected by Central will not appear on the report.

A request can be made on a case by case basis for the bill payment history for a specific provider, a specific provider type, specific dates of treatment, or the complete bill payment history. If the history is requested during the week, bills paid since the Central history purge date (usually two years) will be shown on the history report. If the history is requested on a Friday, all bills on the BPS, both active and purged, will be shown on the report.

b. Suggested Usage. BILL007 may be used whenever a complete bill payment history is required for a particular case. The information contained in the report is more detailed than the information found in the on-line bill payment history, and covers a longer period of time. The report is particularly useful for determining third party disbursements, for determining actual payments when the on-line history is inaccurate, or for obtaining history which predates the on-line history.

c. Instructions for using BILL007 may be found in the FECS Users' Manual.

11. Central Provider History Request, BILL008. This job is used to request a Central bill payment history for a specific provider. To use this function, both a provider identification number and a provider zip code must be entered, and the entry must be done on a Friday.

12. Provider Inquiry, BILL010. Provider Inquiry is used to determine whether a particular provider is on the Provider Master File. Since it is a query only function, it may be used by individuals who do not have access to the provider file via BILL005. Provider inquiry is option 08 under the FECS001 Query menu.

13. Batch Locator, BILL055. Batch locator, option 09 under the bill payment menu, is used to determine the current status of bill batches. It shows all open, closed (unedited), and transmitted batches. It is often accessed just prior to running the bill batch edits to determine whether all completely keyed bill batches have been closed.

14. Batch Open/Close/Delete. This function, option 11 under the bill payment menu, shows open batches, and unedited closed batches, and allows the user to enter a batch identification number for opening, closing, or deletion. Access to this option should be very limited. Once a closed batch has been subjected to the edit program (BILL552), it cannot be reopened or deleted using Batch Open/Close/Delete.

15. Provider Labels. Provider Labels, option 12 under the Bill Payment Menu, allows the user to generate a mailing label for a specific tax identification number. The user can generate a label for a particular sequence, all sequences under one zip code, or all sequences and all zip codes.

16. Suspended Bill Query. This option, which is item 13 under the Bill Payment menu, provides a variety of means to view bills which have not been finalized. Bills with the following status codes may be viewed:

K - keyed, but the batch in which it was keyed has not been closed;
N - keyed, but not yet edited by the BILL552 program;
S - suspended for resolution;
R - set to recycle through the BILL552 program by a bill resolver;
I - internally denied bill;

D - bill has been denied (as soon as daily transmission takes place, bill is not accessible through suspended bill query, but instead appears in the on-line history); and

C - bill has been approved or partially approved for payment (as soon as daily transmission takes place, bill is not accessible through suspended bill query, but instead appears in the on-line history). Users may specify the query by case file number, batch identification number, provider number, or bill status code.

After specifying the parameters of the search, a list appears of all bills fitting the search criteria, with a count. The user may then select a bill for viewing. The screens are very similar in appearance and function to those in the suspense resolution program, except that no updates are possible.

17. Zip Code Search. A data file on the Sequent contains a list of zip codes and the associated state codes. This data file is updated periodically. Various Sequent and Central programs edit for the validity of the zip code/state combination in a given record. Zip code search may be used to determine what state is considered valid by the system for a given zip code. If a zip code/state combination is known to be valid, but is not on the system, National Office should be notified.

18. ICD-9 Description. ICD-9 codes are frequently found on medical bills, and are also used to designate accepted conditions in cases. The ICD-9 Description option allows the user to view ICD-9 codes and descriptions through four different query options:

- a. Locate ICD-9 Code - the user enters a specific code, and the screen displays the code and the correlating description;
- b. Locate ICD-9 Codes by IC Code Range - the user enters beginning and ending ICD-9 codes, and the screen displays those codes and all the valid codes that fall in between, with the corresponding descriptions;
- c. Locate ICD-9 Codes by IC Code Prefix - the user enters the beginning digits of an ICD-9 code (one to five characters), and the screen displays all of the ICD-9 codes that start with those characters, along with the descriptions; and
- d. Locate ICD-9 Code by Description Prefix - the user enters the first word of a condition description, and the screen displays all descriptions which start with that word, with their ICD-9 codes. This option is particularly useful to claims examiners who know what condition they want to accept, but don't recall the ICD-9 code for the condition.

19. Excluded Provider Query. This program enables the user to query the excluded provider file by name or by tax identification number. After entering the data, the screen displays the full name and mailing address of the provider, the sanction and notification dates, and the source of the exclusion. If more than one record meets the search criteria, the user is asked to indicate whether he/she wishes to view the next record. When the name query is used, all records with names beginning with whatever is entered will be displayed. For example, if "BROWN" is

entered, all records with a last name of "Brown" will be displayed, but in addition, records with names such as "Brownlee" and "Browns Medical Supply" will be displayed as well.

Chapter 5-0202, Fee Schedule Appeals, Bill Adjustments, District Director Exceptions, and Cases/Providers on Review

1. Purpose and Scope. This chapter provides guidance and instructions for processing appeals of medical fee schedule determinations and adjustments to erroneous bill payments. It also contains information on Return to Provider Letters (RTPs) and Remittance Vouchers (RVs). The chapter also contains information on District Director exceptions and cases/providers on review.

2. Fee Schedule Appeals. Under 20 C.F.R 10.812, a medical provider whose charge for service is only partially paid because it exceeds a maximum allowable amount set under the Office of Workers' Compensation Programs (OWCP) fee schedule may, within 30 days of payment, request reconsideration of the fee determination. Only three circumstances will justify reevaluation of the paid amount. These are:

- a. The actual procedure performed was incorrectly identified by Current Procedural Terminology (CPT) code;
- b. The presence of a severe or concomitant medical condition made treatment especially difficult; or
- c. The provider possesses unusual qualifications, beyond Board-certification, in a medical specialty.

The provider must submit evidence to support the request for reconsideration of the paid amount. Under 20 C.F.R. 10.813, the provider may not seek any additional amount from the claimant in excess of the charge allowed under the fee schedule.

3. Timeliness. The Federal Employees' Compensation (FEC) district office (DO) servicing the claimant's case is responsible for processing the provider's request for reconsideration of the fee determination. Under 20 C.F.R. 10.812 (a)(2), the DO is to respond, in writing, within 30 days of receiving the request stating whether or not an additional amount will be allowed as reasonable.

4. Authority.

a. District Director (DD). The reconsideration decision is to be prepared for the signature of the DD.

b. Regional Director (RD). If an appealed amount continues to be disallowed by the DO, the provider may seek further review. A decision from this further review, stating whether or not an additional amount is to be allowed as reasonable, is to be made within 60 days of receipt of the request for review. This decision is to be prepared for the signature of the RD.

5. Processing Fee Appeal Requests from Providers. In order to appeal a payment, the provider may, within 30 days of the date of payment, make written request for reconsideration of the fee determination; identify the procedure(s) in question; attach documentary evidence relevant to the circumstances upon which the appeal is based (Paragraph 2, above); attach a copy of the RV; submit the request to the Central Mail Facility (CMF). All appeals are logged and linked to the bill that prompted the appeal. They are tracked by Medical Bill Pay Contractor (MBPC) through the appeal process.

Once a fee appeal request has been received in the CMF, it is forwarded to the DO via Omnitrack thread. The Claims Examiner (CE) who receives the thread should notify the DD that a new fee schedule appeal has been received on a case. The designated person(s) in the DO reviews the appeal request and either approves or denies the appeal or requests more information; this person should also reply to the thread. Any additional information that is requested should be sent to the CMF for imaging into the case record.

The appeal status is entered into AchieveHCS by the MBPC staff. When a bill is in an open appeal status, duplicate bills for the same service are denied.

a. The Fee Schedule Appeal Reviewer. The person(s) to be charged with the responsibility of processing fee schedule appeals is left to the discretion of the DD and RD. However, when an appeal is made to the regional level, the person handling the appeal must be someone other than the person who processed the earlier appeal.

6. Evaluating a Fee Appeal Request. The reviewer should consider the following:

a. Incorrect Procedure/Service Code. In addition to the evidence submitted on appeal, review any medical reports of record pertinent to the service or procedure in question. If it is not furnished by the provider, the reviewer may wish to review the original bill in the SIR system for the description of the service provided. If technical assistance is needed, the reviewer should obtain the opinion of the District Medical Director (DMD)/District Medical Advisor (DMA) or appropriate Office consultant as to the appropriateness of the coding of the service or procedure in question.

b. Severe or Concomitant Medical Condition. The evidence submitted, along with pertinent medical evidence which may already be on file, must establish the presence of a severe or

concomitant medical condition and show that this condition made the billed treatment especially difficult. As examples, cardio-pulmonary problems or severe diabetes may make treatment (e.g., surgery) of the injury-related medical condition especially difficult. However, the mere fact that a severe or concomitant condition was present should not result in additional payment without regard to the service or procedure in question. For example, it would not be expected that difficulty in treatment would warrant an additional payment for an office visit or the taking of x-rays.

Review and opinion may be obtained from the DMD/DMA or Office consultant concerning the presence of a severe or concomitant condition, its effect upon treatment and the amount of the additional fee requested given the added difficulty, if any. Any evidence used as a basis for finding that a severe or concomitant medical condition was not present or did not make the billed treatment more difficult must clearly and convincingly represent the weight of the evidence. Where the DMD/DMA or Office consultant's opinion is in disagreement with, but of nearly equal weight to, the evidence submitted by the provider, payment of an additional amount in excess of the fee schedule should be authorized. Such "conflicts" of opinion as to whether or not a severe or concomitant medical condition made treatment especially difficult are not subject to resolution by the use of an impartial third physician.

c. Unusual Provider Qualifications. The evidence upon which such a decision is based is the provider's curriculum vitae. Board certification in a medical specialty is not, by itself, sufficient evidence of unusual qualifications. Professorial rank or the publication of articles authored or co-authored by the provider which are pertinent to the medical condition or procedure in question are considered evidence of unusual qualifications. The DMD/DMA or Office consultant in the appropriate specialty may also be requested to provide an opinion as to the qualifications of the provider and the amount of the additional fee requested given those qualifications and the procedure or service in question.

7. Additional Amount Payable. Where it is determined that an additional amount is payable, the DO generates a letter informing the submitter of the approval. The reviewer must prepare a memorandum for the file stating the findings and the basis for the approval of the additional amount. Second review and approval of this memorandum by a higher authority is not required, but may be implemented by the DO if desired. Where additional payment is denied, the provider must be furnished with a letter decision concerning the findings and the reason for the denial.

8. Denial of Appeal Payment. Where additional payment is denied at the DO level, the letter decision must contain a notice of the right to further review similar to the following: If you disagree with this decision, you may, within 30 days of the date of this decision, apply for additional review. The application may be accompanied by additional evidence and should be addressed to the Regional Director, District ____, Office of Workers' Compensation Programs, U.S. Department of Labor, OWCP/DFEC, PO Box 8300, London, KY 40742-8300. Where additional payment is denied at the regional level, the letter decision should advise the provider that this decision is final and is not subject to further review.

9. Payment. If an additional amount is approved, the DO staff will complete the DO Adjustment Request form ([Exhibit 1](#)) and the form will be forwarded to the MBPC via the District Office Troubleshooter (DOT). The MBPC will then make the adjustment, issue a remittance voucher and update the system with the new data.

10. Additional Payment Based on Unusual Provider Qualifications. Where an additional amount is found to be payable based on unusual provider qualifications, the DD should determine whether future bills for the same or similar service from that provider should be exempt from the fee schedule. If so, procedures for "Provider on Review" should be followed. (See paragraph 18, below.)

11. Adjustments: Correcting Errors Without an Appeal. Obvious errors warranting additional payment, identified internally or by contact from the claimant or provider, may be adjusted by the MBPC without following the formal appeal procedures.

a. Submission of Adjustment Requests. If a claimant feels a payment should be adjusted, he/she should submit a copy of the original bill containing the original Transaction Control Number (TCN) and an explanation of what needs to be adjusted. The claimant should write "Corrected Bill" or "Adjustment" at the top of the form. The claimant may also submit a copy of the Explanation of Benefits (EOB) or a letter to the MBPC at the CMF requesting adjustment of a bill. If either of these is submitted, a written explanation as to what needs correction must be included.

A provider who requests an adjustment should submit a copy of the original bill with the original TCN, an explanation of what needs to be adjusted and a copy of the RV. At the top of the original bill, the words "Corrected Bill" or "Adjustment" should be written. A letter sent to the MBPC at the CMF will also be accepted for adjustment as long as the information described above is included in the letter.

If a DO requests that a payment be adjusted, the DO should complete an Adjustment Request Form (Exhibit 1) with the original TCN and a description of the charges to be processed. These may be forwarded to the MBPC via the DOT.

b. Adjustments Based Upon Eligibility. If the adjustment is for an eligibility reason, iFECS should be updated to reflect the current case status and accepted condition(s). Once case eligibility has been updated, an adjustment request form should be completed and forwarded. The adjustment will be processed at that time.

c. Authorization Issues. If the adjustment is related to an authorization issue, the treatment suite will be reviewed to determine the authorization level. If an authorization is required for the service, the MBPC will review the authorization subsystem to see if an authorization has been created. If not, the CE will be notified via the Omnitrack system.

d. Types of Adjustments. There are several types of adjustments.

(1) Single bill voids/credits. A bill credit (void) is a reversal or offsetting of a previously paid bill.

(2) Single bill adjustment. An adjustment is a net change to a previously paid bill as opposed to a complete reversal or credit. Adjustments may be necessary for a variety of reasons, although they usually involve some error in provider reimbursement.

(3) Gross adjustments. Gross adjustments are those paid to a provider and may include multiple claim numbers. An example of a gross adjustment would be if a provider was incorrectly enrolled as a chiropractor. All of his bills have been denied for that reason. Once the enrollment status was corrected, the MBPC would make a one-time payment to the provider for all bills denied due to the incorrect enrollment status. Gross adjustments are special cases and it is preferable to adjust specific bills when possible.

(4) Mass adjustments. Mass adjustments and credit transactions are submitted online. An example of a mass adjustment is the correction of bills paid based on an error in the fee schedule. The mass adjustment process should be used cautiously due to the potential impact on the processing system since large numbers of bills may be affected.

12. Provider Billing Claimant for Full Payment. A claimant may contact the DO and advise that he/she paid the medical provider in full and was only partially reimbursed by the Office as a result of the application of the fee schedule, or that a provider who was only partially reimbursed by the Office is demanding payment of the balance of the full charge, either directly or by referral to a collection agency or by legal action.

a. The claimant does not have the right to appeal the fee determination per se. However, under 20 C.F.R. 10.337(b), the DO should advise the claimant that he/she may:

- (1) Request that the provider make appropriate refund or credit for the amount the claimant paid in excess of the fee schedule;
- (2) Request that the provider submit, on the claimant's behalf, and at no additional cost, a request for reconsideration of the fee determination as discussed above; and

b. Where the claimant has made payment to the provider and is only partially reimbursed due to the application of the fee schedule, the DO should release a letter to the provider, with a copy to the claimant, which:

- (1) Identifies the specific charges at issue;
- (2) Notifies the provider of the provisions of the pertinent regulations;
- (3) Requests that appropriate refund or credit be made within 60 days;
- (4) Offers the provider the opportunity to appeal the allowable fee; and

(5) Advises the provider of the possible consequences of failure to make appropriate refund or credit.

A sample letter is shown as Exhibit 2. If, after receipt of the above letter, the provider appeals the fee determination and it is found that no additional amount is payable, the letter decision should again request that appropriate refund or credit be made within 60 days.

c. Where the provider has initiated collection action, or has actually collected from the claimant, an amount in excess of the maximum allowable charge paid by the Office, the DO should release a letter similar to Exhibit 3 to the provider, with a copy to the claimant, requesting that the amounts in excess of the maximum allowable fee which have been collected, be refunded to the claimant or credited to the claimant's account, or that the provider cease attempts to collect such additional amounts. The provider should be given 60 days to comply.

13. Sanctions for Provider Noncompliance.

a. If the provider does not comply with the written request of the Office within 60 days, the DO should contact the provider to make appropriate refund or credit, or to cease collection action. If this contact does not satisfactorily resolve the problem, action should be taken to exclude the provider from participation and payment under the Federal Employees' Compensation Act (FECA). See PM 3-0800. (20 C.F.R. 10.815[h])

b. Where all efforts to have the provider credit or refund to the claimant an amount the claimant paid the provider in excess of the maximum allowable have failed, the DO should reimburse the claimant for the amount paid in excess of the maximum allowable fee. (See 20 C.F.R. 10.337[c].)

14. Return to Provider Letter and Remittance Vouchers. The MBPC issues automated Return to Provider Letters (RTPs) and Remittance Vouchers (RVs) to explain benefits paid or to provide the reason for non-payment of the charges.

a. Return to Provider Letter (RTP). This letter contains specific information explaining why a bill was returned. It is most commonly sent to the provider, but may be sent to a claimant if a request for reimbursement has been submitted improperly. The reason for the returned bill is noted on the letter.

Reasons for RTPs include missing claimant information, missing/invalid billing information, missing provider information, the need for attachments, inability to image the claim form and/or the submission of an incorrect form. The erroneous bill is attached to the RTP letter. All information cited must be corrected before the bill can be processed. The claimant/provider is advised to make the necessary changes and resubmit the bill for processing. This is not a formal decision and no appeal rights are issued with this letter.

b. Remittance Voucher (RV). A remittance voucher is created for every processed bill, showing the amount paid and/or the reasons for line item/bill denial. The MBPC produces and mails RVs

on a weekly basis. They are issued separate from the actual payment. An electronic RV (ANSI 835) can be issued to authorized providers. Appeal rights are included on RVs where bill(s) have been reduced or denied.

- (1) Each RV has its own unique number that will appear on the corresponding check that is issued.
- (2) Each check has its own reference number. This number is different from the RV number; the check reference number will appear on the RV. This number should be referenced when inquiring about a specific payment.
- (3) The RV shows the date the bills were paid and the MBPC number of the "pay-to" provider.
- (4) The Transaction Control Number (TCN) for each bill processed will appear on the RV. Adjustments will always result in two TCNs, one crediting the original bill and the second processing the adjustment.
- (5) Bills are grouped by payment status, paid or denied.
- (6) The treating provider's name is listed on the RV, along with the claimant's name and case file number.
- (7) Detail is provided for each line item of the bill.
- (8) EOB codes are shown for each line item or total bill that is denied.
- (9) An explanation of each EOB code is provided.
- (10) The RV will stipulate whether the bill is an original or an adjustment.
- (11) The remittance summary totals all bills covered under the RV with the total amount billed and the total amount paid for each category.

15. DO Edits. The majority of edits are handled by the DOT and MBPC Liaison process. However, two situations may require direct intervention by the CE or the DD.

a. Edit 391. This edit describes reimbursements that exceed \$50,000. The National Office (NO) will regularly forward a list of these high cost bills to the DD. These bills suspend for resolution of entitlement issues, if any, and DD authorization. Once the DD authorizes the payment, the bill is sent to the DOT who enters the data required to resolve the edit into the AchieveHCS system. The DD is required to keep a high-cost bill log in the DO for audit and accountability purposes.

(1) DD Designate. The DD may designate the Assistant District Director (ADD) or a Supervisory Claims Examiner (SCE) to authorize payments for reimbursement requests that exceed \$50,000. The DD Designate should also maintain the high-cost bill log for audit purposes.

b. Edit 487. Edit 487 is for short form closure (SFC) cases in which bills exceed the \$1500 limit and therefore suspend. iFECS generates a task for the responsible CE for each SFC case which has bills exceeding \$1500; the OQS2 reports can also generate a list of all such cases. CEs then have five (5) workdays to review the cases and either adjudicate or develop them before bills begin to deny. If a case is accepted within that time-frame, the bills recycle through the MBPC and pay or deny as appropriate. If the CE develops or denies a case, the bills are automatically denied. If no action is taken on a case within five (5) workdays, the case status "flips" to a UD status and the bills deny.

16. Exceptional Case Processing. Exceptional Case Processing is used when the DO decides that, although a service is not in the treatment suite for a specific case, they wish to have the service paid; or if the DO decides that a service/procedure should be paid in full and not reduced under the fee schedule. Exceptions in both instances must be authorized by the DD.

As with the Edit 391 cases described above, the DD may designate the ADD or a SCE to review and authorize the DD exceptions described below.

a. DD Exceptions: Treatment Suite Issues. If the DO needs to authorize a procedure/service that does not fall within the treatment suite for the accepted conditions in a specific case, the DO will do the following:

(1) The CE, through the SCE, will complete the DD Exception Memo, Treatment Suite (Exhibit 4). This memo must contain the case number, claimant's name, description of the procedure/service being authorized and procedure code(s), date or date range of service(s) to be covered, provider's name, provider number and provider contact information. It must also contain rationale for authorizing the procedure/service. The memo must contain an ending date for the exception (60 days from the date of the memo). The memo is then forwarded to the DD (or designate).

(2) The DD (or designate) reviews the request and either agrees with the proposed exception or requests additional rationale from the CE.

(3) If the DD (or designate) agrees with the proposed exception, he/she then e-mails the memo to NO staff, Myra Kingsland, Frances Ingram and Cheryl Bullock, with a copy to Peter Krah. The e-mail subject must be titled, "DD Exception Request - Treatment Suite - DO ____".

(4) NO staff will review the exception request, the accepted International Classification of Diseases (ICD) code(s) and the procedure/service code(s). If the ICD code is not consistent with the diagnosed condition shown in the medical evidence submitted with the requested procedure/service, NO staff will attempt to locate a more consistent ICD code. If another ICD code is found that will permit payment of the service, the exception request showing the recommended code will be returned to the DO. Before changing or adding an accepted condition and ICD code, the CE must review the case file to make certain that the recommended condition is supported by medical evidence. If the CE determines that an ICD code should be added or changed, the bill should be processed in the usual manner. NO staff will also review the billed CPT code to verify that it properly describes the procedure/service provided. If NO staff cannot

locate an ICD code permitting payment of the procedure/service (and appropriate for the case) and the procedure/service code billed is appropriate, they will forward the DD exception to the MBPC (with a copy to the initiating DO) for payment.

(5) The MBPC will enter the authorization into AchieveHCS and place the case on review along with appropriate notes in the AchieveHCS case file. The MBPC will issue an authorization letter for the procedure/service. They will instruct their Prior Authorizations, Customer Service Representatives and Bill Resolution staff to note this information to ensure that no denial statements for these authorizations are made and that bills for these procedures/services are not denied unless they are true duplicates. They will ensure the payment of these bills through the bill processing system. When actions are complete, the MBPC will send an e-mail response to all parties, including the DO that initiated the request.

b. DD Exceptions: Fee Schedule Issues. The fee schedule exception is used for specific procedure(s) or service(s) that require a DD override as full payment is being authorized with no reduction under the fee schedule. For fee schedule issues, the DO should do the following:

(1) The CE, through the SCE, will complete the DD Exception Memo, Fee Schedule (Exhibit 5). This memo must contain the case number, claimant's name, description of the procedure/service for which full payment is requested, procedure/service code(s), date or date range of service(s) to be covered, provider's name, provider number and provider contact information. It must also contain rationale for payment in full and must show an ending date for the exception (60 days from the date of the memo).

(2) The DD (or designate) reviews the request and either agrees with the proposed exception or requests additional rationale from the CE.

(3) If the DD (or designate) agrees with the exception, he/she then e-mails the memo directly to the MBPC with a copy to NO staff, Myra Kingsland, Frances Ingram, Cheryl Bullock and Peter Krah. The e-mail subject title must be "DD Exception Request - Fee Schedule - DO ____".

(4) The MBPC will enter the authorization into AchieveHCS, place the case on review for the listed procedure/service code(s) and enter Notes into the AchieveHCS system (including the authorization number for the services in question).

(5) The MBPC will instruct their Prior Authorizations, Customer Service Representatives and Bill Resolution staff to note this information and advise that payment will be made in full. The MBPC will ensure proper processing of the bills through the bill processing system. When actions are completed, the MBPC will send a response to all parties including the DO that initiated the request.

c. DD Exceptions: Authorizing Diagnostic Testing in UD Cases. On rare occasions, authorization for diagnostic testing may be needed before a case has been adjudicated. If the CE believes that a requested diagnostic procedure is necessary for adjudication of the claim, he/she may request that the DD approve the authorization.

- (1) The CE, through the SCE, will complete the DD Exception Memo, UD Diagnostic Authorization Request (Exhibit 6). This memo must contain the name and the provider number of the provider requesting the procedure; the name/description and CPT code of the requested procedure and the date or date range of the requested procedure. Additionally, the CE must include rationale for authorizing a diagnostic procedure for a case that has not yet been accepted. The memo is then forwarded to the DD (or designate).
- (2) The DD (or designate) reviews the request and either agrees with the proposed authorization or requests additional rationale from the CE.
- (3) If the DD (or designate) agrees with the proposed authorization, he/she then e-mails the memo to NO staff, Myra Kingsland, Frances Ingram, Cheryl Bullock and Peter Krah. The e-mail subject must be titled, "DD Exception Request - UD Diagnostic Authorization - DO ____".
- (4) NO staff will review the CPT code to verify that it properly describes the diagnostic procedure requested and is supported by the rationale provided. If the requested CPT is a valid diagnostic procedure, the exception request will be forwarded to the MBPC (with a copy to the initiating DO) for payment.
- (5) The MBPC will place the case on review, with appropriate notes in the AchieveHCS case file. The MBPC will instruct their Prior Authorizations, Customer Service Representatives and Bill Resolution staff to note this information to ensure that no denial statement for this authorization is made and that the bill for this diagnostic procedure is not denied unless it is a true duplicate. They will ensure the payment of the bill through the bill processing system. When actions are complete, the MBPC will send an e-mail response to all parties, including the DO who initiated the request.
- (6) Because the MBPC cannot issue an authorization letter in UD cases, the DO will issue the authorization letter for the requested diagnostic procedure, if necessary, after receiving the e-mail response from the MBPC.

17. Case on Review. "Case on Review" is used only for catastrophic cases. Catastrophic cases are defined as those that are life-threatening or have extensive functional deficits (such as head or spinal cord injuries or severe burns) where the medical recovery is expected to extend over long or indefinite periods of time. Those cases with multiple (more than 12) accepted conditions are also often catastrophic. Catastrophic cases should be rare and must be authorized by the DD or designate.

The procedures for placing a catastrophic case on review are as follows:

- a. The CE, through the SCE, should complete the DD Exception Memo, Catastrophic Case (Exhibit 7). This memo must contain the case number, claimant's name, accepted condition(s) and rationale for placing a case in catastrophic status. The memo must state specifically how bills are to be handled for the case. i.e. "force all treatment suite edits" or "pay all non-duplicates". There is no ending date for review with a catastrophic case but these cases must be regularly monitored by the CE for improvement and consideration of return to regular bill processing.

- b. The DD (or designate) reviews the request and either agrees with the proposed exception or requests additional rationale from the CE.
- c. If the DD (or designate) agrees to place the case on review, he/she then e-mails the memo to NO staff, Myra Kingsland, Frances Ingram and Cheryl Bullock, with a copy to Peter Krah. The e-mail subject must be "DD Exception Request - Catastrophic Case - DO ____".
- d. NO staff will forward the exception memo to the MBPC for processing. A copy of this e-mail will be sent to the DO that initiated the request.
- e. The MBPC will place the case on review and update the AchieveHCS system information by placing instructions on Screen 6. They will issue all authorization letters. The MBPC will instruct their Prior Authorizations, Customer Service Representatives and Bill Resolution staff to note this information and to ensure that no inappropriate denial statements are made for these cases and that bills for these cases are handled exactly as the DO instructs.

18. Provider on Review. A provider may be placed on review to ensure proper coding and/or billing. Examples of appropriate situations for "provider on review" would be if the provider has been consistently submitting bills with questionable coding, in cases where there is round-the-clock nursing care requiring complex billing or if the provider has unusual provider qualifications that would exempt him/her from the fee schedule (see paragraph 10, above). All of a provider's services may be placed on review or just specific procedure codes billed by that provider. If specific procedure codes are on review, all bills containing those codes will suspend.

Procedures for placing a provider on review are:

- a. The CE, through the SCE, completes the DD Exception Memo, Provider on Review (Exhibit 8). The memo must contain the case number, claimant name, description of the procedure code(s) on review (if for specific procedures or services), dates of services or service range (if any), provider name, provider number and provider contact information. Rationale for placing a provider on review must be included in the memo. An ending date is optional for provider on review. The memo must state that this request is "FECA specific".
- b. The DD (or designate) reviews the request and either agrees with the proposed exception or requests additional rationale from the CE.
- c. If the DD (or designate) agrees with the proposed exception, he/she e-mails the memo to NO staff, Myra Kingsland, Frances Ingram and Cheryl Bullock, with a copy to Peter Krah. The e-mail subject must be "DD Exception Request - Provider on Review - DO ____".
- d. NO may approve or deny the requested exception. If the request is denied, the form will be returned to the DD with the reason for the denial. If the request is approved, NO staff will forward the exception memo to the MBPC for processing. A copy of the e-mail will be sent to the DO that initiates the request.

e. The MBPC will place the provider on review. The MBPC will place all services or specific procedure codes billed by the provider on review, as specified by the DO. The MBPC will add Notes to the Achieve Provider File on screen 7 with the proper instructions. When actions are complete, MBPC will send a response to all parties, including the DO that initiated the request.

Exhibit 1: DO Adjustment Request Form:

ADJUSTMENT REQUEST FORM

Date:

To: MBPC Liaison

From: DO _____ Troubleshooter

Case Number:

Claimant:

TCN:

Description of Charges to be processed:

Date(s) of Service:

Provider Name:

Provider Number:

Provider Contact Information:

Exhibit 2: Letter to Provider Requesting Refund to Claimant:

File No.:

Claimant:

Date of Injury:

PROVIDER NAME

ADDRESS

CITY, STATE ZIP CODE

Dear

The Office of Workers' Compensation Programs (OWCP) administers the Federal Employees' Compensation Act (FECA) which provides workers' compensation coverage for civil employees of the United States. Under the provisions of the FECA, this Office authorizes payment to physicians and other persons for medical services to injured Federal employees. In cases where the injured employee has made payment directly to the medical provider, reimbursement for those medical services is made to the employee. In connection with payment for these services, this Office uses a schedule of maximum allowable medical charges.

Under current Federal regulations (Part 20, Sections 10.811, 10.813, and 10.815 of the Code of Federal Regulations), a provider whose fee for service is only partially paid because it exceeds the maximum allowable fee set under the schedule may not request reimbursement from the injured employee for any amount in excess of the maximum allowable charge. A provider who collects or attempts to collect from the injured employee, an amount in excess of the maximum allowable fee may be subject to exclusion from participation and payment under the Federal Employees' Compensation program. Such exclusion is reportable to all Federal employing agencies, the Health Care Financing Administration, and the state or local authority responsible for licensing or certifying the excluded provider.

The claimant identified above has made direct payment to you for the services described below in an amount in excess of the maximum allowable charge for those services.

CPT Code	Service Dates	Amount Paid	Maximum Fee	Amount Over Maximum Fee

In view of existing Federal regulations, and in order that the claimant not bear an expense which would not have otherwise occurred had payment been made to you directly by this Office, it is requested that you make refund to the claimant (or credit the claimant's account) in an amount equal to the amount over the maximum fees as shown above. It is also requested that such refund or credit be made within 60 days of the date of this letter.

If you choose, you may, within 30 days of the date of this letter, request a reevaluation of the allowable fee for the above services. The request should be made at no additional cost to the employee. The only circumstances which will justify reevaluation are (1) the procedure was incorrectly identified by CPT code, (2) the presence of a severe or concomitant medical condition made treatment especially difficult, or (3) the provider possesses unusual qualifications (Board certification in a medical specialty is not sufficient evidence in itself of unusual qualifications).

Any request for reevaluation of the allowable fee should be in writing and be accompanied by a copy of this letter and documentary evidence relevant to one or more of the circumstances described above (e.g., evidence of use of an incorrect CPT procedure code, a report showing a severe or concomitant medical condition and how that condition made treatment especially difficult or a copy of your curriculum vitae). The request should be sent to this office with the notation ATTENTION: FEE SCHEDULE APPEAL.

If it is determined that an additional amount is payable, such amount will be reimbursed directly to the employee.

If you wish to receive additional information concerning the schedule of maximum allowable medical charges, please do not hesitate to contact this office.

Your cooperation and prompt attention to this matter will be appreciated.

Sincerely,

NOTICE TO EMPLOYEE: Please advise this office if appropriate refund or credit is not made within 60 days. If we do not hear from you, we will assume the matter has been satisfactorily resolved.

Exhibit 3: Letter to Provider Requesting Termination of Collection Action/Refund of Excess Payment:

File No.:

Claimant:

Date of Injury:

PROVIDER NAME

ADDRESS

CITY, STATE ZIP CODE

Dear

The Office of Workers' Compensation Programs (OWCP) administers the Federal Employees' Compensation Act (FECA) which provides workers' compensation coverage for civil employees of the United States. Under the provisions of the FECA, this Office authorizes payment to physicians and other persons for medical services to injured Federal employees. In connection with payment for these services, this Office uses a schedule of maximum allowable medical charges.

The claimant identified above has notified this Office that you have initiated collection action or have collected an amount in excess of the maximum allowable charge paid by this Office. Under current Federal regulations (Part 20, Sections 10.811, 10.813, and 10.815 of the Code of Federal Regulations), a provider whose fee for service is only partially paid because it exceeds the maximum allowable fee set under the schedule may not request reimbursement from the injured employee for any amount in excess of the maximum allowable charge. A provider who collects or attempts to collect from the injured employee an amount in excess of the maximum allowable fee may be subject to exclusion from participation and payment under the Federal Employees' Compensation program. Such exclusion is reportable to all Federal employing agencies, the Health Care Financing Administration, and the state or local authority responsible for licensing or certifying the excluded provider.

In view of existing Federal regulations, it is requested that you cease all collection actions initiated or make refund to the claimant (or credit the claimant's account) the excess amount already collected. It is also requested that you cease collection action or refund/credit be made within 60 days of the date of this letter.

If you choose, you may, within 30 days of the date of this letter, request a reevaluation of the allowable fee for the above services. The request should be made at no additional cost to the employee. The only circumstances which will justify reevaluation are (1) the procedure was incorrectly identified by CPT code, (2) the presence of a severe or concomitant medical condition made treatment especially difficult, or (3) the provider possesses unusual qualifications (Board certification in a medical specialty is not sufficient evidence in itself of unusual qualifications).

Any request for reevaluation of the allowable fee should be in writing, and be accompanied by a copy of this letter and documentary evidence relevant to one or more of the circumstances described above (e.g., evidence of use of an incorrect CPT procedure code, a report showing a severe or concomitant medical condition and how that condition made treatment especially difficult, or a copy of your curriculum vitae). The request should be sent to this office with the notation ATTENTION: FEE SCHEDULE APPEAL.

If you wish to receive additional information concerning the schedule of maximum allowable medical charges, please do not hesitate to contact this office.

Your cooperation and prompt attention to this matter will be appreciated.

Sincerely,

NOTICE TO EMPLOYEE: Please advise this office if appropriate refund or credit is not made or collection activity has not ceased within 60 days. If we do not hear from you, we will assume the matter has been satisfactorily resolved.

Exhibit 4: DD Exception Memo, Treatment Suite:

Date:

To:

District Director

From:

Supervisory Claims Examiner

RE:

District Director Exception, Treatment Suite Issues

Case

Number:

Claimant:

Accepted Condition(s) and ICD-9 codes:

The following procedure(s) or service(s) require District Director override as they are not included in the treatment suite for the accepted conditions:

Description:

Date(s) of Service:

Provider Name:

Provider Number:

Provider Contact Information:

Ending date for exception (required):

Rationale for Acceptance (required):

FOR DISTRICT DIRECTOR (or DD Designate) USE ONLY

----- I agree with the proposed exception. Memo attached to email sent to National Office.

----- I do not agree with the proposed exception, please provide additional rationale.

District Director

Exhibit 5: DD Exception Memo, Fee Schedule:

Date:

To:

District Director

From:

Supervisory Claims Examiner

RE:

District Director Exception, Fee Schedule

Case Number:

Claimant:

Accepted Condition(s) and ICD-9 codes:

The following procedure(s) or service(s) require District Director override to pay bill in full (no reduction under the fee schedule):

Description:

Date(s) of Service:

Provider Name:

Provider Number:

Provider Contact Information:

Ending date for exception (required):

Rationale for Acceptance (required):

FOR DISTRICT DIRECTOR (or DD Designate) USE ONLY

----- I agree with the proposed exception. Memo attached to email sent to National Office.

----- I do not agree with the proposed exception, please provide additional rationale.

District Director

Exhibit 6: DD Exception Memo, UD Diagnostic Authorization Request

Date:

To:

District Director

From:

Supervisory Claims Examiner

RE:

District Director Exception, UD Diagnostic Authorization Request

Case Number:

Claimant: _____

Name / Description of Requested Procedure:

CPT Code of Requested Procedure:

Date(s) of Service:

Provider Name:

Provider Number:

Provider Contact Information:

Rationale for authorization:

FOR DISTRICT DIRECTOR (or DD Designate) USE ONLY

---- I agree with the proposed authorization. Memo attached to email sent to National Office.

---- I do not agree with the proposed authorization; please provide additional rationale.

District Director

Exhibit 7: DD Exception Memo, Catastrophic Case:

Date:

Memo To:

From: District Director

Supervisory Claims Examiner

RE: District Director Exception, Catastrophic Case

Case Number:

Claimant:

Accepted Condition(s) and ICD-9 codes:

Reason(s) case is catastrophic:

Special bill processing instructions:

FOR DISTRICT DIRECTOR USE ONLY

---- I agree with the proposed exception. Memo attached to email sent to National Office.

---- I do not agree with the proposed exception, please provide additional rationale.

District Director

Exhibit 8: DD Exception Memo, Provider on Review:

Date:

Memo To:

From: District Director
RE: Supervisory Claims Examiner
Case District Director Exception, Provider on Review
Number:
Claimant: _____

Provider name:

Provider number:

Provider contact information:

THIS IS FECA SPECIFIC.

---- All services/procedures to be manually reviewed.

OR

---- Specific services/procedures to be manually reviewed. (If this option is checked, only the following procedure code(s) submitted for payment will suspend.)

Procedure code(s) at issue:

Description:

Date(s) of Service:

Rationale (required):

Ending date of exception:

FOR DISTRICT DIRECTOR USE ONLY

---- I agree with the proposed exception. Memo attached to email sent to National Office.

---- I do not agree with the proposed exception, please provide additional rationale.

District Director

Chapter 5-0203, BPS Codes

1. Purpose and Scope. The purpose of this Chapter is to provide a comprehensive guide to the various coding schemes which are relevant to the Bill Processing System.

2. Provider Types.

a. A Provider Type Code is assigned to each provider entered into the medical provider file (v46). The provider type codes are defined as follows:

A	Transportation (GTR)
B	Physician, not M.D. or D.O., or nurse under contract to the Office
C	Tuition
D	Dentist
F	Pharmacy
H	Hospital
I	Nursing Service
J	Assisted Reemployment
K	Transportation (not GTR)
L	Laboratory
M	Homemaker
N	Nursing Home
O	Other
P	Physician (M.D. or D.O.)
Q	Rehabilitation Maintenance
R	Chiropractor
S	Supplies
T	Therapist
U	Rehabilitation, Plan Development
V	Rehabilitation, Training
W	Rehabilitation, Placement
X	X-Ray
Y	Relocation

b. If a provider code on the provider file is incorrect the person designated as having responsibility for the provider file should be asked to make a change in the Provider Master File.

c. Bills for providers of types B, L, P, R, T and X must have procedure codes keyed for each line item. The procedure codes are used by the BPS to determine whether a particular service is payable for a certain accepted condition. In addition, charges for services coded with CPT-4 codes and some HCPCS codes are compared to the FEC medical fee schedule (see paragraph 4, below, for details on CPT-4 coding and the FECA PM 5-205 concerning the FEC medical fee schedule).

d. Outpatient hospital bills (provider type H) require itemized coding of services on both the bill and on the BPS. Outpatient hospital charges for physician's professional charges, physical therapy, laboratory, radiology, and pathology must be coded with CPT-4 codes. The FEC fee schedule is applied to these charges. All other outpatient services should be coded using RCCs (Revenue Center Codes). Inpatient hospital bills are coded with RCC 001 only.

e. Bills for other provider types are not subjected to the fee schedule, and therefore do not require medical coding on the BPS. If codes were supplied by the provider, they need not be keyed into BILL051. However, various types of procedure codes are valid for these other providers, and if present on the bill, they should be keyed in accordance with paragraph 5-201.d(24)(e).

f. An R after a provider type (such as PR, HR) is an indication that the record is for claimant reimbursement. The first character indicates the type of reimbursement. For example, provider type PR indicates a reimbursement to the claimant for a physician bill.

g. For provider types FR, KR, QR, and VR, there does not have to be a provider file record for the bill record, and no specific provider information is retained in the bill record.

h. Provider type Q (without an R) does not exist, because rehabilitation maintenance is by definition always reimbursement to the claimant.

i. Provider type AR does not exist, because GTR transportation is by definition a payment made directly to a transportation provider.

j. A single provider should not have multiple records on the provider file with different provider types. For instance, a radiologist should not be entered as both provider type P and provider type X.

3. Locator 4 Codes. The UB-82 and UB-92 forms have different areas on the form, which are known as locators. The fourth locator area (locator-4) designates the type of services performed, whether inpatient or outpatient. The BPS requires entry of a locator-4 code for all bills for the "H" provider type (hospital). The locator-4 code allows the system to determine whether the bill is for inpatient or outpatient services, and whether itemized procedure codes are required. A description of the locator-4 coding scheme is shown as Exhibit 1.

4. Procedure Codes.

a. Procedure codes should not generally be changed or added if invalid or missing. The BR has a certain amount of discretion in situations where it is obvious that an incorrect code has been used. However, the procedure code determines the amount payable for the service under the fee schedule. Using an incorrect procedure code can result in significant under- or overpayment. If it is necessary to change a code, the correct code should be written in colored pen and should be clearly recognizable as a change to the form by OWCP.

b. CPT Codes. The American Medical Association publishes a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians in its Physicians' Current Procedure Terminology, Fourth Edition. The identifying codes are generally referred to as "CPT codes" or "CPT-4 codes". This coding scheme is updated on a yearly basis. CPT codes consist of five numerics, and can be further modified by the addition of a modifier (see item i below).

c. HCPCS Codes. HCPCS is a coding system that describes physician and non-physician services and supplies. These codes supplement the CPT codes and contain physicians' services not included in CPT and non-physician services, such as ambulance, audiology, speech pathology, and such supplies as drugs, durable medical equipment, orthotics, prosthetics and others. The codes consist of five characters, the first being a letter, which is followed by four numbers.

d. Codes for medical examinations or case reviews requested by the district office should be as follows:

Case file review (by district medical adviser or consultant):	CNSLT
Second opinion examination, or other specially requested examination:	SECOP
Referee examination to resolve conflict:	IMPAR
Case file review (by district medical adviser or consultant) for back surgery:	SURB1
Second opinion clinical examination for back surgery:	SURB2
Case file review (by district medical adviser or consultant) for carpal tunnel surgery:	SURC1
Second opinion clinical examination for carpal tunnel surgery:	SURC2

Since all these services are covered under Prompt Payment, it is advisable for the district office to have the appropriate code entered on the numbered "Prompt Pay" HCFA-1500 which is sent to the physician. Consistent use of these codes enables the district office and the National Office to collect statistical information about the use of consultants and the cost of such services. The single code encompasses the entire exam, even if several line items would have been required if the bill had been CPT-4 coded.

e. Codes for chiropractic services should generally be limited to the following:

(1) Spinal manipulation (one area) - Use CPT code 97260. For additional areas (up to a maximum of two additional areas during visit), use CPT code 97261. HCPCS code A2000.

Note that cervical, thoracic, lumbosacral, etc., each represent one area.

(2) X-rays - Use the appropriate CPT code for radio-logic examination for the area of the spine and pelvis (see the 72000 CPT series).

(3) Office visits - Given the relatively narrow scope of coverage of reimbursable chiropractic services, some levels of service for office visits as defined by CPT are not reasonably applicable to chiropractic services. Therefore, the coding of office visits for chiropractic services should be limited to the following CPT codes: 99201 - New Patient, Brief Service; 99202 - New Patient, Limited Service; 99211 - Established Patient, Brief Service; 99212 - Established Patient, Limited Service

If services other than those shown above have been prescribed by a qualified physician (an M.D. or D.O.), consideration must be given to whether the services are likely to cure, give relief, reduce the degree or period of disability, or aid in lessening the amount of monthly compensation. These additional services are usually physical therapy types of treatment.

f. RCC Codes. Revenue Cost Center (RCC) Codes are used by hospitals and other providers which bill on the UB-92 form. These codes consist of three numbers, and vary as to their specificity. A listing of RCC codes may be found in the OWCP Medical Fee Schedule. Certain RCC codes for outpatient laboratory, pathology, physician professional, radiology and physical therapy services are not valid in the BPS. These services must be coded using CPT or HCPCS codes. A listing of the invalid RCC codes is also found in the OWCP medical fee schedule. In DFEC, the RCC code of 001 (total) is always keyed for bills for inpatient services. Outpatient services must be keyed using itemized codes.

g. Dental Codes. The American Dental Association (ADA) has developed its own coding scheme. ADA codes resemble CPT codes, in that they consist of five numbers, however, the codes all begin with the number 0, and range from 00110 to 09999. Very few ADA codes are identical to CPT codes. Although dental codes are not required on the DFEC system, and dental services are not subjected to the fee schedule, if the codes are present on a bill, they should be keyed.

h. Nurse and Other DOL Codes. DFEC has developed a series of codes to be used for various specially authorized services. These services are generally subject to the provisions of the Prompt Payment Act. In addition, a few other codes were developed for administrative purposes, and are not subject to the Prompt Payment Act. The DFEC-developed codes are shown in Exhibit 2.

i. Procedure code modifiers. CPT codes may be modified under certain circumstances. The modifiers generally consist of two numerics, or an alpha and a numeric. Different modifiers are valid for different groupings of CPT codes. Modifiers valid for specific groups of CPT codes are listed and described in the "Guidelines" section which precedes each grouping in the CPT coding book. In addition to the modifiers recognized by the AMA, DFEC has designated the following modifiers:

(1) A - appended to a surgical procedure code when used to bill anaesthesia for the surgery;

(2) B - used to denote a combination of modifiers 50 (bilateral procedure) and either 80 (assistant surgeon), 81 (minimum assistant surgeon), or 82 (assistant surgeon when qualified resident surgeon not available); and

(3) TC - appended to a procedure which involves both a technical and professional component; indicates that the charges are for the technical component only.

5. Bypass Codes.

a. The Central bill processing system and the BPS edit program (BILL552) contain various checks to prevent duplicate payments or incorrect adjustments.

b. A record type B line item is considered to be a duplicate or possible duplicate of another line item when the case file number, payee identification number (9-digit EIN or SSN), and procedure codes (all 8 digits, including base code, modifiers, and fee schedule appeal code) are the same, and the dates of service are the same or overlap. With respect to procedure codes, a blank procedure code acts as a "wild card"; that is, it matches both an actual procedure and a blank procedure code. Thus two B records with matching payee identification numbers, case file numbers, dates of service, and with a procedure code on one record and no procedure code on the other will be considered duplicate. Two records with matching case file numbers, payee identification number, dates of service, and no procedure code on either record will also be considered duplicate.

c. If the potential duplicates are contained within the same bill, in other words, two separate charges for the same procedure code and dates of service are on one bill, the system does not consider them to be duplicates.

d. Duplicate checking on bills being processed for payment (record type B) is done at the district office Sequent level as part of the BILL552 edit program. These duplicate checks are done using the same table of information which is used to display on-line BPS history. The edit program does not perform duplicate checking against same-day input. However, the Central System duplicate checking is performed on a weekly basis, and takes both weekly bill input and history into consideration. For provider types FR, KR, and QR, Sequent (district office) and Central System duplicate checking is done against history only.

e. Record type B line items which are considered to be potential duplicates will either fail BILL552 edits, or be rejected by the Central processing system. If a record which appears to be a duplicate is to be paid, an appropriate bypass code must be used.

f. Bypass codes for record type B are:

1 - required whenever a B record type line item appears to be a duplicate or a possible duplicate when compared to other bill input of any record type. Input is considered by the Central system to be any line processed in the same weekly billing cycle (usually Tuesday through Monday). If two "duplicate input" lines are to be processed through to payment by Central, at least one of the lines must have a bypass code 1. If three "duplicate input" lines are being processed for payment, and only one line is given a bypass code 1, only that line will be paid, and the other two lines will drop in Central processing. If any number of "duplicate input" lines exist, and none of the lines have bypass codes, all the lines will drop in Central processing.

2 - required whenever a B record type line item appears to be a duplicate or possible duplicate when compared to other bill history. History is considered by the Central system to be any line processed in a previous weekly billing cycle. In the district offices, paid history will appear in the on-line history as a payment with a check date. Paid history which predates the d10 purge date on the system and postdates the Central System purge date is available from Central by requesting an overnight or Friday history. To obtain history that predates the Central System purge date, a Friday history must be requested. To pay a line which is a duplicate against history, a bypass code 2 is needed. Without the bypass code, the payment will drop in weekly processing.

3 - required whenever a B record type line item appears to be a duplicate or possible duplicate when compared to both input and history, as defined above.

g. BILL002, Resubmit Duplicate Bill, is an option on the FECS001 Bill Payment menu which may be used to enter bypass codes on records which have dropped from the weekly processing because a bypass code is needed.

h. For maintenance adjustments, bypass codes have a different meaning. No maintenance adjustments use procedure codes. For manual payments (record type M), bypass codes 1, 2, and 3 are used in the same circumstances as for B record types, where the case file number and payee identification number match and the dates of service match or overlap another record.

However, for other maintenance adjustments (record types C and D), bypass codes 4, 5, and 6 are used. Record types C and D are used to cancel out previous payments. If a record type C or D line is being entered which has the same case file number, payee identification number, and dates of service (including year) as a previously paid item, and there is no duplicate input within the current processing cycle, no bypass code is needed. For record types C and D, bypass codes are used under the following circumstances:

4 - required when entering a record type C or D line which has the same case file number, payee identification number, and service year (but not service dates) as a previously paid item, and there is no duplicate input within the current processing cycle.

5 - required to enter a record type C or D line if the case file number, payee identification number, and service year (not dates) match an item already paid AND an item being processed in the same weekly billing cycle.

6 - required to enter a code C or D line if the previously paid item has been purged from the active Central history. No duplicate input within the same weekly cycle is allowed.

i. To avoid overpayments, bypass codes 1, 2, and 3 should be used correctly and only when appropriate.

j. Bypass code 9 may appear on Central BPS histories. Bypass code 9 is assigned by the system under certain circumstances involving same-bill duplicate input. A bypass code 9 cannot be entered by the district offices. If a bypass code 9 appears on a bill payment report, the bill record was processed by the district office without a bypass code.

6. Ineligible Amount Codes. Ineligible amounts are portions of line item charges which are not payable. The difference between the charge amount and the ineligible amount must be more than \$1.00. If a portion of a line item charge is not payable, the ineligible dollar amount and the ineligible code should be written next to the charge amount. The bill total must be adjusted to deduct the ineligible amount. For example, if a travel voucher for a total of \$50.00 includes \$10.00 worth of charges which are not payable, the bill could be processed with line charge of \$50.00, ineligible amount of \$10.00, ineligible amount code of H, and bill total of \$40.00. The ineligible amount codes are as follows:

Drugs not identified	A
Non-reimbursable drugs	B
Partial payment previously made	C
Charges for other than claimant	D
Private room differential	E
Personal comfort charges deducted	F
Previous balance not itemized	G
Disallowed travel expenses	H
Allowable fee exceeded	I
Services unrelated to injury	J
Explanatory letter to follow	K
State tax disallowed	L
Drug charge reduced by contractor	M
Previously paid based on fee schedule limit	N

Ineligible amounts and messages associated with the ineligible amount code will appear on the payment statement issued with the bill payment check.

7. Maintenance Type Codes. Maintenance transactions must be performed using BILL052 or BILL053 for manual payments, check cancellations, cash deposits, and fund transfers. The maintenance programs require entry of a maintenance type code, which are as follows:

Manual Payment	M
Cancelled Check	C
Cash Deposit	D
Fund Transfer	F

If a maintenance adjustment is used to correct an error in a previous adjustment, the address field should be used to refer to the erroneous entry by type and date.

8. Fee Schedule Appeal Codes. Mark the appeal reason code on the bill immediately after the CPT-4 code. The appeal reason codes are entered as the eighth character of the procedure code field. The codes and their definitions are as follows:

- B - Use where the fee schedule function is to be bypassed in connection with the payment of a given line item. This code would be used, for example, to make continuing payment for certain services to a provider who the district office has determined should not be subject to the fee schedule because of his or her unusual qualifications. This code is not to be confused with and does not in any way replace existing duplicate edit bypass codes.
- 1 - Use this code in cases where the appeal was based on the use of an incorrect CPT code. Appeal decision level: District Director [DD] (or Assistant District Director [ADD]).
- 2 - Use this code in cases where the appeal was based on the presence of a severe or concomitant medical condition making medical treatment especially difficult. Appeal decision level: DD (or ADD).
- 3 - Use this code in cases where the appeal was based on unusual provider qualifications. Appeal decision level: DD (or ADD). (This code would be used in connection with a specific appeal. If the district office determines that the unusual qualifications of the provider warrant nonapplication of the fee schedule on a continuing basis for a certain service or procedure, code "B" would be appropriate for subsequent billings.)
- 4 - Same as 1, except the appeal decision level is the Regional Director [RD] (or DD).
- 5 - Same as 2, except the appeal decision level is the RD (or DD).
- 6 - Same as 3, except the appeal decision level is the RD (or DD).
- 7 - Error identified and corrected without formal appeal.

9. Bill Status Codes. The BPS uses several one-letter codes. These codes may be viewed in either the suspense resolution or suspended bill query programs, at either the bill header or line item level. Note that header status takes precedence over line status. The codes and their meanings are as follows:

- C - Continue; bill or line item has been allowed for payment.
- S - Suspend; bill or line item has suspended for manual review.
- D - Deny; bill or line item has been denied.
- N - New; bill or line item has been keyed, and the bill batch in which it was keyed has been closed, but the bill has not yet been edited by the BILL552 program.
- K - Keyed; bill or line item has been keyed, but the batch in which it was keyed has not been closed, and the bill has not yet been edited by the BILL552 program.
- R - Recycled; bill has been worked and set to recycle through the BILL552 edit program, or has been automatically set to recycle by BILL505.
- I - Internal Denial; bill has been marked for deletion because it is to be rekeyed, or should never have been keyed in the first place.

10. ICD-9 Codes. Claims Examiners are required to enter ICD-9 (International Classification of Diseases, 9th Revision) codes on the system for all accepted conditions. The BPS relies on the accepted ICD-9 codes on the system to determine which services are payable. As accepted conditions are amended or additional conditions are accepted on a case, the ICD-9 codes are supposed to be updated. Up to six ICD-9 codes may be entered on an individual case. Special one-character identifiers are used to give more specificity to a particular ICD-9 code. These identifiers are unique to the FECA system and are as follows:

R	Right
L	Left
B	Both
A	Aggravation
D	Denied

The identifiers are entered in the sixth position of the six-character ICD-9 code field. In addition, ICD-9 code procedures may also be entered on the system. These are found in Volume 3 of the ICD-9 coding manual. On the system, the ICD-9 procedure codes will have a P in the first position.

11. EOB/Edit Codes. Explanation of Benefits (EOB) Codes correlate with the Edit Number Codes, except that not every edit has a related EOB message. Exhibit 1 in Chapter 5-0205 shows all of the EOB messages. All EOB/Edit Code numbers consist of three numbers. Any code of 900 and above is referred to as an "alternate EOB". Edit Codes may be seen in the suspense resolution and suspended bill query programs. EOB codes are seen in the On-line BPS History program. A separate job aid gives detailed edit information.

Exhibit 1: Locator 4 Codes

LOCATOR 4 CODES

Locator 4 codes are used by several Federal programs. Locator 4 codes consist of three numeric digits. Each digit has its own significance. The first digit indicates the type of facility:

1	Hospital
2	Skilled Nursing
3	Home Health
4	Christian Science (Hospital)
5	Christian Science (Extended Care)
6	Intermediate Care
7	Clinic
8	Special Facility
9	Reserved for National Assignment

The second digit indicates the bill classification. The classification codes are as follows (except for clinics and special facilities):

- 1 Inpatient (Including Medicare Part A)
- 2 Inpatient (Medicare Part B only)
- 3 Outpatient
- 4 Other (for hospital referenced diagnostic services, or home health not under a plan of treatment)
- 5 Intermediate Care - Level I
- 6 Intermediate Care - Level II
- 7 Intermediate Care - Level III
- 8 Swing Beds
- 9 Reserved for National Assignment

The second digits for clinics are:

- 1 Rural Health
- 2 Hospital Based or Independent Renal Dialysis Center
- 3 Free Standing
- 4 Outpatient Rehabilitation Facility (ORF)
- 5 Comprehensive Outpatient Rehabilitation Facility (CORF)
- 6-8 Reserved for National Assignment
- 9 Other

The second digits for special facilities are:

- 1 Hospice (non-hospital based)
- 2 Hospice (hospital based)
- 3 Ambulatory Surgery Center
- 4 Free Standing Birthing Center
- 5 Rural Primary Care Hospital
- 6-8 Reserved for National Assignment
- 9 Other

The third digit indicates frequency, as follows:

- 0 Non-Payment/Zero Claim
- 1 Admit through Discharge Claim
- 2 Interim - First Claim
- 3 Interim - Continuing Claim
- 4 Interim - Last Claim
- 5 Late Charge(s) Only Claim
- 6 Adjustment of Prior Claim
- 7 Replacement of Prior Claim
- 8 Void/Cancel of Prior Claim
- 9 Reserved for National Assignment

The definitions for frequency are as follows:

Non-Payment/Zero Claim (0) - This code is to be used when a bill is submitted to a payer, but the provider does not anticipate a payment as a result of submitting the bill; but needs to inform the payer of the non-reimbursable periods of confinement or termination of care.

Admit Through Discharge Claim (1) - This code is to be used for a bill which is expected to be the only bill to be received for a course of treatment or inpatient confinement. This will include bills representing a total confinement or a course of treatment, and bills which represent an entire benefit period of the primary third party payer.

Interim - First Claim (2) - This code is to be used for the first of a series of bills to the same third party payer for the same confinement or course of treatment.

Interim - Continuing Claim (3) - This code is to be used when a bill for the same confinement or course of treatment has previously been submitted and it is expected that further bills for the same confinement or course of treatment will be submitted.

Interim - Last Claim (4) - This code is to be used for the last of a series of bills, for which payment is expected, to the same third party payer for the same confinement or course of treatment. It is not intended to be used in lieu of a code for Late Charges, Adjustments, or Zero/Non-Payment Claims.

Late Charge(s) Only (5) - This code is to be used for submitting charges to the payer which were received by the provider after the Admit Through Discharge or the Last Interim Claim has been submitted. It is not intended to be used in lieu of an Adjustment Claim or a Replacement Claim.

Adjustment of Prior Claim (6) - This code is to be used when a specific bill has been issued for a specific Provider, Patient, Payer, Insured and "Statement Covers Period" date and the reimbursement amount is to be recalculated through an increase or decrease in charges, per diem calculations, deductibles, co-insurance, and/or prior third party payments. To properly adjust a prior bill, the respective plus or minus adjustment must be provided, along with the net overall change and the new reimbursement amount.

Replacement of Prior Claim (7) - This code is to be used when a specific bill has been issued for a Provider, Patient, Payer, Insured and "Statement Covers Period" and it needs to be restated in its entirety, except for the same identity information. In using this code, the payer is to operate on the principle that the original bill is null and void, and that the information present on this bill represents a complete replacement of the previously issued bill. This code is not intended to be used in lieu of a Late Charge(s) Only claim.

Void/Cancel of Prior Claim (8) - This code reflects the elimination in its entirety of a previously submitted bill for a specific Provider, Patient, Payer, Insured and "Statement Covers Period" dates. The provider may wish to follow a Void Bill with a bill containing the correct information when a Payer is unable to process a Replacement to a Prior Claim. The appropriate Frequency Code must be used when submitting the new bill.

Exhibit 2: DFEC-Developed Procedure Codes

CODE	DEFINITION	PROMPT PAY?
ACUPU	Acupuncture	No
ATTMD	Attending Physician Medical Report Request	No
AUTHO	Payment Authorized (No fee schedule)	No
NCAA1	Nurse Intervention; Claimant Advocate (Administrative Services or Working/Not Working Call) -15 minutes	Yes
NCAA2	Nurse Intervention; Claimant Advocate (Administrative Services or Working/Not Working Call) -30 minutes	Yes
NCA00	Nurse Intervention; Claimant Advocate (Professional Services) -30 minutes	Yes
NCA01	Nurse Intervention; Claimant Advocate (Professional Services) -1 hour	Yes
NCA02	Nurse Intervention; Claimant Advocate (Professional Services) -2 hours	Yes
NIA00	Nurse Intervention; Administrative Services - less than 1 hour	Yes
NIA01	Nurse Intervention; Administrative Services - 1 hour	Yes
NIP00	Nurse Intervention; Professional Services - less than 1 hour	Yes
NIP01	Nurse Intervention; Professional Services - 1 hour	Yes
NITRA	Nurse Intervention; Travel	Yes
NIPTC	Nurse Intervention; Phone Calls	Yes
SURB1	Case File Review by DMA or Office Consultant (Back Surgery)	Yes
SURB2	Second Opinion Clinical Examination (Back Surgery)	Yes
SURC1	Case File Review by DMA (Carpal Tunnel Surgery)	Yes
SURC2	Second Opinion Clinical Examination (Carpal Tunnel Surgery)	Yes
TAXES	Hawaii Excise Tax	No
SECOP	Second Opinion Medical Examination	Yes
IMPAR	Impartial Medical Examination	Yes
CNSLT	Case File Review by District Medical Consultant	Yes

Chapter 5-0204, Principles of Bill Adjudication

1. Purpose and Scope. This chapter describes the rules and principles which underlie bill adjudication.

2. Reviewing Medical Evidence. The BR may need to determine whether the diagnosis on the bill matches the condition which OWCP accepts, and the diagnosis on the medical report; whether the treatment is reasonably related to the diagnosis; whether the dates of treatment in the medical report match the dates of service on the billing form; and whether the amount and period of treatment are within reason.

a. A completed form CA-16 obligates OWCP to pay for any injury-related treatment performed by the physician or medical facility identified in Part A. The BR should look at the reported condition in the system or on the CA-1, Notice of Injury, to determine whether the treatment is reasonably related to the accident for which the CA-16 was issued. A description of the injury may also be found in Box 5, Part A of CA-16.

b. If the treatment occurred more than 60 days from the date of injury, and authorization was not explicitly extended in a letter or telephone message to the provider, the bill should be treated as if no CA-16 had been issued, and reviewed in connection with the accepted condition and information in the medical reports.

3. Hospital Treatment. No inpatient hospital bill should be paid unless the hospital discharge summary, or hospital record if the claimant is not yet discharged, is present in the case file. Alternate EOB 901 may be used to request these. The discharge summary will give a final diagnosis, dates of hospitalization, and will describe the course of treatment while in the hospital. It may be necessary to refer to the treating physician's report as well to evaluate the bill.

The BR should be alert for any pre-existing conditions which may be treated while the claimant is hospitalized for the work injury. If the hospital record or physician's summary show that a personal condition was treated, the BR should ask the hospital to separate out the charges for this treatment and refer them to the claimant for payment. The BR should approve only charges related to the accepted condition.

4. Discounts on Hospital Bills.

a. Some hospitals offer discounts for prompt payment of their medical bills. Since a fee schedule is applied to most outpatient hospital bills, no discount will be applied to outpatient bills. However, for inpatient bills, if a discount is offered on the bill itself or an attachment, a discount should be considered.

b. All inpatient hospital bills fail BILL552 edit 002. When a bill fails this edit, in addition to considering other pertinent issues, the resolver should determine whether a discount is offered.

c. If a discount is offered, the amount is specified, and the bill will be paid within the period of time indicated by the provider, the resolver should:

(1) Calculate the amount of the discounted bill;

(2) Note the discounted amount on the bill itself;

(3) Adjust the bill total and line item charge through bill resolution to equal the discounted amount.

d. When considering whether a bill will be paid timely, the resolver must take the bill payment cycles and check dates into consideration.

e. If the amount of the discount is not specified, the office will pursue the matter further.

f. If a provider whose payment has been discounted later objects to the reduction, a written explanation of the reduction should be provided. If the provider continues to object to the discount, an additional payment equal to the amount of the reduction should be processed.

g. Discounts should be applied only to those charges which would have been reimbursable under the FECA. For example, charges for a private room are usually reduced to the amount for a semi-private room unless the attending physician prescribes a private room. Charges for television are generally not reimbursable.

h. If the method of computing a discount is not obvious from reviewing the bill, a short memorandum should be placed in the case file or attached to the bill, explaining the computation. This would include situations in which the amount of the discount was negotiated with the provider.

5. Prescription Drugs. Physicians should list in their reports the names of drugs prescribed for the patient. Bills for prescription drugs should contain the names and amounts of the drugs, and the name of the prescribing physician. The BR may consult the Physicians' Desk Reference to determine whether a specific drug is being prescribed for the accepted condition. If drugs cannot be verified in this manner, the BR should prepare a brief memorandum to the District Medical Adviser asking for an opinion as to whether the drugs are appropriate for the accepted condition.

6. Submission of Bills for Reimbursement and Third Party Payment.

a. When the claimant has paid a provider for a service performed for a work-related injury, the claimant may request reimbursement by submitting a completed HCFA-1500 signed by the physician, with the amount of payment entered in Block 28, and a statement as to who made the payment. The claimant must sign the bill at item 12 and all information must be present. Hospital bills must be stamped "paid" or otherwise certified to show that payment has been received. A copy of the canceled check should be submitted to support reimbursement of amounts over \$500.

b. Bills and receipts which do not appear on printed stationery or billhead must show the full signature of the person issuing the receipt and indicate the capacity in which the payee was represented. Bills that have been prepared on bookkeeping machines (not typewriters) showing debits and credits will be acceptable if the charges may be properly identified and if the cash credits are shown. Such billings, of course, must identify the injured employee as the person for whom the service or supply was furnished. (Billings of this sort prepared on a typewriter are not acceptable as they are obviously only copies of the original billings.)

c. Cash sales receipts that bear imprints of mechanical cash registers may also be accepted if the nature of sale can be identified and the record supports the purchase of an item which may be paid for by OWCP.

d. Photocopies of the canceled checks may also be accepted in lieu of receipts but must be accompanied by itemized bills or other acceptable evidence of the charge for which payment was made.

e. Prescription receipts must include the name of the drug, the prescribing physician, the amount of medication, and the date.

f. In occupational disease cases, a claimant may have incurred and paid medical expenses for some time before filing a claim and being notified that HCFA-1500 or OWCP-1500a is required. The claimant may thus be entitled to reimbursement for these expenses but not have adequate information to support the request. In such cases the office should assist the claimant to obtain completed standard billing forms or, where this is extremely difficult, to obtain adequate information to support payment.

g. Insurance carriers may learn after having made payment on a claim that it was a workers' compensation claim. They should submit a completed HCFA-1500 or facsimile listing procedures, charges, and paid amounts for each individual provider (including tax identification number), and should attach signed certification of the payments made by the insurance company. The National Association of Letter Carriers Health Benefit Plan uses Form NALC-200 to request reimbursement, which when signed by the carrier's representative, requires no further verification of payment. Any third party payee, such as a health insurance company, must be entered in the Provider Master File, using the corporate Tax Identification Number for payment to be made.

Since the BPS edits do not block duplicate payments to two different "providers," the bill payment history must be checked carefully before the BR authorizes payment. Insurance carriers are generally entered as provider type O on the system, so that their claims are not subjected to the fee schedule. However, insurance companies should not be confused with third party billers, such as managed care groups. These providers should be entered as a provider type which is appropriate for the type of services being provided.

7. Appliances, Supplies, and Dental Treatment.

a. Major Appliances. Prior authority is to be obtained from the OWCP for the purchase of major orthopedic or prosthetic appliances. A claim for payment of such an item should be approved without question if the claim is submitted on the AMA standard form and if the item was supplied in accordance with the terms of a prior authorization. If the item was supplied without the OWCP's prior authorization, the BR shall determine whether the appliance was necessary for the proper management of the injury and whether the charges are reasonable. (Assistance from the District Medical Adviser may be indicated in some cases.)

b. Minor Appliances. Prior authorization from the OWCP is not expected in the case of minor appliances such as a truss, a sacroiliac belt, an ankle strap, or items such as crutches and canes. Reasonable charges for these items may be approved if they were prescribed by the attending physician or the injury was such that the items were necessary for its proper management.

c. Dental work should be performed only if authorized by OWCP unless the work is rendered by or upon order of a United States dental officer or United States medical establishment. A claim for payment of such services should be approved if the claim is in proper form and if the services were performed in accordance with the terms of the prior authorization.

Charges for unauthorized dental work may be approved for payment if the work performed was in the nature of emergency care or it is shown that the injured employee and attending physician were unaware of the need for prior authorization from the OWCP. In this case, the BR should determine whether the work performed was needed because of the injury and whether the charges are reasonable. In some instances the advice of a District Medical Adviser will be necessary. The same procedure is to be followed with respect to furnishing artificial dentures.

d. The FECA 1974 Amendments allowed the destruction or damage of certain appliances to be considered as an injury under the Act. Therefore, if a medical brace, artificial limb, or other prosthetic device is damaged or destroyed on the job, the employee may file a CA-1 for a traumatic injury. The injured employee will be entitled to have the appliance replaced or repaired and will be entitled to continuation of pay (COP) during repair or replacement.

e. Eyeglasses and hearing aids may be repaired or replaced if they were damaged or lost incident to a personal injury for which the claimant required medical treatment. Thus, if the claimant stumbles and breaks his or her glasses but is not otherwise injured and requires no other treatment, replacement of glasses may not be authorized under FECA.

f. It is the responsibility of OWCP to maintain and replace orthopedic or prosthetic appliances that are initially furnished to an injured employee as part of the medical care of a compensable injury. Such repairs and replacements should be rendered upon recommendation of a qualified physician, and OWCP must give prior authorization unless the amount is under \$500. However, there may be certain exceptions, notably if the artificial appliance is essential for the employee to work without interruption.

8. Travel.

a. 20 C.F.R. 10.412 provides in part as follows:

Where the means of transportation is not furnished by the Government, a claim for reimbursement of the cost of necessary transportation and of necessary incidental expenses incurred by an injured employee who has been authorized to travel for the purpose of securing medical or hospital treatment, appliances or supplies or for medical examinations, may be submitted promptly to the OWCP for consideration. Standard Form 1012 properly executed shall be used for this purpose. Where transportation by automobile is furnished by an employee of the United States or by a relative of the injured employee, reimbursement may be made at the rate per mile fixed by law, Executive, administrative, or other order for employees of the United States authorized to travel at Government expense.

b. Rates fixed by law and payable for the use of privately-owned vehicles are periodically announced by means of FECA Bulletins. Consult the latest FECA Bulletin to determine the currently prevailing authorized rate. The latest FECA Bulletin is to be filed in front of this chapter.

c. The BRs should be familiar with the contents of Form CA-77, "Instructions for Submitting Travel Voucher." This form carries the OWCP's instructions for claiming reimbursement of travel expense and should accompany any Standard Form 1012 that may be sent to a beneficiary. Most questions about travel expense will be answered in the Form CA-77. Other questions that may arise may be disposed of by consulting the applicable provisions of the Standardized Government Travel Regulations.

d. Travel expense incurred to secure treatment as defined by 5 U.S.C. 8103 is reimbursable irrespective of prior authority. Generally, the injured person may be reimbursed for travel expense if the OWCP approves payment of the medical treatment which necessitated the travel. The one exception to this rule is where the OWCP pays for medical care but not for travel expense. This would occur in situations where the employee, for personal reasons, did not obtain medical care at the nearest available source consistent with the requirements of the FECA and regulations. In the case of examinations provided by 5 U.S.C. 8123 travel expense may be allowed if the examinations were authorized by an official superior with full expectation that such examination would have otherwise been authorized by the OWCP.

e. Injured employees are expected to travel by public transportation wherever its use is practical. When examination or treatment is authorized outside the injured employee's home city, taxi service may be used:

(1) From the employee's home to the place where public transportation is obtained to travel to the distant city;

(2) From that place to the hospital or doctor's office;

(3) From the hospital or doctor's office to the place where public transportation is obtained to return to the home city; and

(4) From that place to the employee's home.

The actual taxi fares may be allowed plus tips of 15 percent; if the 15 percent is not a multiple of 5, it may be allowed for the next multiple of 5. No receipts are necessary for these charges, unless the fare exceeds \$20. However, the BR may insist upon the submission of proper receipts if the amounts claimed appear to be excessive.

f. Reimbursement for the hire of special transportation (including taxis) may be approved only:

(1) If no other means of transportation is available or its use is impractical; or

(2) Where the injured employee has a disability which prevents the use of public transportation.

Charges for special transportation which are necessary because of the traveler's disability may be justified by this statement: "Special conveyance necessary due to physical condition of injured employee." The BR should write this statement on the voucher and sign it.

To be approved, charges for special transportation used under other circumstances must be supported by an appropriate statement. This may be added by the BR and the charge may be approved by the BR if satisfied from the evidence that the use of the special conveyance was necessary or in the best interest of the Government.

g. Transportation Requests. When treatment or examination is authorized by the OWCP it is sometimes necessary to furnish the injured employee with Government Requests for Transportation so that the necessary travel may be made by common carrier at no expense to the traveler.

When considering a travel voucher which includes items of transportation (not travel in the nearby area), the BR must first determine whether Transportation Requests (TRs) were issued and, if so, what disposition has been made of them. If they have been returned with the travel bill, they should be marked "Canceled" and routed for proper disposition. The copy of letter forwarding the TRs to the beneficiary should be annotated to show that the TRs have been returned and canceled. The BR should then proceed with the audit of the bill.

If the TRs have not been returned and canceled, the BR must request their return or determine what happened to them. Consideration of such a bill must be held in abeyance pending clarification as to the use or disposition of the Transportation Requests. This is of utmost importance because the OWCP is responsible for the payment of the transportation furnished even though the travel may have been made by unauthorized persons or for unauthorized purposes.

h. Actual expenses. All other items incident to the travel will be reimbursed on actual expense basis. There may be no per diem allowance in lieu of subsistence expenses. Receipts are

required, whenever it is practicable to obtain them, in support of a claim for any incidental item (such as meals, lodging, hiring of special conveyance, etc.) where the amount exceeds \$25 and for the purchase of gas and oil when reimbursement is claimed on an actual expense basis in lieu of a mileage basis. Inasmuch as most injured employees have little occasion to travel at Government expense it is to be expected that there will be no available receipts. In such cases the BR should use discretion and give the employee benefit of doubt.

i. Government travel regulations state that employees traveling on official business "are expected to exercise the same care in incurring expenses that a prudent person would exercise if traveling on personal business." The BR should not approve claims for amounts which appear to be excessive. This is particularly true when the amounts claimed are not supported by proper receipts. The traveler may or may not be requested to submit an explanation for charges that appear excessive.

In some cases it will be proper for the BR to reduce the charges and allow such sums as appear reasonable under the circumstances. The BR's action in any particular case will be guided by the existing facts. No maximum allowable amounts have been established for meals and lodging because of the variety of conditions involved. Such costs will in some measure be controlled by geographical location.

j. Time Frame for Meals. With respect to allowance for meals, a traveler may be allowed reimbursement for breakfast when the time of departure is prior to 8:00 A.M. Reimbursement for dinner may be allowed when the time of return is after 6:00 P.M.

k. Unnecessary Items. Amounts claimed for items which are not necessary or not incidental to the travel should be disallowed. Inquiry should be made of the traveler when the record fails to clearly show whether an item of expense was necessary or incidental to the travel.

l. Time on Bill. The travel voucher should show the hour and date of departure from the traveler's home as well as arrival at and departure from the designated place of treatment or examination and arrival at home. The hour of arrival and departure are unnecessary if claim has not been made for meals or lodging. Likewise the actual elapsed time of travel is unnecessary when no claim for subsistence expense has been made.

m. Verification. No travel expense shall be allowed until the evidence shows that travel was performed for the purpose authorized. This is usually established by reviewing the on-line BPS history to determine whether there was medical treatment on that date, or a report from the attending or examining physician.

In the case of repeated trips the medical report will, in many cases, show the dates when the injured employee reported to the physician. If not, and if the BR has reason to believe trips were not made as claimed, a signed statement should be obtained from the physician showing the dates the traveler reported. This statement may appear on the travel voucher or may be in the form of a supplemental report. The desired confirmation as to actual dates of travel will in some cases appear on the voucher or bill received from the physician or may be taken from any other evidence in the file. In some cases the BR may approve reimbursement of repetitive trips without

definite confirmation from the physician as to the dates of travel. The BRs are expected to use good judgment and base their action on the evidence appearing in the record. The nature and extent of injury will furnish some guidance in determining whether the number of trips is reasonable.

n. Attendant. The cost of hire and travel of an attendant to accompany an injured employee may be approved if the injured employee's condition is such that travel cannot be performed without an attendant. Generally speaking, the medical evidence on file will show whether an attendant was necessary. Where there is doubt as to such necessity the BR should seek advice from the District Medical Adviser.

The attendant's travel expenses may be included in the injured employee's travel voucher if such expenses were paid from the injured employee's own funds. Otherwise, the attendant should submit a separate travel voucher. Per diem in lieu of actual expenses may not be allowed for an attendant.

o. Claim for the attendant's salary, if unpaid, may be made on the attendant's travel voucher. A salaried employee of the United States may not be paid a wage in addition to salary for acting as an attendant for one of the OWCP's beneficiaries. A member of the injured employee's immediate family or household may not be allowed a salary or wage to act as the employee's attendant unless it is shown this person gave up gainful employment to do so. The face of a travel bill from an attendant should bear a notation that the person claiming payment was an attendant for the injured employee.

p. Delays in Travel. All travel is to be performed with reasonable dispatch. There are to be no unnecessary or unreasonable delays. In other words, the injured employee and attendant should proceed promptly to the hospital or doctor's office upon arrival in the city where the hospital or office is situated. The employee and attendant should also return home promptly after discharge by the hospital or physician unless it is impractical to do so. It is particularly important that the BR give careful consideration to this question when travel vouchers include charges for meals and lodging. When the BE determines that there has been an unnecessary or unreasonable delay, the charges for meals and lodging that resulted from such delay should be deducted from payment.

9. Itemization of Medical Expense Claims.

a. All medical expense claims must be itemized. There must be sufficient itemization on all vouchers and bills so that the charges may be properly evaluated by the BR. As a general rule the BR should insist upon a further breakdown of charges if unable to determine with reasonable certainty whether:

- (1) The charges are excessive in rate; and
- (2) Services have been rendered to justify the charges.

b. The A.M.A. Current Procedural Terminology code (CPT-4) or HCPCS code for each medical, surgical, X-ray, or laboratory service should be shown in Block 24c of the OWCP-1500. Outpatient hospital services for physicians' professional, radiology, pathology, laboratory, and physical therapy must also be CPT-4 or HCPCS-coded on the UB-82 or UB-92 form. If charges are not itemized in such a way that the BR can determine what code applies, the bill should be denied.

Bills should show the dates when the respective services or supplies were furnished. Individual dates are not necessary if the billing is for repeated charges over a period of time. In such cases the billing should show the inclusive period covered by the billing, the number (units) and nature of repeated charges, the rate of each charge, and the total charge.

For example, if a physician rendered 10 office visits to an injured employee during June and his regular charge for each office visit is \$50.00, it would be acceptable for the physician's billing to show: June 1 to 30, with the appropriate year -- 10 office visits at \$50 each, \$500.

The BR should be certain that evidence justifies the need for the number of repeated items during the period claimed. (Charges for items at a rate in excess of one per day should generally not be allowed unless the voucher or bill bears an explanation showing that the greater number is necessary.)

c. Bills from hospitals for inpatient services are frequently submitted in a summarized manner. Charges for the room may be accepted if so shown. Charges for a private room are acceptable only if necessary for treatment of the approved disability. The supplemental charges on such a billing (meaning X-ray, drugs, supplies, anesthesia, operating room) need not show the dates when the individual services were rendered. The BR must ascertain from the evidence, however, whether all of the miscellaneous services during that period are proper charges against the Compensation Fund.

d. Billings need not be itemized on a day-to-day basis. They may be itemized on any other specified basis, such as a weekly or monthly basis. This is frequently applicable in the case of practical nursing services, nursing homes, and sanatoriums.

e. When nursing services (not contract nurse) are employed on critical cases on a shift basis, the charges for such services must carry the inclusive hours of duty. This is a practical necessity for the BR because, without such information, it soon becomes impossible to determine whether there has been any duplication of charges.

10. Disallowance of Part of a Bill.

a. Bills or line items may deny automatically through the application of the BILL552 edits, without intervention by the BR.

b. When a bill suspends for review, if the bill is approved in part only, it is the responsibility of the BR to inform the potential payee of the reasons for non-payment. If the existing EOB

messages or an alternate EOB message do not adequately explain the reason for denial, a narrative letter should be used (in addition to the EOB message).

c. Portions of line items may be disallowed by using the ineligible amount codes and amounts.

d. It is not necessary to give a payee prior notice of a denial or reduction of bill. The EOB letter (BILL654) tells payees what to do if they disagree with the decision. At times, if requested by the claimant, a formal decision may be needed. This would generally be done by a claims examiner rather than a BR.

e. Sometimes it is better to approve a bill for a reduced amount (those charges which are clearly allowable) and give the payee an opportunity to resubmit a claim for the items in controversy. This method of handling the bill is preferable when the greater portion of a bill may be approved immediately or when the questionable item apparently may be approved when placed in proper order.

For example, payment of an entire inpatient hospital bill should not be withheld merely because the drug charges are not itemized adequately while the other charges are in order for approval. The drug charge should be entered as an ineligible amount and the bill approved for the remaining items. The payee should be advised of such action and asked to submit an itemization for the drug charge on another bill. If the itemization is submitted later and found to be acceptable, the remaining charges should be approved.

11. Adjustment Because of Mistake in Bill.

a. Various decisions of the Comptroller General of the United States have established the rule that administrative or accounting officers or employees may not increase the amount of a voucher representing a claim against the Government. The underlying principle of that rule is that no change in a claimant's account should be made by other than the claimant so as to increase the amount claimed to be due from the Government. This is founded upon the policy of the courts where no greater amount than is claimed can ordinarily be recovered without an amendment of the pleading.

b. However, in Comptroller General decision B-131105, dated May 13, 1957, it was stated in part that:

in furtherance of our policy of continuously reviewing our practices and procedures with the view of developing improvements in the fiscal transaction of the Government, we have recognized that strict application of this rule to claims by employees and Government creditors involving minor errors of computation or extension in the stating of a bill, can only be costly in administration and productive of many small claims for the additional amount due. Thus, we have sanctioned the administrative adjustment upward or downward of claims involving such errors in amounts not in excess of \$10, without amendment of the claims by claimants. To the extent that this adjustment procedure may be inconsistent with the cited decisions, they may be regarded as modified.

c. Bills which are out of balance (sum of the line item charges does not equal bill total) will fail BILL552 edit 019. In keeping with the above-cited decision, if the imbalance is due to an undercharge or overcharge of \$10 or less, the amounts may be adjusted without notice to the payee.

This practice will apply only if the undercharge or overcharge is one of computation or extension and where the payee has clearly made claim for the full quantity of material or service and at the proper unit price. If the undercharge or overcharge is in excess of \$10, appropriate notification (deny with EOB 019) should be furnished the payee in order that the error may be corrected.

d. This will not change established procedure for decreases and partial disallowance of claims.

e. The Comptroller General has ruled that when payment of a bill has been accepted without protest, the payee may not at a later date be paid an additional sum because of an error in the first bill. In the case of a claim for an additional amount because of an alleged mistake in the original bill, the Comptroller General stated:

It is well settled that the submission of a claim to a disbursing officer of the United States and certification of the bill, therefore, as correct and just, and acceptance of payment without protest, precludes a claimant from receiving any additional amount on account of the alleged mistake.

f. In view of the foregoing, the BR should disapprove any claim for an additional amount resulting from an alleged mistake in the original bill if payment of the first bill was accepted without protest.

g. If the payee refuses to accept payment because of an alleged mistake in the original bill, the payee should be instructed to return the check and to submit a corrected bill. If the charges on the new bill are found to be reasonable and otherwise in order for payment, the returned check should be canceled and the new bill approved for payment in the usual manner.

12. Loss of Wages.

a. 5 U.S.C. 8123 provides an employee shall be paid for any loss of wages incurred in order to submit to any examination required by the OWCP. The CE will make the decision whether the claim will be paid for actual wage loss or as compensation for temporary total disability.

b. If a claimant has returned to work following an accepted injury or the onset of an occupational disease, and must leave work and lose pay or use leave to undergo treatment, examination or testing, compensation should be paid for wage loss under 5 U.S.C. 8105 while undergoing the medical services and for a reasonable time spent traveling to and from the location where services were rendered. Of course, any leave used cannot be compensated until it is converted to leave without pay. (See Myrtle B. Carlson, 17 ECAB 644, and Jeffrey R. Davis, 35 ECAB 950.)

Absence from work for the purpose of medical evaluation or treatment does not constitute a recurrence of disability. Therefore, such absence will not qualify the claimant for a higher pay rate under 5 U.S.C. 8101(4). In Andrew W. Eickbolt, 30 ECAB 360, the Board stated that in the

definition of monthly pay at section 8101(4), the word "disability" means "incapacity because of injury." An absence to obtain medical services while otherwise capable of working does not reflect an incapacity for work and therefore does not establish "disability" in the context of section 8101(4), for purposes of changing the pay rate.

If a claimant loses wages to obtain medical services during the period of a schedule award, the additional hours of wage loss compensation due may be paid at the end of the award, rather than interrupt the schedule award for payment of wage loss compensation.

c. Temporary Total Disability. A claim for loss of wages may not be approved during any period when an injured employee is receiving continuation of pay, compensation for temporary total disability as provided by 5 U.S.C. 8105, or leave pay. Likewise, such claim may not be approved unless the record clearly shows the desired examination took the injured employee away from a remunerative position in which the employee would have otherwise been present for duty. In other words, loss of wages should not be allowed if the injured employee would have otherwise not been present for duty because of disability or some personal reason.

It may generally be assumed that an absence of duty was necessitated because of an examination if the absence is for a period no longer than that required to report for such examination (including necessary travel time). Where the absence is for a longer period, the claim should be given careful consideration in the light of the available evidence. Additional evidence or appropriate explanations should be requested wherever the information is insufficient to make a proper determination.

d. Partial Disability/Schedule Award. The receipt of compensation for partial disability as provided by 5 U.S.C. 8106 or a schedule award as provided by 5 U.S.C. 8107 is no bar to the receipt of a payment for loss of wages if the employee was gainfully employed and lost wages while reporting for an examination in accordance with the provisions of 5 U.S.C. 8123 or treatment in accordance with paragraphs 2 or 3 above. The case record will reveal whether the compensation being paid is for total or partial disability.

e. An allowable claim for loss of wages should be approved for a sum equal to the actual loss resulting from the examination. The claim may be submitted on CA-7 or CA-8, or in the form of a signed statement from the employer indicating the rate of pay and the number of hours or days lost from work for examination or treatment. The CE should prepare a brief memorandum to the Fiscal Officer authorizing payment for wage loss under 5 U.S.C. 8123 or 5 U.S.C. 8103 through the BPS, indicating the dates covered and the amount to be paid. The CE should also ensure that the case status will allow payment through the BPS.

f. When an employee hires someone to work while reporting for an examination, the employee is entitled to payment for loss of wages. The amount to be allowed will equal the sum the employee paid to the individual who worked in the employee's place if such sum is reasonable and represents a fair wage for the service performed. In these instances it is required that the injured employee submit a receipt in duplicate, from the person who worked in the employee's place. The receipt must be so prepared that the purpose for which payment was made, including necessary dates and rates, is clearly shown.

g. Payment is keyed using provider type KR.

13. Recurrent Disabilities.

a. The official superior may issue authorization for further treatment of an injured employee when the employee complains of recurrent disability if there is reason to believe the alleged disability is due to the injury, and not more than six months have elapsed since final action was taken by the OWCP. The official superior should not issue an authorization if there is doubt that the disability is due to the injury, or more than six months have elapsed since final action by the OWCP. Instead, the employer should communicate with the OWCP and ask for instructions. If the claim is otherwise in order, a bill based upon authorizations issued more than six months after final action by the OWCP may be approved for payment. However, the issuance of such authorization should be brought to the attention of the employee responsible for communication with employing agencies (usually the technical assistant).

b. Form CA-16, Authorization for Medical Treatment, is the proper form to authorize medical treatment for a recurrence. CA-16 authorizations for recurrences should be entered on the system upon receipt in the mail room, as any other CA-16 would be.

c. Generally, no unauthorized medical expense for a major recurrent disability should be approved for payment until the CE has taken action on the original injury and the alleged recurrence. Bills for examinations may be approved without action by the CE if supported by an authorization and medical report. The BR may approve bills for small sums covering examinations and brief periods of treatment without requiring action by the CE if:

(1) The disability is such that no loss of pay is involved and no permanent disability or further recurrences are anticipated;

(2) The BR is satisfied that the recurrent disability is due to an injury sustained while in the performance of duty; and

(3) The bill is supported by an authorization and medical report.

The BR should require action by the CE before approving bills on cases not falling within these three categories.

14. Third-Party Recoveries.

a. When an injury occurs under circumstances creating a legal liability in some person other than the United States to pay damages, the injured person is required, after deducting the costs of suit and a reasonable attorney's fee, to refund the amount of compensation paid by the United States from any money or property received in satisfaction of such liability. This refund is made after the claimant receives a percentage of the recovery as indicated in 5 U.S.C. 8132 of the Act.

b. Whenever there has been a recovery from the third party, the Office of the Solicitor will obtain a refund for the amounts paid by the OWCP and will provide a brief accounting showing the total recovery, the court costs and attorney's fees, the amount refunded to cover the OWCP's payments, and the amount of the surplus to be credited against the future payments. The CE will also record an entry on the Summary Sheet (Form CA-800) showing the third party credit. Similar entries will be recorded at subsequent intervals when there is accrued compensation or paid medical expense which is allowable as a charge against the third party credit.

c. Usually medical expense should not be approved for payment while there is a third party credit except if the expense involves an examination authorized by the OWCP. Such examinations are not frequently authorized while there is a third party credit but such expenses, if reasonable, must be paid in view of the contractual obligation arising from the authorization, and since the examination is for the benefit of the OWCP.

d. Where proper authorization has been issued for medical care, the OWCP has a contractual obligation to see that reasonable medical expenses for treatment rendered under the authorization are paid. Where bills for such services are outstanding at the time of settlement, and they are otherwise correct, payment may be made. If the amount of the bills was not included as a refund to the OWCP, the case should be referred for collection of the medical expense from the injured employee if credit against future payments exists. Such refund will, of course, reduce those credits.

e. The injured employee having a third-party credit may submit receipted bills to be applied as charges against the third-party credit. Such receipted bills will be keyed in the usual manner. Cases in which a third-party credit remains should have a case status of A0, which will cause edit 111 to fail. When the bill suspends, if payable except for the third-party credit, the resolver will post the amount of the bill as a charge against the third-party credit balance, and deny the bill with EOB 922. Interested parties should be informed by separate letter that the amount of the bill has been applied against the third-party credit. If aside from the third-party credit the bill is not payable, it should be denied using an appropriate EOB message.

15. Hospitalization Required Because of Injury While in Travel Status.

a. The Government Travel Regulations provide for continuing per diem allowance to an employee in travel status who becomes incapacitated due to illness or injury, not due to the employee's own misconduct, for periods not to exceed 14 calendar days in any one period of absence.

b. The regulations also provide that a refund of the per diem allowance shall be required from the employee in any case where the employee received hospitalization under any Federal statute or receives reimbursement under such statute for hospitalization expenses paid by the employee.

c. In those cases where beneficiaries were in a travel status at the time of injury or illness requiring hospitalization, and the OWCP pays the bills for such hospitalization (direct or reimbursement), the BR should notify the employee's official superior (by letter) of the approval of the hospital bill. The letter should show the inclusive dates of hospitalization for which we

have paid the expenses and refer to the requirements of section 6.5(a) of the Government Travel Regulations and decision 32 Comptroller General 113 dated August 28, 1952.

16. Payment for Medical Reports by OWCP. On occasion, it is necessary to request an attending physician to supplement medical reports for reasons other than the physician's previous laxity in submitting timely reports or poor reporting. This is usually, but not limited to, requests for rationale to support a prior opinion on causal relation, the history of injury, work limitations, etc. Most of these requests do not require further examination of the claimant. However, it may be a routine expense in addition to the examination. A charge for such report is a proper expense to the Compensation Fund and may be paid. If any question arises as to the propriety of a charge for a medical report, authorization should be obtained from the responsible claims examiner.

5-0205, Bill Resolution

1. Purpose and Scope. This chapter provides detailed procedures and instructions for resolving bills which have suspended for resolution as a result of the BILL552 process. BILL054, Suspense Resolution, is the program used to resolve suspended bills.

2. Responsibility for Bill Resolution. In some offices, fiscal or bill processing personnel are responsible for resolving suspended bills, while in other offices, claims personnel have this task. In most offices, bill resolution is a shared responsibility between claims and fiscal staff. District office managers decide the staffing structure and responsibilities within an office. Authorization and decision-making functions which have been within the purview of claims examiners, such as authorizing specific medical treatment or surgery, should remain with claims examiners.

3. Responsibility for Monitoring Bill Resolution.

a. After bills have been data-entered and the batch edits (BILL552) run, the intact bill batches should be forwarded to the bill processing unit supervisor along with the BILL552 Suspense Worksheets. The worksheet lists each bill which has been suspended in the batch, along with the error code numbers of the edits which have failed, by line. Line 000 is the header, and line 001 corresponds with the first detail line on the bill, line 002 with the second, etc.

b. Upon receipt of the bill batches, the bill processing unit supervisor will assign batches to resolvers. A record of the assignments should be kept, if assignments are not made according to an organizational scheme.

c. At least once a week, the bill processing unit supervisor will be provided with report BILL652, Suspense Aging Report, or an equivalent report. The report will be reviewed to determine what suspended bills are aging, and to direct resolution of aging bills.

d. The bill processing unit supervisor will also be responsible for auditing and storing batches of bills in which all bills have been finalized (see Chapter 5-0208).

4. Initial Actions. Generally, if any of the edit failures require action which involve other office functions, those edits should be dealt with first. For example, edit failures 023 or 024 result when the provider is not on the Provider Master File. Before the bill is edited through the bill resolution screens, the individuals responsible for security input on the provider file should enter the provider on the provider file. As noted above, this may be done before the batch goes to the bill resolvers.

5. Using BILL054 (Suspense Resolution).

a. To view and potentially modify data on a suspended bill, the bill resolver chooses option 10 from the FECS001 bill payment menu.

b. A job aid which gives details of the individual edits has been published under separate cover. It includes the error description, the edit description, whether the edit denies or suspends when it fails, whether an edit may be overridden or not, the EOB message which goes out if the bill or line is denied based on that edit failure, the edit priority, and detailed bill resolution instructions for that edit. Exhibit 1 lists the EOB messages only.

c. Data on bills may be accessed by batch number, case file number, provider number, or bill identification number. For persons performing suspended bill resolution, the most frequently used means of access will be by batch number.

d. When the user accesses bills by batch number, case file number, or provider, a list of all suspended bills which fit that particular selection criterion will be displayed. From the list, the user may select an individual bill to work on. If the user specifies a bill identification number, the header information for that bill is displayed.

e. The FECS User's Guide provides detailed step-by-step data entry instructions for all of the means of access.

f. Once a bill has been selected for suspense resolution, the first screen which appears relates to header level data. Header level data such as the payee, provider type, receive date, etc., applies to the entire bill, rather than just an individual line item. The information on the left of the screen shows the header data which is currently in the bill record for that bill. The box on the right of the screen shows all of the header level edit failures. At the bottom of the screen, a message describes the purpose of several function keys. By using the function keys, one may move the cursor from the data area to the edit area, move to the line item screen, view case file

information, view and modify provider information, or exit the bill (saving any changes that were made). Esc-Esc allows one to exit the bill without saving the changes.

g. The line item screens show data and edit failures for individual line items. There is a separate detail screen for each line item on a bill. The detail screen shows the status of the line, which line item is being viewed, and has bill data on the left, and edit failures in the box on the right. A message at the bottom shows what the function keys do: exit the line, move the cursor to the data or edit area, view case information, view bill payment history data, access provider information, or exit the bill. To view a different line item, one must enter N (for next) or P (for previous). To resolve a suspended line, one must enter U (for update). After a line has been worked, the F1 key must be pressed to exit the line, whether the changes are to be saved or not.

h. The case information screen contains the claimant's name, Social Security Number, case type, date of injury, date of death, responsible examiner, case location, adjudication status, current and previous and case status, form received, the accepted/reported condition(s) (and ICD-9 codes, if present), CA-16 authorizations, physical therapy authorizations, general suspense flag, and all of the case notes. This information may be useful in making decisions on some of the suspended edits.

i. The provider information screen allows one to view provider file information for the provider selected during data entry of the bill, and also allows one to update the bill record if the wrong provider was selected. This screen does not allow any provider file updates. One may also correct the provider from the header screen, except for claimant reimbursements. For claimant reimbursements (other than provider types FR [pharmacy], KR [travel], QR [maintenance allowance], or VR [training reimbursement]), the provider screen must be used to change provider information. For provider types FR, KR, QR, and VR, the provider screen does not function, because no provider data is entered for these reimbursements.

j. Edit failures may be resolved in two different ways: either by correcting bill data, or by setting override or deny flags on the individual edit failures. Which type of action is appropriate depends on the nature of the edit. The edit-by-edit instructions provided under separate cover describe which type of action should be taken for the particular edit failure. Not all edits may be overridden, and not all edits may be set to deny. In addition, Chapter 5-204 describes general principles of bill adjudication.

k. If a header level edit is set to deny, usually the entire bill will be denied, even if there are other header or detail level edits which failed and suspended. The two exceptions to this general rule are:

- (1) If a payee address error is present (edits 020, 023, 024); and
- (2) If the case has a general suspense flag (edit 112).

The system requires that edit failures 020, 023 and 024 be corrected before a bill is denied, so that the denial letter will go to a correct address. The general suspense edit must be either overridden or set to deny in order to deny the bill for another header edit failure.

l. In all other instances, when a header level edit is set to deny, the explanation which will go out on the EOB letter is the one associated with that edit number, unless an alternate (900 series) explanation is specified (see subparagraph m, below).

m. Edits or EOBs 900 through 998 are "alternate" EOBs, which may be used if the usual EOB message is not appropriate. It is not necessary to enter the EOB number when setting an edit to deny, unless an alternate EOB is desired. The alternate EOB number is entered in the "alt EOB" column next to the particular edit failure, inside the box on either the header or line item screens. A complete listing of the "alternate" EOBs is found at the end of Exhibit 1.

n. EOB 999 is assigned by the system to lines which are approved for payment, if other lines are being denied, and may not be entered as an alternative EOB.

o. EOB 920 is "Explanation to follow," which may be used if none of the other EOBs are appropriate. If EOB 920 is used, the user must make certain to follow up with an appropriate letter.

p. If a line edit is set to deny, the line will be denied if there is not a header level suspension, even if there are other edit failures for the same line which have not been addressed. Note, however, that if any individual line suspends, the entire bill suspends. Thus, when resolving a suspended bill, each suspended line item must be worked, or the entire bill will suspend.

q. To approve a bill with multiple edit failures, each edit failure must be addressed either by modifying data on the bill record, or by overriding the edit. Certain edit failures are linked, and correction of the data for one edit failure will also resolve the other edit failure. An attempt has been made to identify these linked edits in the detailed bill resolution instructions.

r. Once a suspended bill has been completely worked, the bill must be recycled by pressing <F10> and responding "Y" to the "Changes made are about to be saved -- has bill been completely updated, and is it ready for recycling? Y/N" prompt. Recycling the bill will allow all of the batch edits to be reapplied when the daily run of batch edits is made. If the bill has been completely worked, recycling the bill will in most instances result in the bill being approved for payment (and transmitted to Central) or denied (and an EOB generated). Some bills will suspend more than once.

s. It is not necessary to resolve all suspended bills in a batch before any of them will be paid. After the initial processing by BILL552, each bill is handled individually, while still retaining its batch identification number. However, all suspended bills in a batch must be resolved before the batch identification number may be reused.

t. If a bill is only partially worked, but is not yet ready for recycling, the revised data may be retained without recycling by pressing <F10>, then responding "N" to the "Is bill ready for recycling? Y/N" prompt.

u. The CTRL-B function may be used to dispose of bills which should never have been keyed, or which must be rekeyed. After pressing CTRL-B, the system asks, "Are you sure that you want to

do this? (Y/N)." The bill is then tagged as an "internal denial", and after being listed on a report of internally denied bills, will be deleted from the system. Use of CTRL-B should not be frequent. The reports which list internally denied bills are to be reviewed by bill resolution supervisors to ensure that the option is not misused.

An example of a bill which should never have been keyed is one which is an exact duplicate of another bill in the same batch, or another bill in a different batch which was keyed the same day. An example of a bill which must be rekeyed is one which was keyed with an incorrect case file number, or one in which the number or types of edit failures are such that rekeying the bill is preferable to trying to resolve it.

v. A bill resolution referral sheet (see Exhibit 2 ([Link to Image](#))) may be used if resolving a bill requires input from other office personnel. An effort should be made to keep the original bill in the batch. If a bill must be removed, a copy of the bill or referral form should be kept in the batch or a "placeholder sheet" (see Exhibit 3 ([Link to Image](#))) may be used. The disposition of the referral sheet is up to the office: the sheets may be associated with the physical bill batch; or supervisors may wish to retain the sheets for various purposes.

w. A bill batch should be kept in an accessible location until all suspended bills have been resolved. The BILL651 summary report identifies batches which contain suspended or internally denied bills. After all bills have been resolved the batch may be audited and stored in the usual manner.

x. When changes are made to a record using BILL054 and the changes are kept, the login ID of the person who made the changes is also recorded on the bill record. This ID is overlaid if subsequent changes are made.

6. Actions Related to Bill Resolution.

a. Prompt action should be taken when bills are referred to other office personnel by the bill resolver.

b. Claims examiners must update accepted conditions on the system whenever appropriate, and enter notes concerning authorization of surgeries, supplies, or other medical services on the system. Failure to make updates may result in erroneous bill adjudications.

c. Cases in which no compensation is being paid, but in which medical treatment continues, should not be closed prematurely.

d. When denying a case which was previously unadjudicated, CEs should check for a CA-16 authorization, and if such an authorization exists on the system, revise the "to date" to coincide with the denial date, if the "to date" is later than the denial date.

e. If a CA-16 authorization is terminated before 60 days has elapsed, the "to date" should be revised on the system.

f. To manually review every bill which comes in on a case, enter a bill suspension flag for that case record. A suspense flag could be used in a case where the claimant has a history of submitting unauthorized medical expenses, or in a case in which, because of unusual circumstances, bills which are payable are erroneously rejected.

g. If physical therapy services are authorized beyond 120 days from date of injury, the periods of authorization should be entered on the system via Case Management option 34. Up to two date ranges may be specified. Physical therapy services which have service dates which fall outside of an authorized date range are automatically denied.

h. CA-16 Authorizations.

(1) CA-16s which do not come in with a CA-1 or CA-2 should be separated from the rest of the mail, so that they may be data-entered under case management menu option 32, "CA-16 Authorization."

(2) If the case has been denied, the claims examiner should enter the CA-16, because the ending date of the authorization will have to be specified. If the case is unadjudicated or accepted, the office may have data entry or mail room personnel enter the CA-16.

(3) If a CA-16 comes in with a CA-1 or CA-2, the forms should be kept together, and the CA-16 should be entered by case create or other personnel after the case has been created.

(4) For a CA-16 authorization to be valid, it must be signed by an appropriate individual from the employing agency. If the CA-16 is not signed, it should not be entered on the system.

(5) When entering a CA-16 on the system, the "from" date is the date the form was signed. A "to" date 60 days after the "from" date is generated automatically, and may be changed if the authorization is terminated earlier (such as when the case is denied). Up to two CA-16s may be entered.

i. Each bill which is data-entered is assigned a bill identification number by the system, which consists of the batch identification number and the sequence the bill was keyed within the batch. For example, the first bill keyed in batch XXX111 will have the number XXX111.001, the second bill XXX111.002, and so on. To aid in bill resolution, the office may wish to have the data entry or other office personnel number the keyed bills in a batch.

Exhibit 1: Explanation of Benefits (EOB) Messages (October 2, 1995)

- 001 Please submit itemized bill for outpatient services. Physician professional services, radiology, clinical laboratory/pathology, and physical therapy should be AMA CPT-4 codes; other services should be RCC codes.
- 002 Hospital stay not related to the accepted work injury/illness.
- 003 We are unable to determine whether this is inpatient or outpatient from a review of the services provided and the Locator 4 code. Please resubmit the bill with correct codes.

- 004 A valid Locator 4 code is not present. Please supply the correct code and resubmit.
- 005 Eligible charges for dates of service have been previously paid.
- 006 From/to-dates-of-service greater than processing date. Resubmit with correct dates if appropriate.
- 007 The dates of service appear to be in error or excessive. Please correct or submit explanation for the lengthy service period.
- 008 To-date-of-service prior to from-date-of-service. Resubmit with correct dates of service.
- 009 Services not payable because bill was submitted more than one year after the calendar year in which services were provided, or in which claim was first accepted, whichever is later.
- 010 Date of service from/to dates are after the date of death. Resubmit with justification if warranted.
- 011 From and/or to-date-of-service is prior to recorded date-of-injury. Resubmit with justification if warranted.
- 012 Case inactive more than 120 days. Services not authorized. For further consideration, send a medical report to support the need for continuing work-related medical care, and resubmit the bill with a copy of this notice.
- 013 The date of receipt is prior to the date of injury. Resubmit with correct dates or justification if warranted.
- 014 Valid AMA CPT-4 or other procedure code is not present. Resubmit with valid procedure code. If bill is hospital outpatient, physician professional, radiology, laboratory/pathology, and physical therapy services should be AMA CPT-4 coded on the UB-82 or UB-92.
- 017 Line item quantity is equal to zero. Please correct and resubmit if warranted.
- 018 The line item amount is equal to zero or was left blank. If there are charges for these services, please correct and resubmit.
- 019 The sum of the line item charges does not equal the total amount billed. Please correct and resubmit.
- 025 Your address as shown on the bill is different from the address this letter is being sent to, which is the address in our records. Please verify your correct address in writing and resubmit.
- 027 Date of service is missing. "Balance due" bills are not payable. Please resubmit an itemized billing for this service.
- 029 Billed service denied. Case has been inactive more than 180 days.
- 030 Eligible charges for dates of service have been previously paid.
- 031 Dates of service are after the date bill was received in the office. Future charges are not payable. Rebill after services have been rendered.
- 101 This case has been denied. If authorization for services was given, resubmit bill with authorization. You may wish to seek reimbursement from another insurance carrier.
- 102 This case has been denied. If authorization for treatment was given, resubmit bill with authorization. You may wish to seek reimbursement from another insurance carrier.

- 103 The case has been denied. No valid treatment authorization has been received for these dates of service.
- 104 This case is denied for these dates of service.
- 105 A work-related injury has not yet been accepted in this case and there is no valid authorization for the dates of service. Please resubmit if the patient notifies you that the case has been accepted.
- 106 A work-related injury has not yet been accepted in this case and there is no valid authorization for the dates of service. Please resubmit if the patient notifies you that the case has been accepted.
- 109 A work-related injury has not yet been accepted in this case. Please resubmit if the patient notifies you that the case has been accepted.
- 110 A work-related injury has not yet been accepted in this case. Please resubmit if the patient notifies you that the case has been accepted.
- 111 Benefits are not payable in this case. Contact the patient for further information.
- 112 Bill is not payable. Explanation to follow.
- 113 Bill is not payable. Explanation to follow.
- 201 Payments to this provider are excluded under Federal Regulations 20 C.F.R. Part 10, Subpart F.
- 202 Payments to this provider are excluded under Federal Regulations 20 C.F.R. Part 10, Subpart F.
- 210 Please resubmit bill with proof of payment, such as a cancelled check or paid receipt.
- 211 Reimbursable chiropractic services are limited to manual manipulation for spinal subluxation demonstrated by x-ray. Subluxation not accepted in this case.
- 301 Billed service(s) not related to the accepted condition(s) in this claim.
- 302 Billed service(s) not related to the accepted condition(s) in this claim.
- 303 Billed service(s) not considered payable for a job injury/illness.
- 306 Billed service(s) not related to the accepted condition(s) in this claim.
- 309 Procedure requires second opinion evaluation prior to payment; no second opinion evaluation has been obtained. Further information concerning authorization for this procedure will be provided to the patient.
- 311 Billed service(s) not related to the accepted condition(s) in this claim.
- 313 Procedure code is invalid for services rendered. Please resubmit with an appropriate code or with justification for the use of this code.
- 315 Billed service(s) not related to the accepted condition(s) in this claim.
- 317 Service(s) not related to the accepted condition(s) in this claim.
- 318 The AMA CPT-4 modifier code used is not valid for this procedure. Please resubmit bill with a valid modifier code.
- 320 Number of units billed per day exceeds the authorized limit. Please resubmit bill with full explanation for the number of units billed.
- 321 This procedure code appears to be an obsolete AMA CPT-4 or California RVS code. Please resubmit using a currently valid AMA CPT-4 code.
- 402 Payable amount for this bill is less than \$1.00. No checks are issued for less than \$1.00.
- 500 Rebilled service denied.

- 501 Charges for this service appear to be excessive. Please resubmit with written explanation/itemization.
- 502 Procedure codes are missing or invalid for this type of provider. Resubmit bill with AMA CPT-4, HCPCS, RCC codes as appropriate.
- 601 Case has not been approved. Resubmit bill upon notification of case approval. You may wish to seek reimbursement from another insurance source.
- 602 This case is under development and there is no valid authorization on file for these services. If authorization was issued, resubmit bill with a copy. Otherwise, resubmit upon notice of case approval.
- 704 Billed service(s) not related to the accepted condition(s) in this claim.
- 705 Billed service(s) not related to the accepted condition(s) in this claim.
- 707 Billed service(s) not related to the accepted condition(s) in this claim.
- 708 Billed service(s) not related to the accepted condition(s) in this claim.
- 710 Further physical therapy treatments require authorization by OWCP. For further consideration, send medical justification along with a copy of this notice and your resubmitted billing.
- 713 Billed service(s) not related to the accepted condition(s) in this claim.
- 714 Billed service(s) not related to the accepted condition(s) in this claim.
- 716 Billed service(s) not related to the accepted condition(s) in this claim.
- 720 These physical therapy services were not authorized by OWCP.
- 721 These physical therapy services were not authorized by OWCP. For further consideration, send medical justification, a copy of this notice, and a resubmitted billing.
- 801 Billed service denied. Duplicate of a service previously paid.
- 802 Billed service denied. Duplicate of a service previously paid.
- 803 Billed service denied. Duplicate of a service previously paid.
- 804 Billed service denied. Duplicate of a service previously paid.
- 805 Billed service denied. Duplicate of a service previously paid.
- 901 The UB-82 (or UB-92) admission history and physical examination, and discharge summary should be submitted along with your itemized rebilling.
- 902 Services were provided after the case (including medical payments) was denied.
- 903 The GTR travel was not authorized by this office.
- 904 Procedure codes (AMA CPT-4 or HCPCS) are missing. Resubmit with all services coded.
- 905 This tuition bill is not for training authorized under an OWCP rehabilitation plan.
- 906 These dental services are not related to the work injury/illness.
- 907 These medications are not for treatment of the accepted condition.
- 908 Hospital services must have AMA CPT-4, RCC or HCPCS codes. Resubmit with services coded. If bill is hospital outpatient, physician professional, radiology, laboratory/pathology, and physical therapy services should be AMA CPT-4 coded on the UB-92.
- 909 Nursing services have not been authorized in this case.
- 910 Travel dates do not correspond with known treatment dates. Medical reports for the dates of travel must be submitted if the travel voucher is resubmitted.
- 911 Laboratory charges must be coded using AMA CPT-4 codes. Resubmit bill with appropriate coding.

- 912 Homemaker services have not been recommended by a qualified physician for the work-related condition.
- 913 Nursing home services do not appear to be warranted for the work-related condition. Seek reimbursement from another insurance carrier.
- 914 Physician services must be coded with AMA CPT-4 or HCPCS codes. Resubmit bill with codes complete.
- 915 Maintenance allowance is not payable for the period claimed.
- 916 Bills for therapy services must contain AMA CPT-4 or HCPCS codes.
- 917 These rehabilitation services were not authorized.
- 918 A report is required to pay for these rehabilitation services. Resubmit bill with your report.
- 919 X-ray services must be coded using AMA CPT-4 or HCPCS codes. Resubmit bill with codes complete.
- 920 Explanation to follow.
- 921 Provider was not authorized to provide services to this claimant.
- 922 There is a third party credit balance remaining in this case. This bill is therefore not payable. Contact patient for further information.
- 923 Benefits have been suspended for failure to submit to a medical examination required by the office. Bill is therefore not payable. Contact patient for further information.
- 924 This line will be combined with another billed line for payment purposes.
- 925 These dates of service overlap a previously paid bill. Please resubmit bill identifying each date of service.
- 926 Services not related to accepted condition.
- 927 Send medical report for services performed, along with your resubmitted billing and a copy of this notice. 928Charges appear to be duplicate of previous charges which were reduced under the fee schedule. If you disagree with the fee schedule reduction, you must follow the instructions given at time of reduction.
- 929 These services are not payable under the Federal Employees' Compensation Act.
- 930 Please resubmit these pharmacy charges with the names of the medication(s) and the prescribing physician, along with a copy of this notice.
- 931 Please submit your original pharmacy receipts, along with a copy of this notice.
- 932 Payment for billed service is denied, as charges appear to have already been paid by another source.
- 933 Billed service denied. Duplicate of a service previously paid.
- 934 Reimbursable chiropractic services are limited to spinal manipulation, x-ray of the spine and pelvis, and limited office visits.
- 935 Services not authorized.
- 936 Case inactive more than 120 days. Services not authorized. For further consideration, send medical report to support need for continuing work-related medical care, and resubmit bill with copy of this notice.
- 937 Case denied. Please seek payment from another source.
- 938 "Balance due" bills are not payable. Please submit an itemized bill for these services.

- 939 Bills for reimbursement of provider services must be itemized. Please submit a completely itemized bill for reimbursement, including the provider's employer identification number.
- 940 This procedure code appears to be an obsolete AMA CPT-4 code. Please resubmit using a currently valid AMA CPT-4 code.
- 941 Missed or cancelled appointments are not payable.
- 999 Still in process.

Exhibit 2: Bill Resolution Referral Sheet ([Link to Image](#))

Exhibit 3: Placeholder Sheet ([Link to Image](#))

Chapter 5-0206, Appeals of Fee Schedule Determinations and EOB Denials

1. Purpose and Scope. This chapter provides guidance and instruction for processing appeals of medical schedule determinations, and for coding and keying additional payments resulting from such appeals. In addition, this chapter provides guidelines for handling and processing EOB returns in the district offices.

2. Introduction. Under 20 C.F.R. 10.411 a medical provider whose charge for service is only partially paid because it exceeds a maximum allowable amount set under the OWCP fee schedule may, within 30 days of payment, request reconsideration of the fee determination. Only three circumstances will justify reevaluation of the paid amount. These are:

- a. The actual procedure performed was incorrectly identified by CPT code;
- b. The presence of a severe or concomitant medical condition made treatment especially difficult; or
- c. The provider possessed unusual qualifications beyond Board-certification in a medical specialty.

The provider must submit evidence to support the request for reconsideration of the paid amount. The provider may not seek any additional amount in excess of the charge allowed under the fee schedule from the claimant.

3. [Fee Schedule Advice to Payees.](#)

a. When a charge for service is reduced by the fee schedule, the provider will receive, in addition to the description of payment which accompanies the check, a separate statement (Form CA-98 shown as Exhibit 1 ([Link to Image](#))) which lists by procedure code those charges which were reduced as a result of the fee schedule. The CA-98 also advises the provider of the right to appeal the fee determination and provides instructions for doing so.

b. In reimbursement situations where the claimant is only partially reimbursed as a result of the application of the fee schedule, a CA-98 will be sent to the claimant (who is the payee in a reimbursement situation). The CA-98 advises the claimant of the actions he or she may take with respect to the amount paid in excess of the fee schedule. The claimant does not have the right to appeal the fee determination per se. However, the claimant is advised that he or she may:

(1) Request that the provider make appropriate refund or credit for the amount the claimant paid in excess of the fee schedule;

(2) Request the provider to submit on the claimant's behalf, and at no additional cost, a request for reconsideration of the fee determination as discussed above; and

(3) Request in writing that the OWCP district office contact the provider with respect to the amount paid in excess of the maximum fee schedule amount.

4. Timeliness. The FEC district office servicing the claimant's case is responsible for processing the provider's request for reconsideration of the fee determination. Under 20 C.F.R. 10.411(g)(2), the district office is to respond in writing within 30 days of receiving the request stating whether or not an additional amount will be allowed as reasonable.

5. [Authority.](#)

a. District Director. The reconsideration decision is to be prepared for the signature of the District Director, except in the Kansas City and Washington, D.C. District Offices. In Kansas City, the decision is to be prepared for the signature of the unit Claims Manager; in Washington, D.C., for the Assistant District Director.

b. Regional Director. If an appealed amount continues to be disallowed by the district office, the provider may seek further review. A decision from this further review, stating whether or not an additional amount is to be allowed as reasonable, is to be made within 60 days of receipt of the request for review. This decision is to be prepared for the signature of the Regional Director, except in the Washington, D.C. District Office, where the decision will be prepared for the signature of the District Director.

6. Processing Appeal Requests from Providers.

a. To facilitate identification of appeals, the CA-98 instructs the provider to address the request for reconsideration of the fee determination with the notation "ATTENTION: FEE SCHEDULE APPEAL." Mail and File personnel should be made aware of the significance of this notation on incoming mail, and of the need to attach this mail to the case file and forward it promptly to the control point.

b. The district office should establish a control point through which all appeals of fee determinations should be routed.

(1) The individual designated as the control point should log the receipt of the appeal showing case number, name of the provider making the appeal, the date received, the date the decision is due (i.e., 30 days after the date of receipt), and the date the decision is issued. This log should be used to track and monitor the adjudication of the schedule appeals.

(2) Following the logging of an appeal request, the control point should forward the case to the person responsible for processing the appeal.

c. The Fee Schedule Appeal Reviewer. The person(s) to be charged with the responsibility of processing fee schedule appeals (hereafter referred to as reviewer) is left to the discretion of the DD and RD. However, where an appeal is made to the regional level, the person handling the appeal must be someone other than the person who processed the earlier appeal.

7. Evaluating an Appeal Request. The reviewer should consider the following:

a. Incorrect CPT Code. In addition to the evidence submitted on appeal, review any medical reports of record pertinent to the service or procedure in question. If it is not furnished by the provider, the reviewer may wish to obtain a copy of the originally submitted bill for the description of the service provided. (It is important that the original bill be returned to the appropriate bill batch immediately after copying.) If technical assistance is needed, the reviewer should obtain the opinion of the DMA or appropriate Office consultant as to the appropriateness of the coding of the service or procedure in question.

It must be remembered that where an additional amount is being paid as a result of a fee schedule appeal (i.e., an appeal reason code is being keyed in the eighth character of the procedure code field), the fee schedule function of BPS does not operate, that is, the system does not compare the keyed charge amount against the fee schedule. To prevent excessive payment as a result of a fee schedule appeal, it may be necessary for the reviewer to manually calculate the correct maximum fee using the fee schedule provided by National Office and to mark the bill with the correct charge amount to enter into the system. This will most frequently occur where an additional amount is being paid because an incorrect CPT code was originally used.

It may be necessary to review the appropriate BP050 or bill pay history to obtain needed information. As an example, a provider submitted a bill for \$200 and it was reduced by the fee

schedule to \$150. Based on a fee schedule appeal, it is determined that the CPT code originally used was incorrect. The correct code has a maximum allowable charge of \$185. If the original charge of \$200 is again entered, BPS will not make the appropriate fee schedule reduction. Therefore, the reviewer must advise the revise the charge amount to \$185 for the line item, with the \$150 previously paid entered as an ineligible amount using "N" as the ineligible amount code. The bill total should also be adjusted to reflect the deduction for the ineligible amount. This will produce a correct additional payment of \$35 for the line item.

b. Severe or Concomitant Medical Condition. The evidence submitted, along with pertinent medical evidence which may already be on file, must establish the presence of a severe or concomitant medical condition and show that this condition made the billed treatment especially difficult. As examples, cardio-pulmonary problems or severe diabetes may make treatment (e.g., surgery) of the injury-related medical condition especially difficult. However, the mere fact that a severe or concomitant condition was present should not result in additional payment without regard to the service or procedure in question. For example, it would not be expected that difficulty in treatment would warrant an additional payment for an office visit or the taking of X-rays.

Review and opinion may be obtained from the DMA or office consultant concerning the presence of a severe or concomitant condition, its effect upon treatment, and the amount of the additional fee requested given the added difficulty, if any. Any evidence used as a basis for finding that a severe or concomitant medical condition was not present or did not make the billed treatment more difficult must clearly and convincingly represent the weight of the evidence. Where the DMA or Office consultant's opinion is in disagreement with, but of nearly equal weight to, the evidence submitted by the provider, payment of an additional amount in excess of the fee schedule should be authorized, if appropriate. Such "conflicts" of opinion as to whether or not a severe or concomitant medical condition made treatment especially difficult are not subject to resolution by the use of an impartial third physician.

c. Unusual Provider Qualifications. The evidence upon which such a decision is based is the provider's curriculum vitae. Board certification in a medical specialty is not by itself sufficient evidence of unusual qualifications. Professorial rank or the publication of articles authored or co-authored by the provider which are pertinent to the medical condition or procedure in question are considered evidence of unusual qualifications. The DMA or Office consultant in the appropriate specialty may also be requested to provide an opinion as to the qualifications of the provider and the amount of the additional fee requested given those qualifications and the procedure or service in question.

8. Additional Amount Payable. Where it is determined that an additional amount is payable, payment may be made without issuance of a letter of explanation. The check for the additional amount and accompanying statement of disbursements is considered sufficient notification. However, the reviewer must prepare a memorandum for the file stating the findings and the basis for the approval of an additional amount. Review and approval of this memorandum by a higher authority is not required, but may be implemented by the district office if desired. Where additional payment is denied, the provider must be furnished with a letter decision containing the findings and the reason for the denial.

9. Denial of Appeal. Where additional payment is denied at the district office level (i.e., the first level of review), the letter decision must contain a notice of the right to further review similar to the following: If you disagree with this decision, you may, within 30 days of the date of this decision, apply for additional review. The application may be accompanied by additional evidence, and should be addressed to the Regional Director (except in District Office No. 25), Office of Workers' Compensation Programs, U.S. Department of Labor, (furnish complete address). Where additional payment is denied at the regional level (i.e., the second level of review), the letter decision should advise the provider that this decision is final, and is not subject to further review.

10. Bill Markup. In making additional payment as a result of a fee schedule appeal by the provider, the following actions should be taken:

- a. Make a copy of the original bill (or use the resubmitted bill, if applicable) and make the notation "FEE SCHEDULE APPEAL" on that copy. This copy will serve as the "bill" for the additional payment.
- b. Mark the new CPT code on the bill, if appropriate. Note that if a different CPT code is used, or if the accepted conditions or case status have changed since the original bill was processed, there could be a different result in the bill editing process (BILL552).
- c. Mark the appeal reason code on the bill immediately after the CPT code. The appeal reason codes are entered as the eighth character of the procedure code field. The codes and their definitions are as follows:
 - B - Use where the fee schedule function is to be bypassed in connection with the payment of a given line item. This code would be used, for example, to make continuing payment for certain services to a provider who the district office has determined should not be subject to the fee schedule because of his or her unusual qualifications. This code is not to be confused with and does not in any way replace existing duplicate edit bypass codes.
 - 1 - Use this code in cases where the appeal was based on the use of an incorrect CPT code. Appeal decision level: DD (or ADD).
 - 2 - Use this code in cases where the appeal was based on the presence of a severe or concomitant medical condition making medical treatment especially difficult. Appeal decision level: DD (or ADD).
 - 3 - Use this code in cases where the appeal was based on unusual provider qualifications. Appeal decision level: DD (or ADD). (This code would be used in connection with a specific appeal. If the district office determines that the unusual qualifications of the provider warrant nonapplication of the fee schedule on a continuing basis for a certain service or procedure, code "B" would be appropriate for subsequent billings.)
 - 4 - Same as 1, except the appeal decision level is the RD (or DD).
 - 5 - Same as 2, except the appeal decision level is the RD (or DD).

- 6 - Same as 3, except the appeal decision level is the RD (or DD).
- 7 - Error identified and corrected without formal appeal.

d. Show any revised line charge on the bill which results from the manual application of the fee schedule (see paragraph 7a above). This should be necessary only where the appeal reason code is 1 or 4. The previously paid amount should be shown as an ineligible amount, with an ineligible amount code of "N". The bill total should equal the applicable line charges less the ineligible amounts.

11. Keying an Additional Amount.

a. In keying payment, the appeal reason code as marked on the bill is keyed as the eighth character of the procedure code field. The total amount for the line item rather than just the additional amount payable is to be keyed. The amount previously paid is then keyed as an ineligible amount with ineligible amount code "N." The bill total should be less the ineligible amount(s).

b. After keying has been completed, the bill should be forwarded to a resolver. It should be noted that bills entered because of a fee schedule appeal are subject to the same editing process as any other bill.

c. If the additional payment was approved on the basis of unusual provider qualifications (appeal reason code 3 or 6), a copy of the memorandum approving additional payment should be referred to the District Director.

12. Additional Payment Based on Unusual Provider Qualifications. Where an additional amount is found to be payable based on unusual provider qualifications, the District Director should determine whether future bills for the same or similar service from that provider should be exempt from the fee schedule. The office should then establish a list of providers with exempted CPT codes or code ranges, and distribute it to all bill examiners and keyers for ready reference. For any provider who is exempt from the fee schedule, the provider payment flag in the provider file should be "N" for "no".

For future bills from these providers, the non-payment flag will cause edit 202 to suspend the bill for review. The bill resolver will determine whether the bill is otherwise payable. If the bill is payable, the resolver will determine from the list provided by the District Director, whether the particular service is one which should be exempted from the fee schedule. If yes, the resolver should enter a "B" as the eighth character of the procedure code in the line item screen.

13. Correcting Errors Without An Appeal. Obvious errors warranting additional payment identified internally or by contact from the provider may be corrected by the district office without following all appeal procedures. Correction of these errors need not be logged by the control point or tracked using the Fee Schedule Appeal Report. However, appeal reason code "7" should be assigned and keyed when the bill is again keyed for payment. This will permit identification of additional payments related to the fee schedule. In keying the payment, the total

amount (rather than just the additional amount) should be keyed as the line charge, and the amount previously paid should be shown as an ineligible amount with code "N." Examples of such situations include, but are not necessarily limited to, the following:

- a. Transposition of numbers within the CPT code resulted in an inappropriate reduction in fee, and the CPT code without transposition is the appropriate code for the service provided.
- b. The provider's bill represented a roll-up of services over a period of time. If the provider advises that his single line item bill for \$200 actually represented five office visits, the office may make additional payment for the four visits (with the initial reduced payment being viewed as payment for one office visit).
- c. Through internal review, the district office finds that the CPT code used in keying the payment (even if furnished by the provider) is clearly inappropriate given the procedure performed, and the correct CPT is readily identifiable. An obvious example would be the use of CPT code 99245 rather than IMPAR for an OWCP-requested impartial examination.

14. Provider Billing Claimant for Full Payment. A claimant may contact the district office and advise that he or she paid the medical provider in full and was only partially reimbursed by the office as a result of the application of the fee schedule, or that a provider who was only partially reimbursed by the Office is demanding payment of the balance of the full charge, either directly or by referral to a collection agency or by legal action. Upon such contact, the office should take the following actions:

- a. Where the claimant has made payment to the provider and is only partially reimbursed due to the application of the fee schedule, the district office should release a letter to the provider, with a copy to the claimant, which:

- (1) Identifies the specific charges at issue;
- (2) Notifies the provider of the provisions of the pertinent regulations;
- (3) Requests that appropriate refund or credit be made within 60 days;
- (4) Provides the provider with the opportunity to appeal the allowable fee; and
- (5) Advises the provider of the possible consequences of failure to make appropriate refund or credit.

A sample letter is shown as Exhibit 2. If after receipt of the above letter, the provider appeals the fee determination and it is found that no additional amount is payable, the letter decision should again request that appropriate refund or credit be made within 60 days.

- b. Where the provider has initiated collection action or has actually collected from the claimant an amount in excess of the maximum allowable charge paid by the office, the district office should release a letter similar to Exhibit 2 to the provider, with a copy to the claimant, requesting

that the amounts in excess of the maximum allowable fee which have been collected be refunded to the claimant or credited to the claimant's account, or that the provider cease the attempts to collect such additional amounts. The provider should be given 60 days to comply.

Since these situations assume that the office made payment to the provider in accordance with the fee schedule, it is also assumed that he or she received the CA-98 which advises of the right to appeal the fee determination. Therefore, unless otherwise indicated by the evidence of record, the letter to the provider need not contain such advice.

15. Sanctions for Provider Noncompliance.

a. If the provider does not comply with the written request of the Office within 60 days, the district office should contact the provider by telephone in an attempt to persuade the provider to make appropriate refund or credit, or to cease collection action. If this action does not satisfactorily resolve the problem, action should be taken to exclude the provider from participation and payment under the FECA. See PM Chapter 3-0800. (Exclusion based on collection or attempts to collect from the claimant an amount in excess of the maximum fee was added to the regulations as paragraph 10.450(h).)

Before initiating such action, the office must ensure that it has documentary evidence that the provider has collected an amount in excess of the maximum fee, is attempting to collect an additional amount from the claimant directly or through a collection agent, or has initiated legal action against the claimant.

b. Where all efforts to have the provider credit or refund to the claimant the amount the claimant paid the provider in excess of the maximum allowable have failed, the district office should reimburse the claimant for the amount paid in excess of the maximum allowable fee (see 20 C.F.R. 10.412(d)).

16. Processing EOB Returns: Background. One of the features of the enhanced Bill Processing System is the capacity to issue automated remittance advice or explanation of benefits letters (EOBs). These letters are issued to the potential payee when a bill is not being paid, either wholly or in part. These letters are not to be construed as formal decisions with formal appeal rights. Many of the EOB letters are requests for corrected procedure codes or other data. The letter contains instructions to be followed if the receiver disagrees with the non-payment of the bill. The receiver is instructed to place a copy of the EOB on top of any materials submitted in response to the EOB.

17. Processing EOB Returns: Actions. When EOBs are received in the office, special handling is required. Often resubmitted bills are attached to a returned EOB letter. If these bills do not receive special handling prior to keying, and are keyed in the usual manner, the same EOB messages may be reissued. The type of handling required depends upon why the bill was originally rejected.

- a. Each office should designate an individual or individuals to be responsible for reviewing EOB returns.
- b. EOB returns should be separated from other mail (including bills) after date stamping. The EOB returns should be easily identifiable because the EOB letter should be placed on top. Bills attached to returned EOB letters should not be detached. The separated EOB returns will then be given to the individual(s) designated to handle EOB returns.
- c. The responsible reviewer should review the EOB return and determine whether the bill should be paid. If the bill is still deniable for the reasons stated in the EOB letter, and none of the data upon which the original decision was made has changed, the bill will be batched, keyed and resolved as it was previously. An additional narrative explanation may be needed if the original EOB explanation was not detailed enough, in which case alternate EOB 920 would be used instead of the assigned EOB for any edit failure.

For example, if the bill was originally denied because information was lacking, and that information is still lacking, set any appropriate suspended edit failures to deny with alternate EOB 920, and send a more detailed narrative explanation of what information is needed. If the bill was originally denied because of eligibility issues (such as case denied, or services not related to the accepted condition), and the eligibility issue has not changed, an appropriate edit failure should be set to deny with alternate EOB 920, and the biller should be informed that the EOB letter does not comprise a formal decision, and that the case claimant (employee) may request a formal decision in writing. If another alternate EOB message is appropriate, that may be used instead of the 920 EOB.

- d. If after review the bill is still deniable, but for a reason or reasons other than those contained in the original EOB, the bill should be batched, keyed, and resolved to deny with EOB 920 (and inform the biller separately in writing of the reason for denial of the bill) or another appropriate message.
- e. If the bill is payable, but was denied automatically by the system, either data on the bill (such as the procedure code or bypass codes) or in the case management record (such as accepted conditions or physical therapy authorization) must change if the bill is to be paid. What data must change depends upon the reason for the original denial. Paragraph 18 (below) describes data which must potentially change for each of the bill batch edits that currently denies automatically. Once the data has been changed, the bill may be batched, keyed and resolved.
- f. If the original bill suspended for review, but then was set to deny by the resolver, changing data may remove some of the original edit failures (as when bill is resubmitted with valid procedure codes, or the accepted conditions are updated). More often, what is needed is a note on the system (authorizing particular services) or a bypass code (for charges which appear to be potential duplicates but are not). The edit-by-edit bill resolution instructions (see Chapter 5-0205) provide guidance to reprocess bills of this nature.

18. Actions Required for Specific Edit Failures.

a. Edit 029. This edit fails when the case closure date is more than 180 days prior to the line item dates of service. To pay the bill, the closed case status must either be made more current, or the case must be in an open, accepted status. If further bills are anticipated, and continuing medical treatment is authorized, the case should be in an open status and an appropriate intervention point and call-up established.

b. Edit 101. This edit fails when the bill is from a non-fee schedule provider type, the case is currently in a denied status, and the prior status was UN or UD. To pay a bill, change case status (and adjudication status) to an acceptance, then change it back to the denied status. Having a prior status other than UN or UD will cause edit 104 to fail rather than edit 101, and edit 104 is an overridable suspense. Note that when the "acceptance" is entered, ICD-9 codes will be needed as well, but these may be deleted when the status is changed back. The bill may be processed with the denied status in place.

c. Edit 102. This edit fails when the bill is from a fee schedule provider type, the case has been denied, the prior status is UN or UD, and there is no CA-16 authorization. To pay a bill, enter a CA-16 authorization (via Case Management Option 32) for the dates of service. The case status does not need to be changed. Note that with the CA-16 authorization, any fee schedule provider type bills with service dates that fall in the CA-16 authorization date range may be paid. The range entered, therefore, should be restricted to the dates which have been determined to be payable.

d. Edit 105. This edit fails when the bill is from a fee schedule provider type, the case status is UN or UD and the adjudication status is blank, and there is no CA-16 authorization entered on the system. To pay the bill, enter a CA-16 authorization covering the dates of service (via Case Management Option 32).

e. Edit 303. This edit fails when the procedure code is one which has been determined never to be payable under FECA. This should occur very rarely. To pay a bill which has failed edit 303, another procedure code must be used. If the original procedure code was incorrect, and the provider has rebilled with a corrected code, use that revised code. However, if the original code was correct, and has been determined to be payable, use AUTHO instead. National Office should also be informed if AUTHO is used under these circumstances, especially if the code will continue to be used.

f. Edit 321. This edit fails if the procedure code used is 72999, 73999, 90026, 90625, 90720, 90730, 90803, 97000, 97050, 97100, 97101, 97200, 97201, 97740, or 97741. These codes are obsolete CPT-4 codes and are commonly used in California, where they are still valid in the state RVS system. To pay, a different procedure code must be used, preferably the correct currently valid CPT-4 code. Requiring the provider to recode rather than recoding by OWCP is strongly urged, to prevent a recurring problem.

g. Edit 704. This edit fails if procedure code/ICD-9 code relationship is one which the v17 table (a reference table on Sequent) says should be denied (range indicator is D). If there is more than

one accepted condition on the system, all procedure code/ICD-9 code relationships must have D range indicators on the v17 table for edit 704 to fail. To pay a service which has been denied with edit 704, at least one accepted condition should be added for which the service is payable or suspendable.

Sometimes, what code is needed is identified by common sense: if the service is psychiatric, and there is no psychiatric diagnosis entered in the system, then a psychiatric diagnosis should be added to pay the bill; if the service is for back surgery, and the only condition accepted on the system is a back strain, then a condition for which the surgery could be payable (herniated disc) is needed. Intelligent Query may be used to query the v17 table, to determine prior to processing whether a particular diagnosis will be adequate to ensure payment or at least suspension of a bill.

In the absence of a valid (and legitimately acceptable) numeric ICD-9 code which will allow the bill to be paid or at least suspended rather than denied, a P-ICD-9 code may be added for the service for which payment is desired. If the service would usually be denied for all of the other accepted conditions, but a P-code is present, edit 716 will fail, which is overridable. For example, if limited behavior modification was being authorized in an orthopedic case, addition of an accepted condition of P94.33 (individual behavior therapy) would be appropriate. However, the P-codes should not be used as a means to delay making a decision on the relatedness of a condition to the work injury.

Another option would be to put a general suspense indicator on the case (via option Case Management option 33) prior to keying the bill, then make adjustments as needed after the bill suspends for edit 112. AUTHO may be used instead of the original procedure code, but this is not strongly encouraged because the fee schedule will be bypassed, and the possibility of duplicate payment increases.

h. Edit 705. This edit applies to certain diagnostic services, primarily radiology codes, which would not ordinarily be related to the accepted condition, but which might be performed within a short period of time after an injury as part of a general screening. For certain procedure code/ICD-9 code combinations, if the procedure is performed within seven calendar days of the date of injury, it is paid; if more than seven days after the date of injury, edit 705 fails. To pay for a service which has been denied with EOB 705, the accepted conditions may be modified - see instructions for edit 704. Use of P-codes may be more prevalent, since many of these procedures will be authorized on a one-time basis for diagnostic purposes, and it would not be appropriate to accept a condition which is more clearly related to the procedure.

i. Edit 710. This edit fails when the date of injury is on or after 8/1/90, the dates of service are more than 120 days after the date of injury, the procedure code/ICD-9 code relationship is one which has been coded in v17 as requiring authorization, and there are no physical therapy authorization dates on the system. To pay a bill which has failed this edit, a date range for physical therapy authorization which encompasses the dates of service should be entered on the system via Case Management option 34 prior to keying the bill. A written authorization should be provided to the provider, with a copy to the claimant.

j. Edit 721. This edit fails when the date of injury is on or after 8/1/90, the dates of service are more than 120 days after the date of injury, the procedure code/ICD-9 code relationship is one which has been coded in v17 as requiring authorization, and there are physical therapy authorization dates on the system, but the authorization dates do not include any portion of the service dates on the line item. To pay a bill which has failed this edit, the physical therapy authorization date range must be modified or another range entered to include the dates of service in the bill. As with edit 710, a written authorization should also be released.

k. Edit 801. This edit fails when the line being processed is for the same provider EIN, case file number, procedure code, and dates of service as another paid bill, according to the on-line bill payment history. To pay a bill which has been rejected because of edit 801, a bypass code 1, 2, or 3, as appropriate, is required.

Exhibit 1: Form CA-98 (Sides 1 and 2, 3) ([Link to Image](#))

Exhibit 2: Letter to Provider Requesting Refund to Claimant

File No.:

Claimant:

Date of Injury:

PROVIDER NAME

ADDRESS

CITY, STATE ZIP CODE

Dear

The Office of Workers' Compensation Programs administers the Federal Employees' Compensation Act (FECA) which provides workers' compensation coverage for civil employees of the United States. Under the provisions of the FECA, this Office authorizes payment to physicians and other persons for medical services to injured Federal employees. In cases where the injured employee has made payment directly to the medical provider, reimbursement for those medical services is made to the employee. In connection with payment for these services, this Office uses a schedule of maximum allowable medical charges.

Under current Federal regulations (Part 20, Sections 10.411, 10.412 and 10.450 of the Code of Federal Regulations), a provider whose fee for service is only partially paid because it exceeds the maximum allowable fee set under the schedule may not request reimbursement from the injured employee for any amount in excess of the maximum allowable charge. A provider who collects or attempts to collect from the injured employee an amount in excess of the maximum allowable fee may be subject to exclusion from participation and payment under the Federal Employees' Compensation program. Such exclusion is reportable to all Federal employing

agencies, the Health Care Financing Administration, and the state or local authority responsible for licensing or certifying the excluded provider.

The claimant identified above has made direct payment to you for the services described below in an amount in excess of the maximum allowable charge for those services.

CPT Code	Service Dates	Amount Paid	Maximum Fee	Amount Over Maximum Fee

In view of existing Federal regulations, and in order that the claimant not bear an expense which would not have otherwise occurred had payment been made to you directly by this Office, it is requested that you make refund to the claimant (or credit the claimant's account) in an amount equal to the amount over the maximum fees as shown above. It is also requested that such refund or credit be made within 60 days of the date of this letter.

If you choose, you may, within 30 days of the date of this letter, request a reevaluation of the allowable fee for the above services. The request should be made at no additional cost to the employee. The only circumstances which will justify reevaluation are (1) the procedure was incorrectly identified by CPT code, (2) the presence of a severe or concomitant medical condition made treatment especially difficult, or (3) the provider possesses unusual qualifications (Board certification in a medical specialty is not sufficient evidence in itself of unusual qualifications).

Any request for reevaluation of the allowable fee should be in writing, and be accompanied by a copy of this letter and documentary evidence relevant to one or more of the circumstances described above (e.g., evidence of use of an incorrect CPT procedure code, a report showing a severe or concomitant medical condition and how that condition made treatment especially difficult, or a copy of your curriculum vitae). The request should be sent to this office with the notation ATTENTION: FEE SCHEDULE APPEAL.

If it is determined that an additional amount is payable, such amount will be reimbursed directly to the employee.

If you wish to receive additional information concerning the schedule of maximum allowable medical charges, please do not hesitate to contact this office.

Your cooperation and prompt attention to this matter will be appreciated.

Sincerely,

NOTICE TO EMPLOYEE: Please advise this office if appropriate refund or credit is not made within 60 days. If we do not hear from you, we will assume the matter has been satisfactorily resolved.

5-0207, BPS Reports

1. Purpose and Scope. This chapter describes the composition, content, and purpose of the several series of ADP reports generated by the BPS at the District Office (DO) level, and as part of the Central system transmission and processing. These reports serve several operational and managerial needs.

2. General Categories.

a. Some BPS reports are generated at the District Office level when various programs are run, and as requested using the FECS002 reports or reports reprint menus. Portions of some of these reports are transmitted to the National Office (NO) for compilation, reprinting, and program management.

b. Other BPS reports are generated as part of the Central system processing on a daily basis or as part of the weekly processing cycle. They are generated to inform the DO systems managers and fiscal staff and the NO production control unit as to the results of each transmission, and the weekly processing. Reports may be received by both the NO and the DO (paragraph 4 below), the DO only (paragraph 5 below), or the NO only (paragraph 6 below).

c. A few reports are provided on microfiche.

3. District Office Reports. The following reports are generated from data on the local system and are available at the District Office. If a report or a portion of the report is also available at the National Office, it is marked with an asterisk (*). All of these reports may be reprinted from the FECS002 Reports Reprint menu, for a limited time after the initial generation.

a. BILL552.SUM* and BILL552.NEW – reports which are automatically generated each time the bill batch edit program (BILL552) is run. BILL552.SUM provides a summary of the number and amount of bills approved, denied and suspended for both recycled and newly processed bills. This report is useful for office managers to monitor the processing of bills in the office. BILL552.NEW provides the same information for the newly processed bills, and also includes suspense work sheets for each batch in which bills were suspended. The suspense work sheets should be separated and associated with their respective bill batches. The suspense work sheets show all of the edit failures at both the header and individual line item levels for the bills that have suspended for manual review. The work sheets may be used by individuals performing bill resolution, to aid in prioritizing and organizing their work.

b. BILL505 – Suspended Bill Recycling – a report that is produced automatically whenever BILL505 is run from the FECS004 menu. The report shows the total number of bills recycled.

c. BILL507 – EDI Pharmacy Data Processing – a report that is produced automatically whenever BILL507 (Load EDI Pharmacy Bills) is run. The report shows the date, the operator, the identification number of the load file, the number of records, number of bills, number of line

items, and the total dollar amount. If more than one day's worth of data is being loaded, there will be a separate report for each load file.

d. BILL511 – EDI Hospital Data Processing – a report that is produced automatically whenever BILL511 (Load EDI Hospital Bills) is run. The report shows the same information as the BILL507 report, except that it includes the inpatient hospital bills (instead of pharmacy bills). To further define any errors encountered when running BILL511, BILL514 (Edit EDI Hospital Bills) is run. Errors may be corrected through BILL515 (Modify EDI Hospital Bills).

e. BILL554 – History Update Errors – a report generated whenever there are errors in the process that updates the on-line BPS history table (d10).

f. BILL605 – Report of Bills Assembled for Transmission – a report generated whenever bill data is assembled for transmission. It shows detailed information for each line item assembled for transmission, and totals for each bill, and for each batch. The final page is a summary of bills assembled, and shows total number of bills, line entries, and dollar amounts for bills, cancelled checks and cash deposits, and manual payments. The report is used for reconciling BPS transmissions. [See paragraph 4.a(1)(a)]

g. BILL610 – Excluded Provider Report – a report produced upon request that lists medical providers excluded from participation in the Federal Employees' Compensation Program. The report can be sorted by last name, tax identification number, or state. The report supplements the on-line query capability available for excluded providers.

h. BILL649 – Specific Edit Failures Report – a report produced upon request, lists all suspended bills that contain failures of a specified edit. The report shows all of the edit failures for those bills, the procedure codes, and the ICD-9 accepted condition codes. When edit 301 is specified, the report may be used to monitor accuracy of procedure codes and to make suggestions to National Office concerning procedure codes which should be added to the relationship table (v17). Other edits may be specified for various reasons, such as a desire for an office to work off all of one particular type of edit.

i. BILL650 – Purged Internally Denied Bills Report – a report that is automatically generated when the system performs a purge of the internally denied bills. Internally denied bills (see Chapter 5-205) are purged from the system automatically each day. The report may be used to monitor appropriate follow-up action on internally denied bills.

j. BILL651 – Suspended/Internally Denied Bills – a report that is run upon request, which lists all batches currently on the system which contain suspended or internally denied bills. The report also lists each of those bills individually by batch. The report may be used to monitor and organize bill batches with suspended bills.

k. BILL652* – Error Summary – a report which is run upon request, summarizes how many times each edit has failed. All complete bills still on the system are incorporated in the report, including bills that have already been paid or denied (the data remains on the system for a short period of time after the bill has been finalized). The report may be used to analyze trends in edit

failures, identify high-frequency edit failures, and possibly high-frequency keying errors. For example, a high rate of edit 014 failure may indicate a need to educate providers about use of procedure codes. A high rate of edit 105 failure could indicate that CA-16 forms are not being keyed into the system properly, or that employers in the area are not issuing CA-16s. A high rate of edit 112 failures could indicate that claims examiners are putting too many general suspense flags on cases, or that prompt action is not being taken when bills with this edit failure are referred to the claims examiner.

l. BILL653 – CPT4/ICD9 Edit Failures – a report which is run upon request, shows all of the edit failures that have occurred because of the relationship of the procedure code to the accepted condition (700 series edits). The report may be used to identify problems due to non-specificity of accepted conditions, or to errors in the CPTTOICD edit table (v17) itself.

m. BILL654 – Explanation of Benefits Letters – letters that are generated on the main laser printer for denied and partially denied bills. This report must be run daily. Running this report also populates the table (b23) that is used to measure timeliness of processing denied bills, thus it is critical that the report be run each day. The user will be asked to enter the dates for processing. If the report is run daily after BILL552 is run, then today's date should be entered.

Each individual letter contains a sequential reference number. When this report is reprinted, the user may specify a particular letter or range of letters that should be reprinted by specifying the reference numbers.

n. BILL655* – Suspense Aging – a report which is run upon request, lists all currently suspended bills, sorted according to batch number (and bill number), age of bill, case file number (triple terminal digit) or responsible claims examiner. The report may be used to monitor and organize pending suspended bill workloads.

o. BILL656 – New Batch Summary – may be run upon request, usually immediately prior to running batch edits (BILL552) to determine the numbers and dollar amounts of newly keyed batches. The user will be prompted to enter the key date, which should be today's date.

p. BILL657 – Error Override – a report which is run upon request, summarizes the number of each type of edit failure (by edit number) which have been overridden, and also shows identifying information for each edit override. The report may be used to monitor edit overrides, to ensure that overrides are appropriate.

q. BILL658 – Pending Internal Denials – a report that is run upon request, lists internally denied bills currently present on the system. The report is to be used to ensure that appropriate action is taken on internally denied bills, and that there is not an excessive number of such bills.

r. BILL661* – Denied Bills Performance – a report which is run upon request, shows timeliness of office action on denied bills, for a specified period of time. The user is prompted for the beginning and end dates of the period for which data is desired. Data is not routinely retained after 5 months. The report shows how many bills were denied during the period, and the numbers and percentages denied within 28 days and 60 days of receipt in the office.

Most office managers will want to receive this report monthly. In addition, since quarterly data is used to measure performance for purposes of the Quarterly Review and Analysis (QR&A), a quarterly report should be run.

s. BILL662 – Returned Bill Letters – generates letters for bills entered on the returned bill log. The letters may be printed for all letters that have not yet been generated, or letters for a specific print date can be regenerated.

4. Central Reports Available at both National Office and the District Office.

a. Daily Transmission Reports include three major types and several subtypes that cover Bill Payments, Inquiries, and EIN changes.

(1) Bill Payment Reports.

(a) BP010 - Transmission Log Report. This report is generated as the result of each successful transmission and furnishes an accounting of the data that has been transmitted successfully and has either been accepted or dropped. This report is useful to the Systems Manager, fiscal personnel, and the National Office production control unit as it confirms performance in both system terms and operational terms. If the report is not received shortly after transmission of the bills, it should be assumed that transmission has failed and a retransmit is necessary. This report is important as it is the basis for the reconciliation of the daily transmission and the weekly processing; therefore it should be routed to the appropriate office location as soon as possible after receipt. For transmission reconciliation purposes, the total count and net amount, plus the count and amounts dropped (as noted on the Report of Unacceptable Bills/Line Entries) should equal the BILL605 Summary line entries and amount.

(b) Report of Unacceptable Bills/Line Entries (BP010). This report is generated as the result of each transmission if the Central edit program identifies any erroneous data. Messages are printed to identify the errors encountered. The data that is printed on this report is dropped from the BPS and will require re-entry; therefore, it should be routed to the appropriate office location as soon as possible after receipt.

(c) BP015 – Accumulation of Transmitted Bill Records. This report is generated the day following a successful transmission and furnishes totals for the accepted records. For transmission reconciliation purposes, the total charges and amounts should equal the total count and net disbursement amount found on the BP010 Transmission Log Report.

(d) The Duplicate Transmission Report will be generated if more than one transmission of data is made within the same day, or if data from a previous day has not yet been processed by the central site daily processing cycle and the district office is transmitting new data.

(e) The Data Deletion Report will be generated whenever the procedure for deleting data previously transmitted, but not yet processed by the central site daily processing cycle, is executed by the district office.

(2) Inquiry Reports.

(a) The Inquiry Transmission Log Report is generated as the result of each successful transmission of inquiry data and furnishes an accounting of the data that has been transmitted successfully.

(b) The Inquiry Duplicate Transmission Report will be generated if more than one transmission of inquiry data is made within the same day, or if data from a previous day has not yet been processed by the central site daily processing cycle and the district office is transmitting new data.

(c) The Inquiry Data Deletion Report will be generated whenever the procedure for deleting inquiry data transmitted previously, but not yet processed by the central site daily processing cycle, is executed by the district office.

(3) EIN/SSN Change Reports.

(a) The Transmission Log Report is generated as the result of each successful transmission of EIN/SSN Change Data and furnishes an accounting of the data that has been transmitted successfully.

(b) The Report of Unacceptable Change Records is generated as the result of each transmission if the edit program identifies erroneous data. Each record that contains erroneous data will be listed on the report and will be followed by appropriate error messages. The records listed on this report are dropped from the system and will require re-entry.

(c) The Duplicate Transmission Report will be generated if more than one transmission of EIN/SSN Change Data is made within the same day, or if data from a previous day has not yet been processed by the central site and the DO is transmitting new data.

(d) The Data Deletion Report will be generated whenever the procedure for deleting EIN/SSN change data transmitted previously, but not yet processed by the central site daily processing cycle, is executed by the DO.

b. Weekly Reports. The weekly processing cycles, aside from producing the payment file which is used by the Treasury Department to produce the payment checks, identify possible duplicate bills, and maintain a history of disbursements. They also produce three series of ADP reports that are transmitted to both the NO and the DO. The purpose of these reports is to furnish information, allow auditing and control, and to determine performance levels.

(1) Summarization of Bill Payment Data (BP030). This report reflects the resulting bill payment data after complete processing has been effected, including updating the Central bill payment

history and identifying unpaid bills due to possible duplication. As this is the "final" report after editing and updating has been completed, it reflects totals for all DOs as well as combined totals. Due to its contents this report is extremely valuable, as it can be used to reconcile all BPS transmissions effected for the current processing cycle and to reconcile all reports produced by the weekly processing cycle.

(2) Manual/Cancelled Checks and Cash Deposits Paid (BP050). This report reflects manual checks, cancelled checks, and cash deposits that have been processed via BILL052 and accepted by the weekly processing cycle.

(3) Analysis of Payment Performance (BP050). This report furnishes an analysis of the services rendered by each DO, as well as for all DOs collectively, in the payment of bills. Payment performance is determined by calculating the time span from the date that a bill is received in the mail room until the check for payment has been issued. For purposes of this report, all payment records in which the submitting district office code, case number, payee EIN/SSN, payee name, provider code, and date received are identical are considered to have emanated from the same bill.

(4) Analysis of Provider Performance (BP050). This report furnishes an analysis of the timeliness of providers' submissions of bills. Time is measured from the latest date of service to the date received in the office. A summary for each office is included.

(5) IRS Levy Report. This report lists bill payments that have been applied to a registered IRS lien against the provider.

c. As Requested Reports. The BPS daily processing cycle, in addition to combining the daily DO inputs for subsequent processing by the weekly processing cycle, produces information relative to previously processed data that is available in special request. Typical of such a request is the "Formatted Bill Payment History Requested" report (BP060D), which contains formatted bill payment history records for a particular case or cases, for use at a particular location within a DO and is produced in response to inquiry data which has been input via BILL007. The information listed may be the complete payment history for a case, or a partial history if a provider type, EIN, or service dates were entered on the inquiry record at the time of keying. This report is generated on an overnight turnaround basis and should be routed to the DO location indicated upon the report. If requested on Monday through Thursday, only history on the active file is provided. If a Friday request is made, active, purged, and archived history data is available.

5. Central Reports Available at the District Office Only. The weekly processing cycle produces various reports for the use of the DO only. These reports are received in each DO and only reflect the data that has been input by or is relative to the receiving DO's operation. The purpose of these reports is to furnish information, allow auditing and control, and to determine performance levels

a. Register of Miscellaneous Checks Paid (BP040). This report is a master listing of all checks written in payment of bills for the DO during a single payment cycle. This report reflects the identification number assigned to each check by the BPS, the net amount paid, the name and

address of the recipient, as well as the positional location of each check on the check tape which is forwarded to the Treasury for check issuance.

b. Detail of Bills Paid (BP050). This report is the record of those bills that have been accepted by the weekly processing cycle for purposes of producing payments to providers or reimbursements to claimants. This report provides information as to which cases there were payments made in behalf of, to whom the payments were made, in what amounts and for what dates of service.

c. Payee Number to Case Number Cross Reference (BP050). This report furnishes the means to identify to whom payments were made during the current processing cycle and for which cases the payments were made.

d. Related History and Possible Duplicate Bills Unpaid (BP060W). This report is the record of those bills and their associated bill history which the BPS has not processed for payment due to suspected duplication and, in the case of cash deposits or cancelled checks, failure to match against the BPS payment history. After appropriate research into the original bill, the bills, if to be paid, can be accessed via BILL002 for entry of an appropriate bypass code (or not) and retransmission. BILL002 must be used within the weekly cycle following the one in which the bills were rejected. If a bill is not deemed to be appropriate for payment because it is a duplicate, and the original payment was made within 60 days of the receive date of the rejected bill, no further action need be taken. If the original payment was made more than 60 days prior to receipt of the duplicate bill, the provider should be informed that the bill is not payable because it was previously paid, and the date of the previous payment should be stated.

e. Payee/Case No Records Not Processed (BP060C) is a listing of the EIN/SSN change records which were not processed by the BPS as they did not match a record contained in the BPS payment history. The records on this report should be researched to determine the reason for their being mismatched and, if appropriate, be reentered for subsequent processing.

f. Payee/Case No Change Records and Related History (BP060C) is a listing of those EIN/SSN change records which were accepted for processing by the BPS and the original and resulting payment history for each case which has had an EIN/SSN change processed against it during the current processing cycle.

6. Central Reports Available at the National Office Only. BPS, in the normal process of operation, generates reports that are received as output at the National Office only.

a. Weekly Reports. The BPS weekly processing cycle (1) produces the payment file which is used by the Treasury Department to produce the payment checks, (2) identifies possible duplicate bills, (3) maintains a history of disbursements, and (4) produces a series of reports. The purpose of these weekly reports is to furnish information, allow auditing and control, and to determine performance levels.

(1) Consolidation of District Office Bill Payment Data (BP020). This report is a summary of all data transmitted by all DOs subsequent to the previous weekly processing cycle. As this report is primarily a summarization of the Accumulation of Transmitted Bill Records Reports which are

produced by each daily processing cycle, it is used to verify that all data transmitted by the DOs and combined by the daily processing cycle is subsequently accounted for in the weekly processing cycle.

(2) The Register of Miscellaneous Checks Paid summary report (BP040) is a summary checks written in payment of bills for all DOs during a single payment cycle.

(3) The Detail of Funds Disbursed report is the record of those bills which have been accepted by the weekly processing cycle for purposes of producing payments to providers or reimbursements to claimants and as such is an elaboration of the Register of Miscellaneous Checks Paid Report. This report reflects the identification number assigned to each check by the BPS, the cases for which there were payments made, the dates of service, and amounts covered by the issued check.

b. Periodic Reports. When the bill purge program runs, it produces the "Purge of Bill History" report, which summarizes all data processed.

7. Reports on Microfiche. The Detail of Funds Dispersed report and the Register of Miscellaneous Checks Paid report are provided to the District Offices and the National Office on microfiche.

Chapter 5-0400, Health Benefits Insurance

1. Purpose and Scope. To describe procedures for handling health benefits insurance (HBI) under the provisions of the Federal Employees' Compensation Act (FECA) and instructions of the Center for Retirement and Insurance, Office of Personnel Management (OPM). The Correspondence Library includes appropriate letter that can be used to make necessary notification to OPM, employing agencies and health benefits insurance carriers.

2. Legislative Authority and Directives. Public Law 86-382, September 28, 1959, the Federal Employees' Health Benefits Act of 1959; the Retired Employees' Health Benefits Act of 1960; PL 100-654; 5 USC 8905(a), Spouse Equity Act and Temporary Continuation of Coverage; and Federal Personnel Manual, Appendix B, Part 890-1, S-17, Federal Employees' Health Benefits Regulations.

3. Enrollment Requirements in Disability Cases. A claimant who is already enrolled in a health benefits program is entitled to continued coverage during a leave without pay status.

a. The claimant's enrollment continues when compensation begins, so long as the claimant was enrolled in a Federal Employees' Health Benefits (FEHB) plan at the time of injury. In order to maintain the coverage, the claimant must be receiving compensation through daily or periodic roll payments for disability or schedule award.

b. Dependent Status. To qualify for enrollment in an FEHB plan, the individual in question must be either a spouse or a dependent child of the claimant:

(1) Spouse. An individual who is legally married to the claimant qualifies for coverage as a spouse. For separated spouses, coverage continues until the separation is legally finalized by divorce. Upon divorce coverage is terminated but may be continued at the ex-spouse's discretion under the Spouse Equity or Temporary Continuation of Coverage (TCC) provisions. See PM 5-400(10)(1) and (2).

(a) Common Law Spouse. In states where common-law marriage is recognized, a common-law spouse is eligible for FEHB coverage.

(b) Same Sex Marriage. Same sex spouses are entitled to FEHB. See FECA Bulletin 14-01 (issued December 12, 2013). Following the Supreme Court's decision of June 26, 2013 in *United States v. Windsor*, which struck down the provision of the Defense of Marriage Act (DOMA) that prohibited the federal government from recognizing same-sex spouses for all purposes, including for federal benefits dependent on marriage, the Office of Personnel Management (OPM) extended health benefits to Federal employees and annuitants who have legally married a spouse of the same sex.

(2) Dependent Child. An unmarried dependent child of a claimant, either biological or adopted, is eligible for coverage as a dependent until the child reaches age 22. The claimant is not required to provide proof of either dependency or student status to keep this coverage in effect. Coverage may be extended beyond age 22 under several exceptions:

(a) Disabled Child. A disabled child may continue coverage as a dependent if totally disabled from gainful employment. The condition causing the child's disability must have been present prior to age 22, while the child was the claimant's legal dependent. If the proper documentation is received, the OWCP may grant dependency status to a disabled child. The district office must then contact the FEHB carrier, indicating that documentation is on file to support the child's disability from gainful employment. The decision to grant disabled child status is made by OWCP, and not the FEHB carrier. See PM 5-400(10)(d) for a detailed explanation.

(b) Foster Child. In order to have a foster child considered an eligible dependent for FEHB purposes, it must be established that a parent-child relationship exists between the claimant and the foster child. The foster parent-child relationship is recognized when the claimant is the primary source of financial support for an unmarried child under the age of 22. Also, the foster child must live with the claimant and the claimant must expect to raise the child to adulthood. The claimant does not need to be related to the child, nor do they need to legally adopt him/her. There is no requirement for any type of legal action or documentation to formalize the foster parent-child relationship for FEHB purposes. The foster parent-child relationship can be

recognized when the child's natural parents are alive, when the child's natural parent lives with the claimant, or when the child receives some support from sources other than the claimant (such as social security payments or support payments from a parent).

(c) Adopted Child. An adopted child is considered a dependent once the adoption process has been formally completed. In a death claim, the adoption must have been legally formalized prior to the claimant's death.

(d) Posthumous Child. A posthumous child will be considered the "dependent" of the deceased claimant so long as the child was conceived during the lifetime of the employee.

(e) Grandchildren. Grandchildren are not considered eligible dependents under the FEHB Plan. However, a grandchild can qualify for dependency status as a foster child, so long as all of those requirements are met.

(f) Tennessee Valley Authority (TVA) Employees. Employees of the TVA are specifically excluded from FEHB coverage.

c. Schedule Award Claim. In most claims where schedule awards are being paid, the claimant is either working or receiving an annuity from OPM. Therefore, although OWCP is paying compensation, the health benefits withholdings are the responsibility of the employing agency or OPM. Coverage is also possible in certain cases where lump sum payments have been granted. See PM 5-400(6)(d).

d. Part-Time Employees. Part-time career employees are defined as those whose regular working schedule is between 16 and 32 hours per week. Those federal employees that began working on a part-time basis on or after April 8, 1979 are only entitled to a partial Agency Share contribution, made by the Government towards their health benefits insurance. For OWCP's purposes, this rule applies only to those claimants that were considered part-time employees prior to their work-related disability. This pro-rated Agency Share is in direct proportion to the number of hours the claimant was scheduled to work in a pay period. The balance of the Agency Share must be paid by these claimants, and included in their periodic premium deduction.

(1) Calculating the Agency Share for Part-Time Employees. The amount of the Agency Share contribution is determined by dividing the number of hours the claimant works during the pay period by the number of hours worked by a full-time employee serving in the same or comparable position (normally 80 hours per bi-weekly pay period). That percentage is then applied to the Agency Share contribution made for full-time employees enrolled in that plan. The amount of the Government's contribution to the Agency Share is then deducted from the total premium (Agency plus Employee Shares), and the remaining amount is withheld from the employee's pay.

(2) Part-Time Employees Prior to April 8, 1979. Employees who served on a part-time basis before April 8, 1979, and who have continued to serve on a part-time basis without a break in service (in that or any other position) are eligible for the full Agency Share contribution. Part-

time employees, who work less than 16 hours or more than 32 hours, per week, are also entitled to the full Agency Share.

e. Temporary Employees. Federal employees with an appointment that is limited to one year or less are not eligible to enroll in the FEHB. If the appointment is renewed at the end of the year, even as a temporary appointment for another single year or less, the employee is then eligible to enroll in the FEHB and the employing agency may create a new enrollment at that time. However, temporary employees receiving benefits from the OWCP are not eligible for a new enrollment at any time.

f. Peace Corps. Volunteers for the Peace Corps are not entitled to FEHB coverage. Only regular employees of the Peace Corps may be enrolled in an FEHB plan.

g. Plans Sponsored by Unions and Employee Organizations. Plans sponsored by unions or employee organizations require that the claimant be a member of that organization in order to participate in the plan. That membership must be paid for by the claimant in order to continue enrollment while receiving benefits from OWCP. OWCP does not make membership deductions from compensation benefits; the claimant must pay the membership dues directly.

h. Denials of Eligibility. If a claimant is ineligible for coverage, the district office should issue the denial, not OPM. Since the decision is made under the FEGLI (and not FECA), the usual FECA appeal rights, which include reconsideration, hearing, and appeal to ECAB, do not apply. The denial letter should include the following address for review of the decision:

U.S. Department of Labor
Office of Workers' Compensation Programs
ATTN: HB/LI Reconsideration
200 Constitution Ave., N.W., Room C-3523
Washington, D.C. 20210

4. Enrollment Requirements in Death Cases. The enrollment of the deceased employee continues for the surviving family members if all of the following requirements are met:

a. The deceased employee must have been enrolled for self and family at time of death.

b. At least one of the covered family members must receive compensation as a surviving beneficiary of the FECA.

c. The decedent must have met all the conditions noted under subparagraph 3(a) above.

d. Denials of Eligibility. Just as in disability cases (described in 3.h., above), the district office should issue the denial when a claimant is ineligible for coverage, and not OPM. The decision is made under the FEGLI, not the FECA. Therefore, the usual FECA appeal rights, which include reconsideration, hearing, or ECAB appeal, do not apply. The letter should instruct the claimant to use the following address in order to request review of the decision:

U.S. Department of Labor
Office of Workers' Compensation Programs
ATTN: HB/LI Reconsideration
200 Constitution Ave., N.W., Room C-3523
Washington, D.C. 20210

5. Information from Employing Agency.

a. Coverage of Beneficiary. If the agency completed Section 10 on the Claim for Compensation (Form CA-7) in the affirmative, and shows a valid health benefits code, the requirements listed in subparagraph 3(a) above will be deemed satisfied. When received, Form SF-2809-1 must be reviewed to support the continuance of health benefits coverage. The agency's negative reply to these items will notify OWCP not to make deductions for health benefits.

b. Enrollment Transfer. OPM has ruled that the "transfer-out" of health benefits is no longer a recognized process (see Benefits Administration Letter (BAL) 94-202, dated October 19, 1994). From that point forward, only a "transfer-in" action will be required to change the controlling office of the claimant's health benefits enrollment. If OWCP completes a transfer-in of the claimant's enrollment it must then request the original enrollment packet from the employing agency. This serves to complete OWCP's records, as well as notify the employing agency that OWCP has assumed control of the health benefits enrollment. If the enrollment is terminated by the employing agency while the health benefits are being deducted by OWCP, the agency must reinstate the claimant's coverage by rescinding the termination action. The agency must also notify the insurance carrier that the claimant's coverage has been reinstated.

6. Procedures in Disability Cases.

a. Deductions. Premiums are withheld from compensation payments based on data entered into the automated system. The CE is responsible for confirming the accuracy of the information entered prior to processing the compensation payment.

(1) Periodic and Death Roll Deductions. For claimants receiving benefits on the automatic 28-day payment cycle, deductions will be routinely made at the appropriate rate from the claimant's gross compensation. This amount is equal to twice the bi-weekly rate for a given plan, as established by OPM at the start of each health benefits year. These rates are programmed into the system by the National Office to take effect at the start of each health benefits year. In order to create this deduction, the appropriate health benefits code must be entered into the ACPS when processing the payment.

(2) Daily Roll Deductions. Health benefits deductions for this type of payment will not be for an exact period, as found in the automatic 28-day cycle. The keyer will be required to enter a date range in addition to the health benefits code, and should enter the exact period covered by the daily roll payment. The system will then make the appropriate withholding, based on the number of days entered when keying the payment.

(3) Deduction Periods. No deduction will be made if compensation is paid for less than 02/229 days. However, if later payments bring the total period to 29 days or more, retroactive withholdings are made to the first day of the compensation period for which no deductions were made. From that point onward, deductions should be made for the exact days of compensation claimed.

b. Transfers In. If the claimant is expected to be on the OWCP rolls for 90 days or more, the district office must transfer-in the health benefits enrollment. This action makes the district office the controlling office for all future health benefits actions associated with the claim. When it is determined that OWCP should have the enrollment, the CE should release the appropriate notice from the Correspondence Library (Form CA-2217), requesting that the employing agency send the enrollment packet to OWCP.

c. Termination. If a claimant elects to terminate coverage while in receipt of compensation benefits, that termination is irrevocable and should be promptly reported to the carrier. OWCP must return the enrollment to the agency promptly. If the claimant elects to terminate coverage, the enrollment is maintained in the case record.

(1) Termination of OWCP Benefits. If compensation benefits are terminated and the claimant has not returned to duty with a federal agency, the enrollment should remain on file in the district office. This may be accomplished by imaging the SF-2809 enrollment form signed by the claimant into the case file. The district office must complete Form SF-2811 (see subparagraph 13(d) below), notifying the carrier of the termination.

(2) Election of OPM Benefits. If the employee elects an annuity from OPM over benefits from DFEC, the CE will advise OPM via Form CA-1107 of the appropriate enrollment code and date of last deduction. The enrollment packet, or a printout of the imaged enrollment documents, should then be mailed to OPM. This will allow OPM to pick up the health benefits enrollment promptly, and avoid a lapse in coverage.

(3) Election of Medicare, TRICARE, or CHAMPVA. When claimants elect to terminate their coverage in favor of one of these health insurance options, they do not irrevocably lose all future FEHB entitlement. The termination of FEHB benefits is treated as a suspension of coverage and allows claimants to re-enroll in the FEHB in the future. See [PM 5-400\(16\)](#) and [\(17\)](#).

d. Lump Sum. If a lump sum has been paid and the claimant asks to continue HBI coverage, the office will obtain the premiums from the claimant for the period of the lump sum.

(1) Collection of Premiums. In order to have the claimant maintain coverage, the district office should collect the necessary premiums on either a quarterly or annual basis, and at the beginning of the specified period. When the premium is received, it will be deposited into the Compensation Fund Account and recorded in the ACPS history file as a credit.

(2) Reporting to OPM. The district office will report premiums via the RITS/OPM Monthly HBI/LI Adjustment (ARMAPAS) monthly, as though the claimant were actually receiving compensation. The National Office will report to the OPM on Form SF-2812 and SF-2812A. The

funds must also be charged under the Create History Record function. The two ACPS transactions cancel one another in the chargeback process.

e. Loss of Wage-Earning Capacity (WEC). Claimants receiving compensation benefits for partial disability remain entitled to FEHB coverage. If the compensation payments being made do not cover the amount of the FEHB premiums, the office should continue to carry the claimant on the rolls and offer the claimant a plan that will cost less than the amount of compensation payable.

If the claimant insists on retaining the same HBI plan, the office may ask the claimant to submit premiums in advance on either a quarterly or yearly basis to continue coverage. Fiscal actions as noted in 6(d) will be completed when the premium is received.

(1) Retention of Enrollment. As noted in subparagraph 3(e) above, part-time Federal employees who elect FEHB coverage are entitled to only a pro-rated share of the government's contribution for the cost of the insurance. Thus, claimants that return to part-time federal employment due to a WEC would be required to pay this partial share of the government contribution, in addition to the full employee share. In order to prevent the disincentive for returning partially disabled WEC claimants to part-time duty, the enrollment should be retained by the district office and not transferred to the employing agency.

(a) Premiums. The premiums for FEHB coverage will remain the same for claimants receiving compensation for partial wage loss as those claimants receiving compensation for total disability. The Agency Contribution of the total premium will also remain unchanged.

(b) Returning the Enrollment to the Employing Agency. When the claimant returns to full-time duty (more than 32 hours per week), DFEC should return the enrollment back to the employing agency. If compensation is terminated without a return to federal employment, the enrollment is to be imaged into the case record.

(2) Postal Service Employees. For all employees that return to duty with the U.S. Postal Service with a LWEC, OWCP will transfer the enrollment back to the Postal Service to make the health benefits deductions.

f. Third Party Credits. If settlement is made and funds are received by a claimant who is entitled to compensation, the third party settlement check must be applied to the compensation previously paid and/or future payments due until the credit is absorbed. In this situation, the claimant is entitled to compensation, and health benefits coverage may remain in effect.

(1) Crediting Accounts Receivable. The district office should maintain an accounts payable on the third party credit, charge the credit during each payment cycle for the amount of the HB deduction, and transmit the funds to OPM, as described in [5-400\(6\)\(d\)](#) above.

(2) Payment by the Claimant. The claimant may wish to pay the premium. If so, instead of crediting the surplus as described above, the district office may continue the coverage by obtaining the premiums directly from the claimant. This is accomplished in the same manner described above in subparagraph 6(d).

(3) Severance Pay. Claimants remain eligible for FEHB coverage, even though they are not receiving regular compensation benefits due to the receipt of severance pay. Once the period of the severance pay has been completed, regular FEHB deductions can be made from ensuing compensation benefits. FEHB premium deductions for the entire severance pay period should be made from the initial payment made by the OWCP.

g. Change in Dependency Status. If a non-Open Season change occurs in the claimant's dependency status, the claimant is entitled to change from "self" to "self and family" (or vice-versa). Claimant may elect to make this change under their current plan, or to any other FEHB plan. This change may be requested from 31 days before a change in family status, and up to 60 days after.

h. Postal Rates. Claimants originally employed by the U.S. Postal Service are entitled to reduced FEHB premiums for one year from their pay rate effective date. After one year the ACPS will automatically adjust the HBI deduction to the standard FEHB rate. If the pay rate effective date is changed in a claim, then the Postal rate will apply for one year from the new effective pay rate date. Postal employees may contact their Injury Compensation Office for a specific USPS form to request reimbursement of any extra FEHB premiums paid after the Postal rate was dropped by OWCP.

i. Suspension of Compensation. If the claimant's benefits have been suspended due to non-cooperation, the FEHB benefits should be terminated. If the claimant is still on the employing agency's rolls (i.e. not separated from the agency), the enrollment may be sent back to the employing agency instead of being terminated. If the enrollment packet is to be returned to the employing agency, a cover letter should be attached explaining the reason for the return. A copy of that letter should also be sent to the claimant for notification purposes. Once the reason for the suspension has been resolved, the claimant may be offered a prospective enrollment rather than reinstating the benefits.

7. Procedures in Death Cases.

a. Deductions. Premiums are withheld from compensation payments by the system in accordance with data entered from compensation payment documents. Procedures for the payroll cycle are outlined in Chapter 5-307, subparagraph 4(b).

b. Transfers In. In most instances, the employing agency or OPM will have the deceased's enrollment and will send it to OWCP on advice that OWCP benefits have been elected.

c. Adjustments. FEHB coverage may be adjusted to account for changes in beneficiary status in a death claim.

(1) Changes in Dependency. If the children of a deceased employee are no longer covered, the coverage should be adjusted from "self and family" to "self only" for the surviving spouse. OWCP must complete an SF-2809-1 form on behalf of the surviving spouse in order to change the enrollment code. In lieu of the surviving spouse's signature on the SF-2809-1, the office may write "Per annuitant request" and type an explanation in the remarks portion of the form.

(2) Re-Marriage of Surviving Spouse. If the surviving spouse remarries prior to age 55, FEHB coverage may continue for surviving children. If the surviving spouse remarries, the enrollment should be placed in the name of the youngest child. If the surviving spouse remarries after age 55, FEHB coverage may continue for the surviving spouse, but the new spouse may not be included in the enrollment. Since FEHB entitlement is based on the decedent's work-related injury, not the death claim of the surviving spouse, a new spouse is ineligible for coverage. See PM 2-700(7)(b) for details regarding former spouses in death claims.

d. Termination. OWCP must return the enrollment promptly to OPM or process a termination when no dependents remain on the OWCP rolls. If benefits are payable to the beneficiary by OPM, the HBI should be transferred to OPM. However, if there are no entitlements to annuity benefits, the HBI enrollment should be terminated.

8. Open Season Changes. Each year OPM announces changes in rates and coverage in health benefit plans. Annuitants and FECA beneficiaries may change plans but may not enroll in the FEHB Plan during Open Season (P.L. 86-382, 9/28/59, Section 2(c)(3)). The effective date of all Open Season changes is the first day of the first full compensation cycle in the new year. Instructions regarding rates, plans available, forms, and procedures to be utilized in recording changes are distributed by OPM in FPM Supplements to the 890-1 series and are detailed further in FECA bulletins.

a. Reporting Changes. Changes are processed into ACPS from SF-2809-1 enrollment forms completed by the recipients of compensation. Copies of the forms should then be sent to the appropriate insurance carrier.

b. Change in FEHB Plan Participants. Claimants enrolled in a plan that drops out of the FEHB Plan must enroll in a new plan to continue coverage. This applies to plans that drop out of the FEHB during Open Season, as well as the plans that drop out during the course of the year.

(1) The district office should immediately inform the claimant of the change required, and supply the claimant with a Form SF-2809-1 and current FEHB guide.

(2) In order to avoid a lapse in coverage should the claimant fail to respond in a timely manner, the district office should change the claimant's coverage. In order to minimize the chance of overpayment to the claimant while awaiting the new plan selection, the health benefits coverage should be changed to Blue Cross Standard Option (self or family, as applicable). However, this action is only carried out to ensure that premiums continue to be deducted from the claimant's compensation benefits. Do not inform the carrier of this enrollment change until the claimant makes a formal election.

(3) Once notification from the claimant is received, the district office should make the necessary adjustment, and promptly notify the carriers of the change. In addition, the compensation payment history should be reviewed for any possible over or under payment to the claimant for the period in question.

9. Overpayments.

a. Temporary Loss of Coverage. If the claimant was denied use of coverage for a period of three months or more, then they are not required to pay for FEHB coverage during that period. If the claimant is returning to the benefit rolls after a period of compensation being denied, they should be provided with a prospective enrollment, if they had no use of or access to the benefits during the period their compensation was terminated. If premiums are withheld for periods when the claimant had no use of the coverage, those premiums should be refunded once it is confirmed that the claimant did not use the coverage. All refunds must be reported via the ARMAPAS process.

b. Underwithholding of Premiums. If it is discovered that there has been an underwithholding of premiums, the entire amount is deemed to be an overpayment of compensation.

(1) Declaring an Overpayment. Any overpayment declared in connection with an underwithholding should be treated in the same manner as all other overpayments of compensation. This includes the waiver provisions in 5 USC 8129, as well as all other regulations and statutes relative to overpayments and debt collection.

(2) Reporting to OPM. An underwithholding of premiums results in a two-tiered liability. The claimant owes the agency the underwithheld funds, and similarly the agency owes the insurance fund/OPM. If this occurs OWCP must make OPM whole, and must remit the entire amount of the underwithholding, even if the debt is eventually waived. This should be accomplished immediately upon discovery via the ARMAPAS process.

10. Continuation of Coverage for a Former Spouse. There are two forms of health benefits coverage available to a claimant's ex-spouse, subsequent to a change in marital status such as divorce or annulment.

a. Temporary Continuation of Coverage (TCC). This plan is administered and regulated solely by the U.S. Department of Agriculture (USDA), National Finance Center (NFC). TCC, established by Public Law 100-654, is similar to the COBRA coverage offered in the private sector. The plan allows a new enrollment to be created for individuals that would ordinarily lose their FEHB entitlement when they lose their dependency status. The entitlement is limited to thirty-six (36) months of coverage. However, former claimants and OPM annuitants are specifically excluded from coverage.

(1) All TCC elections by a claimant's ex-spouse must be submitted in writing to the National Office. The request must include a signed Form SF-2809-1 and a copy of the divorce decree. Since the new enrollment is in the ex-spouse's name, that individual must complete and sign all the necessary paperwork. The NFC is responsible for collecting the necessary premiums and administering the enrollment. Any changes in coverage, such as Open Season or a change in the number of dependents, is processed by the NFC.

(2) If a claimant elects TCC coverage via OPM during a period where his or her compensation benefits have been terminated, he or she may have that money reimbursed by the NFC. Specifically, if the claimant is later deemed entitled to compensation for that period his or her FEHB coverage would be deducted under OWCP benefits, rather than by NFC.

This only applies if the entire period of TCC coverage should have been covered by OWCP. NFC will not grant refunds of premiums paid for partial periods. The claimant's enrollment should be transferred into OWCP effective the date that the coverage was originally terminated. FEHB premiums should be deducted effective that date, and the premiums reported to the carrier via the ARMAPAS process (see PM 5-400-13). Once complete, TCC should be informed of the effective date in writing, so that they may refund any premiums paid by the claimant.

b. Spouse Equity Act: This plan is administered and regulated by OPM for any ex-spouse of an OWCP claimant. A claimant's ex-spouse may elect HBI coverage under the Spouse Equity Act only if the divorce agreement entitles the ex-spouse to a portion of the claimant's Civil Service annuity benefits. If the ex-spouse is not entitled to any portion of the annuity, then he or she must elect coverage under TCC. If the ex-spouse is electing benefits under the Spouse Equity Act, he or she must provide a certified copy of the divorce decree, along with the SF-2809-1 form. The certified copy is distinguished by the raised seal of the court of jurisdiction embossed on the cover page. Unlike TCC coverage, there is no time limitation as to the length of the coverage under the Spouse Equity Act.

c. Premiums and Costs. Both TCC and Spouse Equity coverage require the beneficiary to pay 102% of the total health benefits premium cost. This encompasses the employee and employer costs, as well as a 2% administrative fee. The beneficiary will receive a payment booklet from the appropriate administrative agency, and is responsible for making the monthly payment. The coverage becomes effective 30 days from the qualifying event, i.e. the date of divorce.

11. Continuation of Coverage for a Dependent Child.

a. TCC Coverage. Public Law 100-654 also provides for coverage to be continued under the same TCC regulations that apply to ex-spouses for dependent children when they reach age 22

(1) Coverage Requirements. Unlike OWCP coverage for dependent children, there is no requirement that the child be unmarried or a full-time student. Also, as with the regulations for ex-spouses, the TCC coverage for a dependent child is a new enrollment and considered separate from the claimant's enrollment.

(2) Premiums and Costs. TCC coverage requires the beneficiary to pay 102% of the total health benefits premium cost. This encompasses the employee and employer costs, as well as a 2% administrative fee. The beneficiary will receive a payment booklet from the appropriate administrative agency, and is responsible for making the monthly payment. The coverage becomes effective 30 days from the 'qualifying event', which is the date of the dependent child's 22nd birthday.

b. Federal Employees Health Benefits Children's Equity Act of 2000. This law (Public Law 106-394), enacted October 30, 2000 requires mandatory self and family coverage for employees who do not comply with a court or administrative order to provide health benefits for their children. An employee subject to such an order must enroll in self and family coverage in a plan that provides full benefits to his or her child(ren) in the area where they live, or provide documentation that he or she has other health coverage for the children. If the order does not specify a time limit on the coverage, the employee must keep the self and family enrollment until the last child marries or reaches age 22. This coverage is limited to the claimant's dependent child(ren), and is not extended to the former spouse since the former spouse is no longer considered a dependent.

NOTE: If the claimant has already separated from his or her employing agency at the time of the order, he or she is NOT considered an employee for purposes of the Child Equity Act and it is not applicable to them.

(1) Enrollment. If the employee already has self and family plan coverage that provides full benefits in the location where the children live, written notification should be sent to the entity that issued the order. A copy of the enrollee's SF 2809-1 must be sent to the carrier, along with a copy of the order to notify the carrier of the additional family members being covered under the self and family enrollment.

If the employee is eligible for FEHB but does not have the appropriate coverage, notify the employee that the order has been received, and send him/her a SF-2809-1 form and a plan comparison booklet in order to select appropriate coverage. Allow the employee until the end of the pay period following the one in which notice was given to enroll in an appropriate health plan or provide documentation that he/she has other health benefits for the children.

(2) Involuntary Enrollment. If the employee does not enroll in an appropriate plan or provide documentation of other coverage for the children, you must enroll him or her as follows:

(a) If the Employee Is Not Currently Enrolled in FEHB. If the employee is not enrolled for any FEHB coverage, enroll him or her for self and family coverage in the Standard Option of the Blue Cross and Blue Shield Service Benefit Plan (enrollment code 105).

(b) If the Employee Has Self Only Coverage. If the employee has a self-only enrollment, and the plan serves the area where the children live, change the enrollment to self and family in the same option of the same plan. If the plan does not serve the area where the children live, change the enrollment to self and family in the Blue Cross and Blue Shield Standard Option.

(c) Carrier Notification. If a claimant must be enrolled involuntarily, complete a SF 2809-1 with the employee's identifying information. Use Event Code 1C (Change in family status). In the Part G signature block write "See Remarks." In Part H remarks block note "Involuntary enrollment for self and family coverage under Pub. L. 106-394." Attach a copy of the order to the SF 2809-1 sent to the carrier.

(3) Effective Date. For the order to be valid, it must be received in the office no earlier than October 30, 2000. The order can be issued before October 30, 2000; but if originally submitted before October 30, 2000 it must be resubmitted. The effective date of the coverage will be the first day of the pay period following the one in which the SF 2809-1 was completed. However, if the order specifies an effective date, the enrollment would be retroactive to that date.

(4) Open Season Changes. During open season (or when there is an event allowing an enrollment change), an employee who is subject to a court order can change to a plan that provides full benefits where the children live. However, such an employee cannot cancel the enrollment, change to self only, or change to an HMO that doesn't provide coverage in the area where the children live, as long as the order remains in effect and the children are eligible under the FEHB Program.

d. Continued Coverage for Disabled Dependent Child. FEHB coverage may also continue beyond the age of 22 if the dependent child is physically or mentally incapable of self-support. OPM has defined the specific list of medical conditions that qualify a child as a disabled dependent.

(1) Determination of Entitlement. The determination of disability is made by DFEC, not the health benefits carrier, and is not dependent on any other outside finding of the child's disability. The district office must first determine that the child possesses a medical condition that has been identified on OPM's "List of Medical Conditions That Would Cause Children to be Incapable of Self-Support During Adulthood." This list may be found on OPM's web site at www.opm.gov. To support this determination, the claimant must provide medical documentation of disability. This should include medical evidence that the condition existed prior to age 22, and continues to be disabling. The expected duration of the disability must also be specified and supported.

(2) Notification. Once the determination has been made, a letter must be sent to the health benefits carrier, notifying them of the determination that coverage may be continued beyond age 22. The letter should indicate that medical documentation is on file to support the mental or physical disability for gainful employment. Also, inform the carrier of the approximate expected duration of the disability.

e. Release of Information to Spouse and Children. OPM allows the release of information concerning FEHB coverage to family members who may be affected by a claimant's change from a self-and-family to a self-only enrollment. If the claimant changes to a self-only enrollment without informing his or her family member(s), they do not know that they are without coverage until they file a claim that is denied by the carrier. A family member has only 31 days from the date coverage is terminated in which to convert to a private plan. However, the family member has 6 months to convert if the individual failed to make the request because of a reason beyond his or her control. They are not eligible for TCC.

12. Other Plan Changes. There are also a limited number of events that allow a compensation recipient to change his or her HBI coverage or plan, such as relocation from the health benefits carrier's service area. All of the permissible reasons for change (and the appropriate FEHB codes) are included in the instructions to Form SF-2809-1. Note that these

reasons are more limited than those options allowed to regular federal employees on the SF-2809. Only the allowable changes stated on the SF-2809-1 are available to OWCP claimants. All non Open Season plan change requests should be sent to the district office within 30 days of the described event that allows the change.

13. Health Benefits Reconciliation. All health benefits reconciliation must be processed on the National Finance Center's Centralized Enrollment Clearinghouse (CLER) site. The CLER system, a secure website, receives electronic enrollment information from all health insurance carriers, federal government payroll offices, and OWCP on a quarterly basis. That information is processed by the NFC, who compares the data from the various sources and conducts basic discrepancy resolution. Any health benefits discrepancies that cannot be resolved by the NFC are reported as "errors" on the CLER site, and must be resolved by both the carrier and the appropriate payroll office. For claimants receiving benefits from OWCP, the enrollment is flagged to indicate that OWCP, not the original employing agency, is making the health benefits deductions.

a. Access to CLER. In order to add or remove a user from CLER, the district office must complete the NFC's Access Request form (Exhibit XX). The CLER Security Officer for OWCP is responsible for assigning user reference numbers for each new user request. All other fields should be completed by the district office. Once completed, the Security Officer will forward the form to NFC for processing. The NFC will then complete the new enrollment within five working days and inform the Security Officer of the initial sign-on procedures. The Security Officer must then forward this information to the appropriate user.

b. Identification Numbers. In order to make full use of the CLER site, certain identification numbers should be referenced. These numbers will refine the CLER site query, and allow easier processing of enrollment discrepancies:

(1) Payroll Office Identification Number. This number corresponds to the particular health benefits Agency Location Code (ALC) assigned to the district office.

(2) Agency Identification. The identifier for OWCP is DL00 for all district offices.

(3) Personnel Office Identification. This number is composed of the last four digits of the district office ALC number.

c. Transmission of CLER Data.

(1) National Office Transmissions. The National Office will transmit quarterly all data received from the compensation rolls for each district office. The quarterly transmission will separate the CLER data into individual reports, by the district office ALC number.

(2) District Office Transmission of Data. The local district office will also have the capability to transmit CLER data. This is limited to those cases where the claimant's health benefits deductions are not being made from the automated compensation rolls. This would include cases

being paid on a gross override, or claimants not being paid compensation due to a third party surplus.

d. Contact Information. For more detailed information on the policies and procedures of CLER, the user may download a copy of the procedure manual from the NFC's Publications and forms web page (<http://dab.nfc.usda.gov/pubs/na-pubsmain.html>). In addition, the CLER Help Desk can be reached by telephone at (504) 255-3270, or by e-mail at NFC.CLER@usda.gov.

14. Certification to OPM of HBI Entitlement. As noted above, claimants' entitlement to the FEHB only continues so long as they are unable to "return to duty" as defined above. DFEC may be required periodically to provide OPM with documentation regarding this entitlement for continuing OLI eligibility.

a. Completing Form RI 20-8. If certification by DFEC is necessary, OPM will forward Form RI 20-8 with the front side of the form already completed. The CE need only be concerned with the period after the date requested by OPM on the front side of Form RI 20-8 when completing the back of the form. All relevant items on Form RI 20-8 should be completed, as follows:

- (1) Item 2 - Is an application pending? Complete this item if the individual applying for OPM benefits has filed a claim with the Office but it has not yet been adjudicated.
- (2) Item 3 - Receipt of OWCP Benefit. Complete this item if the claimant has received or is receiving compensation for disability within the last two years.
- (3) Item 4a - Health Benefits Premiums Withheld. If premiums were withheld then list the period of withholding.
- (4) Items 4b & 4c - Transfer of Health Benefits. If the answer to 4b is yes, then complete 4c by providing the name and address of the agency where the HBI information was transferred.
- (5) Item 5 - Basic and Optional Life Insurance. The CE should complete this item if the claimant had life insurance withheld from compensation payments.
- (6) Item 6a - Possible Third Party Settlement. If the answer is yes, then provide the "Ending" and "Commencing" dates of the third party credit. Item 6b should also be answered.
- (7) Item 7 - Last Known Address for Deceased Claimant. This item should be completed if OPM is inquiring about a deceased claimant.
- (8) Item 9 - Certification. The CE should print and sign his or her name. The CE should also provide a phone number for OPM and date the form.

Once completed, the original copy of the form should be returned to OPM and a copy imaged into the case record.

b. Schedule Awards. The inability to return to duty is not a condition of receiving compensation for schedule awards. Therefore, it must be determined whether the claimant is or was unable to "return to duty" during the period of the schedule award in order to have health insurance eligibility to continue. In order to certify continuing eligibility while the claimant receives a schedule award, the case record should contain the following:

(1) Medical evidence showing the physical restrictions caused by the impairment in terms of standing, walking, bending, lifting, hours of duty, etc., and a medical opinion showing whether the impairment would bar the claimant from returning to the work performed at the time of the injury. If this information does not already appear, the CE should ask the attending physician to provide it in a report.

(2) The position description and a statement from the employing agency showing the physical requirements of the job if they are not already in the record.

Once all needed information has been received the CE should compare the requirements of the job to the medical evidence of record. If necessary, the District Medical Advisor (DMA) should be consulted to supply an opinion on the claimant's ability to "return to duty". The CE should prepare a recommendation to the SCE as to whether the claimant could perform the job held at the time of injury. The SCE or higher-level authority must make this determination; it may not be delegated to anyone subordinate to the SCE.

15. Forms and Use.

a. Automated RITS/OPM Monthly HBI Adjustment (ARMAPAS). This electronic form is used to record supplemental health benefits withholdings made from manual or direct payments. The data is then included in the monthly RITS adjustment process conducted by the National Office to transmit the funds to OPM for all DFEC health benefits coverage.

(1) Form Elements.

(a) Case File Number. Nine digits must be entered for the case number, without a dash or letters. Space(s) or "X" can be used as the first two positions for old case file numbers.

(b) Health Plan Code. All three characters for the specific health plan code must be entered in the field.

(c) Employee Share/Agency Contribution. Enter the dollar amounts for each respective field. A dash (-) should be used as the first position for negative amounts.

(d) Total Employee Share and Agency Contribution. This dollar amount is automatically calculated and updated when the form is saved.

(2) Entering Data in PrHealth.

(a) Adding Data. To add new data go to the first blank row and click on the "Case File Number" field. Enter the file number and use the "Enter" key to move one field to the right. Repeat for each field until the entire row is filled. Data must be entered in every field of the row.

(b) Editing Existing Data. To edit a previously entered data field, go to the "Case File Number" field of the appropriate row. Use the "Enter" key to move across the row and enter any new value(s).

(c) Deleting Existing Entries. To delete an entry the entire row must be highlighted, and the "delete" key must be used. Click on the "Save" button to make the delete permanent and remove the blank row.

(3) End of Month Processing. The Month End Processing must be completed on the first workday after the 20th of the month. Clicking on the "Month Clear" button on the form will create the monthly file ("hbmon") that needs to be sent to the National Office. This also clears the data from the form so that new data can be entered during the course of the next month.

(a) Transmission of Data. Once the monthly file has been created, it should be sent as an e-mail attachment to the National Office. The National Office will complete the transmission to OPM for each individual district office.

(b) Multiple Files. If there is more than one "hbmon" file for the district office, they must be combined on a single master file in order to transmit the data to the National Office. To copy individual files to the master file, open the file and highlight all the rows to be copied. Once copied, paste the file on the first blank row of the master file. Repeat this process until all the individual files are copied to the master file. Once all have been copied to the master file, save the contents and transmit to the National Office as described above.

(4) Month Recover. This action restores the monthly file to a daily file, which can be edited. The Month Recover button should be used after the end of month processing is done, and before any data for the current period is entered. When restoring an old month any new data that has been entered will be lost.

b. Health Benefits Registration Form, SF-2809-1. This form must be used to enroll for health benefits, or to make an adjustment in existing coverage, and will be requested on transfer as indicated in subparagraph 7(b) above.

Instructions for its completion and distribution are provided on the form itself. All health benefits actions must be requested on the SF-2809-1 form, which must bear the signature of the claimant. Photocopies of the original SF-2809-1 are acceptable for processing health benefits actions, as OPM has stated that the original forms are no longer mandatory.

c. Notice of Change in Health Benefits Enrollment, SF-2810. This form is used to transfer enrollment. If OWCP is receiving enrollment, the sender will complete the form. Instructions for its completion and distribution are provided on the form itself. Although some agencies may continue to use Form SF-2810, its use is no longer mandatory to transfer-out an enrollment.

d. Transmittal and Summary Report to Carrier, SF-2811. This form was used to transmit the enrollment data to the carrier. OPM has since discontinued the form, stating that it is no longer mandatory (OPM BAL 01-315; April 9, 2001) due to the advent of the CLER system. Thus, the district offices will no longer be required to complete the form. However, it is the responsibility of each district office to create a similar tracking mechanism, in order to maintain a record of all health benefits changes sent to the carriers.

e. Report of Withholding and Contribution, SF-2812. The report is completed and electronically submitted to OPM by the National Office. It is generated with each payment cycle (weekly or 28-day) and details all deductions made during the period.

16. Retired Federal Employees Health Benefits (RFEHB). The RFEHB covers employees who were not eligible for coverage under the FEHB when that law became effective in 1960, and consists of two options.

a. Uniform Plan. This plan is an enrollment in coverage by a Government-wide plan sponsored by AETNA. No change in plan is possible, as the Uniform Plan enrollees are ineligible for FEHB coverage.

b. Private Plan. This plan consists of Government contribution toward payment for any qualified plan the claimant may have. The Private Plan's government contribution is added to the claimant's periodic benefit payment, as opposed to monies deducted from the periodic benefit payment for FEHB coverage. Only enrollees covered under the Private Plan have the right to convert to FEHB coverage at any time they wish.

c. Reporting Deductions. Two forms are used in reporting deductions under the RFEHB:

(1) Notice of Change in Enrollment Status, BRI-41-100. This form is used to record and formulate any allowable changes in the Uniform Plan coverage. The proper distribution of copies is noted on the bottom of the form. The control must be changed whenever a BRI-41-100 is completed by the National Office.

(2) Report of Withholdings and Contributions, BRI-41-101. This form is used both to account for the various codes and to transmit the withholdings to OPM. Private Plan contributions are charged to OPM using this form, as well. Each district is allotted funds for Private Plan expenses each year and charges are reported on the monthly SF-224 against appropriation 16-24x8445(15) by the National Office.

(a) The amount listed in Uniform Plan Total, Withholdings and Government Contributions, for both "Annuitants" (disability) and "Survivors" (death) will agree with the totals of the CP-113 and any manual deductions made.

(b) The amount listed in Private Plan Total for both "Annuitants" and "Survivors" will agree with the totals of the CP-113 and any manual deductions made.

17. Federal Long Term Care Insurance Program (FLTCIP). FLTCIP, or "Long Term Care" is an insurance program sponsored by OPM and administered by Long Term Care Partners, a private sector partnership between the John Hancock Life Insurance Company and the Metropolitan Life Insurance Company.

a. Coverage Basics. FLTCIP provides reimbursement for costs of care when the individual is unable to perform at least two activities of daily living for an expected period of at least 90 days, such as eating, bathing or getting dressed. Also included are situations when the individual needs constant supervision due to a severe cognitive impairment, such as Alzheimer's disease. Care can be received in a variety of settings, including the home, assisted living facilities, adult day care centers or hospice facilities. However, long term care is not the type of medical care needed to get well from a sickness or an injury, nor is it intended as short-term rehabilitation from an accident or recuperation from surgery.

b. Benefit Options. Long term care can be covered completely or in part by the long term care insurance offered by FLTCIP. Reimbursement will be based on the benefit options elected by the claimants, and for the amounts that he or she is approved for. Most plans allow the individual to choose the amount of the coverage desired, as well as how and where to use the benefits. There is also a comprehensive plan that includes benefits for all levels of care, custodial to skilled.

c. Eligibility. Long Term Care is available to all current Federal employees that are eligible for FEHB coverage, whether or not they are currently enrolled in a plan. Individuals receiving compensation who are separated from Federal service remain eligible to elect long term care. In addition, surviving spouses of deceased Federal or Postal employees are eligible. D.C. Government employees are not eligible to apply for coverage in the Federal Program, even if they may be eligible for FEHB coverage.

18. FEHB Coverage and Medicare. The Balanced Budget Act of 1997 (Public Law 105-33) expanded Medicare's health plan options with the creation of Medicare+Choice. Beginning in 1999, Medicare beneficiaries may remain in original Medicare or choose to get their Medicare benefits from an array of Medicare+Choice managed care plan options, depending on where the claimant lives. Generally, everyone is eligible for Medicare if they are age 65 or over. Also, certain younger disabled persons and persons with permanent kidney failure (or End Stage Renal Disease) are eligible. For more specific questions on coverage options, the claimant should contact Medicare directly at (800) 633-4227 or on the web at www.medicare.gov.

a. Electing Medicare Coverage Instead of FEHB Coverage. If the claimant elects to drop FEHB coverage in favor of Medicare coverage, they must inform the office in writing. The notice should advise OWCP that the claimant is suspending their FEHB coverage to enroll in a Medicare managed care plan. The claimant must also complete a SF-2809-1 form (or OPM election form) terminating their current enrollment and provide proof of medicare coverage. However, for purposes of this Medicare coverage, the termination of benefits is treated as a "suspension" of coverage, instead of a total loss of future coverage. Unlike the usual termination of FEHB benefits, this "suspension" of FEHB coverage allows claimants to reenroll in FEHB if they later lose or cancel their Medicare managed care plan coverage.

(1) Voluntary Re-Enrollment in FEHB. If the claimant has previously informed OWCP that they are voluntarily suspending FEHB benefits to enroll in a Medicare managed care plan, he or she has the option to later re-enroll in the FEHB. However, they must wait until the next Open Season to reenroll in FEHB.

(2) Involuntary Re-Enrollment in FEHB. "Involuntary loss of coverage" may occur when a Medicare managed care plan is discontinued or when the claimant moves outside the service area of the Medicare provider. Claimants that opt for Medicare over the FEHB have the right to re-enroll if they involuntarily lose their coverage. They do not have to wait until Open Season to re-enroll in the FEHB. The re-enrollment can be made from 31 days before, to 60 days after, the loss of the Medicare managed care plan coverage. The re-enrollment in FEHB should be made effective the day after the Medicare managed care plan coverage ends.

(3) OPM Election: If the claimant completes the OPM election form, the Form SF-2810 should be used to terminate the current enrollment. The "Remarks" section of the form should indicate that coverage is being suspended due to the claimant's election of Medicare benefits.

b. Medigap. This is a Medicare supplemental health insurance policy sold by private companies to fill "gaps" in Medicare plan coverage. For claimants that seek to drop their FEHB plan in favor of Medicare coverage, one of the ten standardized Medigap policies may be necessary to mirror their current coverage. As with all Medicare options, the claimant should contact Medicare directly for more detailed information.

c. Dual Medicare and FEHB Coverage. When a claimant opts to enroll in a Medicare managed care plan, they may not need FEHB coverage since the Medicare managed care plan provides them with many of the same benefits. Typically, for claimants that opt to keep their FEHB coverage while being covered under Medicare, Medicare is considered the "primary payer" for all medical costs not related to their work-related condition(s). This means that Medicare must pay benefits before the FEHB coverage when the claimant is receiving compensation and OWCP has determined that the claimant is either partially or totally disabled.

19. TRICARE and CHAMPVA Coverage. There are two additional programs available to claimants outside the usual FEHB coverage:

a. TRICARE. TRICARE is a Department of Defense (DoD) health care program for active duty and retired uniformed services members (formerly known as CHAMPUS). Eligible retired members of the military receiving compensation benefits and coverage under the FEHB may elect coverage under TRICARE, as it allows many of the same benefits at a much lower cost. Standard TRICARE coverage has no annual enrollment fees or forms, and the claimant is only responsible for annual deductibles and cost-shares. There are additional TRICARE programs to choose from, including TRICARE Extra, TRICARE Prime, TRICARE Plus, and TRICARE for Life (a combined TRICARE and Medicare program). For details on options and requirements of the TRICARE program, claimants should contact their DoD personnel office, or TRICARE on the internet at www.tricare.osd.mil.

b. CHAMPVA. Public Law 107-14 provides beneficiaries over age 65 of the Department of Veterans Affairs (VA) with coverage secondary to Medicare under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). CHAMPVA provides similar benefits to VA eligible beneficiaries as those benefits provided to uniformed services beneficiaries under the TRICARE programs. CHAMPVA, though separate and distinct from TRICARE, operates in a similar fashion by sharing the costs of medical care with the claimant, reducing the overall health benefits costs. However, any claimant that is eligible for TRICARE is not eligible for CHAMPVA. For additional information on the program, claimants should contact the VA by telephone at (800) 733-8387, or on the web at www.va.gov/hac.

c. Electing TriCare or CHAMPVA Coverage. If the claimant makes the election to drop FEHB coverage in favor of TriCare or CHAMPVA coverage, he or she must inform the office in writing. Similar to Section 16(a) (above) the claimant must complete a SF-2809-1 form, terminating the current enrollment and submit proof of TRICARE/CHAMPVA coverage. As with Medicare coverage, the termination of benefits is treated as a "suspension" instead of a total loss of future coverage.

Chapter 5-0401, Life Insurance

1. Purpose and Scope. This chapter addresses Life Insurance (LI) coverage for recipients of compensation under the Federal Employees' Compensation Act (FECA). It describes eligibility for Basic, Post-Retirement, and Optional Life Insurance (OLI); processing life insurance actions; coordinating with employing agencies and the Office of Personnel Management (OPM); and maintaining life insurance records.

2. Authority and Directives. The law governing life insurance for federal employees is found at 5 U.S.C. §§ 8701-8716.

a. Basic Coverage. Section 5 U.S.C. § 8706(b)(2) provides that Federal Employees' Government Life Insurance (FEGLI) coverage may continue while a claimant is in receipt of compensation, when the coverage would otherwise cease. OPM sometimes requires OWCP to certify the periods that compensation is paid and the claimant's inability to return to duty.

b. Optional Coverage. Since OWCP does not enroll claimants in LI, any inquiries about enrollment should be referred to the claimant's employing agency or OPM.

3. Responsibilities. Fiscal and claims staff share responsibility for ensuring that premiums for life insurance are deducted when appropriate and that such deductions are accurate. In most offices, the fiscal staff is responsible for keying life insurance data into ACPS, and claims staff is responsible for making determinations of eligibility when so requested by OPM. See paragraphs 5b and 5c.

4. Coverage Options. Before 1981 only one optional life insurance plan was available to Federal employees. Currently there are three optional life insurance options available, in addition to the basic life insurance options.

a. Basic Life Insurance. In order to be eligible for Optional Life Insurance (OLI), the claimant must also be enrolled in Basic Life insurance coverage. Although a claimant may be enrolled in only Basic Life coverage, he or she must elect Basic Life in order to qualify for OLI coverage. Federal employees are automatically enrolled in Basic Life Insurance as of the first day of their employment, unless they specifically waive the coverage. Premiums are only withheld until the claimant reaches age 65, and deductions from compensation payments should cease during the first full periodic roll payment after the claimant's 65th birthday.

The Basic Life insurance benefit will reduce at a rate of 2% per month until it reaches 25% of its original value, unless the Post Retirement option has been elected.

(1) Claims With Date of Injury Prior to January 1, 1990: For all claims with a date of injury prior to January 1, 1990, Basic Life Insurance coverage is free of charge, and no premiums for Basic Life need be deducted from the claimant's compensation payments.

(2) Claims With Date of Injury January 1, 1990 and Later. For all claims with a date of injury of January 1, 1990 and later, Basic Life insurance premiums are deducted from the claimant's compensation payments. This is based on the original date of injury, and not a date of recurrence. Bi-weekly premium rates are found in Exhibit 1.

b. Post-Retirement Basic Life Insurance. This premium is being paid to prevent the reduction of the life insurance benefit at age 65. Federal employees who retired or separated from Federal employment and continue to receive benefits from either DFEC or OPM on or after December 9, 1980, have the option of paying the extra premium for No Reduction or a 50% reduction in Basic Life insurance. The claimant must elect the coverage when he or she separates from federal employment, usually after twelve months of Leave Without Pay (LWOP). The coverage takes effect immediately, regardless of age, and premiums are paid until time of death. The election of Post-Retirement Basic Life Insurance at the time of retirement determines the amount that Basic Life insurance will decline or reduce to after the claimant reaches age 65.

(1) Coverage Effects. The claimant may elect to continue Basic Life insurance under this provision at the 75% reduction, 50% reduction, or no reduction of the original value of the policy (No reduction guarantees full value of the Basic Life policy at death). A recipient of compensation is entitled to elect the benefit at the time of separation or retirement, if this occurs at age 65 or later. If Post-Retirement is elected prior to age 65, premiums for both Post-Retirement and Basic Life insurance are paid until age 65, at which time Basic Life Insurance premiums stop.

(a) 75% Reduction. Basic Life insurance will automatically reduce at the rate of 2% per month after age 65, until it reaches 25% of its original value. All claimants receive this "75% reduction" unless they specifically elect a different Post-Retirement option. There is no charge for the 75% reduction coverage.

(b) 50% Reduction. A premium is charged for this option, which reduces the Basic Life insurance coverage at a rate of 1% per month after age 65, until it reaches 50% of its original value. The claimant must pay a premium for this coverage from the date of the election.

(c) No Reduction. A premium is charged for this option, which retains the full value of the Basic Life insurance coverage after age 65, without reduction. The claimant must pay a premium for this coverage from the date of the election.

(2) Notification. OPM will notify OWCP of this coverage if it applies, and OWCP is responsible for deducting premiums when advised to do so by OPM. As with Basic Life insurance, the amount of the bi-weekly deduction must be manually entered in ACPS. The rates for Post-Retirement Basic Life Insurance are shown in Exhibit 1.

c. Option A - Standard Life Insurance. This option provides \$10,000 life insurance in addition to the basic policy. Its coverage is the sole option available before April 1, 1981, and claimants on the compensation rolls prior to that date who never returned to duty thereafter are still covered under this option. Withholdings from compensation payments will cease at age 65, though FEGLI coverage continues at a reduced rate. At age 65 the Option A benefit reduces at a rate of 2% per month, until it reaches 25% of its original value.

d. Option B - Additional Life Insurance. This option is based on multiples of the claimant's annual salary. The claimant may elect coverage from one to five times their salary, and the premiums charged are based on the total amount of coverage.

(1) Premium Calculations. For example, a 40 year old claimant with a salary of \$25,000.00 who elects Option B coverage for three times his salary would pay \$9.00 in premiums every 28 days. ($\$25,000.00 \times 3 \text{ times salary} = \$75,000.00$ in coverage. $75 \times \$0.06$ bi-weekly for a 40 year old = \$4.50 bi-weekly or \$9.00 every 28-days). The premiums listed in Exhibit 1 detail the specific costs per \$1,000.00 in coverage, based on the claimant's age band.

(2) Limitations. All deductions for Option B coverage automatically stop when the claimant reaches age 65. This change in compensation benefit deduction takes effect during the first full roll cycle after the claimant's 65th birthday. Although the deductions have stopped, the claimant's Option B eligibility for FEGLI purposes actually continues at a declining rate. Unless the claimant elects to "freeze" the coverage, the eligibility reduces at the rate of 2% per month for 50 months, until it reduces to zero. See Paragraph 8d for further details on continuing OLI beyond age 65.

e. Option C - Family Life Insurance. This option provides insurance coverage for the claimant's spouse and eligible dependent children.

(1) Coverage Effects. All eligible family members are automatically covered and claimants may elect up to five multiples of coverage. Each multiple is equal to \$5,000 for the spouse and \$2,500 for each eligible dependent child. For example, if the claimant elects three multiples, he or she would receive \$15,000 ($3 \times \$5,000$) upon the death of the spouse. If one eligible dependent child

dies, the claimant would receive \$7,500 (3 X \$2,500). The claimant is always the beneficiary of the Option C benefits, and may not designate a beneficiary.

(2) Eligible Dependents. The claimant's current spouse, unless legally separated, is covered by Option C coverage. Eligible dependent children are those that are unmarried and under age 22. If age 22 or over, the child must be incapable of self-support because of a mental or physical disability that existed before he or she reached age 22.

(3) Limitations. All deductions for Option C coverage automatically stop when the claimant reaches age 65. This change in compensation benefit deduction should take effect during the first full roll cycle after the claimant's 65th birthday. Although the deductions have stopped, the claimant's Option C eligibility for FEGLI purposes actually continues at a declining rate. Unless the claimant elects to "freeze" the coverage, the eligibility reduces at the rate of 2% per month for 50 months, until it reduces to zero. See Paragraph 8d for further details on continuing OLI beyond age 65.

5. Requirements for Coverage. The employing agency determines the claimant's eligibility for LI. Therefore, when Box 28 of Form CA-7 indicates coverage, OWCP automatically considers the claimant eligible for continued coverage for the first 12 months of non-pay status, or separation from federal service.

a. Notification of Eligibility by Employing Agency. DFEC must be informed by the employing agency if the claimant does not meet OPM's eligibility requirements for life insurance. The employing agency must make this initial eligibility determination, and it is their responsibility to notify both OPM and DFEC of any change in the claimant's entitlement to FEGLI coverage.

(1) Reporting Non-Eligibility. For those claimants where it is clear that they will not meet OPM's "Five-Year/All-Opportunity" requirement, the employing agency must notify DFEC. This notification is necessary to ensure that life insurance withholdings can be appropriately stopped at the end of 12 months in non-pay status or separation. In order to notify DFEC, the agency must complete the Notice of Life Insurance Ineligibility, and submit it along with the Form CA-7. A copy of the form will be sent by the employing agency to notify the claimant that FEGLI coverage will terminate upon separation or completion of 12 months in non-pay, whichever comes first.

(2) CE Responsibility. The CE is responsible for monitoring the claim to ensure that life insurance premiums are stopped at the end of 12 months of non-pay or separation.

b. Continuing Enrollment While Disabled. An employee receiving disability benefits may retain LI coverage while receiving compensation, if the claimant would have been eligible to continue the insurance as an employee. Specifically, the claimant must satisfy the requirements of the "Five Year/First Opportunity" rule and has had LI as an employee for no less than:

(1) The five years of service immediately preceding the disability; or

(2) The full period or periods of service during which OLI was available to the employee, if less than five years.

c. Ability to Return to Partial Duty. The term "return to duty" as used in 5 U.S.C. § 8706(c) means "return to duty or occupation or work which the employee was doing at the time of injury." Thus, claimants who continue to receive compensation for even a minor Loss in Wage Earning Capacity (LWEC) do not lose FEGLI coverage, even though they are able to work part-time or to perform light-duty work. Coverage may continue in the presence of a reduced level of compensation under the following circumstances:

(1) Return to Federal Service. If the claimant returns to federal service, the life insurance as a compensation recipient stops, and he or she becomes insured as an employee. NOTE: The amount of OLI coverage for claimants in this group will be based on their return to work federal salary.

(2) Private Sector Employment. For those claimants employed outside of federal service, LI may be continued so long as some compensation payments for the LWEC continue. The LI salary for these claimants will be based on the total salary used to compute the LWEC. Claimants that return to work in the private sector without receiving any type of compensation from DFEC lose their FEGLI entitlement.

(3) Constructed LWEC. If the claimant's constructed LWEC results in no continuing compensation benefits, then the claimant loses entitlement to LI benefits.

d. Denials of Eligibility. If a claimant is ineligible for coverage, the district office should issue the denial which is a decision under the FEGLI, not the FECA. Thus, the usual FECA appeal rights (reconsideration, hearing, or appeal to ECAB) do not apply. The letter should include the following address for review of the decision should the claimant request it:

U.S. Department of Labor
Office of Workers' Compensation Programs
ATTN: HB/LI Reconsideration
200 Constitution Ave., N.W., Room C-3523
Washington, D.C. 20210

6. Certification to OPM of LI Entitlement. As noted above, claimants' entitlement to LI only continues so long as they are unable to "return to duty" as defined above. DFEC may be required periodically to provide OPM with documentation regarding this entitlement for continuing OLI eligibility.

a. Completing Form RI 20-8. If certification by DFEC is necessary, OPM will forward Form RI 20-8 with the front side of the form already completed. In completing the back of the form, the CE need only be concerned only with the period after the date requested by OPM on the front side of Form RI 20-8. The CE should then complete all relevant items on the back side of Form RI 20-8, as follows:

- (1) Item 2 - Is an application pending? Complete this item if the individual applying for OPM benefits has filed a claim with the Office but it has not yet been adjudicated.
- (2) Item 3 - Receipt of OWCP Benefit. Complete this item if the claimant has received or is receiving compensation for disability within the last two years.
- (3) Item 4a - Health Benefits Premiums Withheld. If premiums were withheld then list the period of withholding.
- (4) Items 4b & 4c - Transfer of Health Benefits. If the answer to 4b is yes, then complete 4c by providing the name and address of the agency where the HBI information was transferred.
- (5) Item 5 - Basic and Optional Life Insurance. The CE should complete this item if the claimant had life insurance withheld from compensation payments.
- (6) Item 6a - Possible Third Party Settlement. If the answer is yes, then provide the "Ending" and "Commencing" dates of the third party credit. Item 6b should also be answered.
- (7) Item 7 - Last Known Address for Deceased Claimant. This item should be completed if OPM is inquiring about a deceased claimant.
- (8) Item 9 - Certification. The CE should print and sign his or her name. The CE should also provide a phone number for OPM and date the form.

Once completed, the original copy of the form should be returned to OPM and a copy imaged into the case record.

b. Schedule Awards. The inability to return to duty is not a condition of receiving compensation for schedule awards. Therefore, it must be determined whether the claimant is or was unable to "return to duty" during the period of the schedule award in order for life insurance eligibility to continue. In order to certify continuing eligibility while the claimant receives a schedule award, the case record should contain the following:

- (1) Medical evidence showing the physical restrictions caused by the impairment in terms of standing, walking, bending, lifting, hours of duty, etc., and a medical opinion showing whether the impairment would bar the claimant from returning to the work performed at the time of the injury. If this information does not already appear, the CE should ask the attending physician to provide it in a report.
- (2) The position description and a statement from the employing agency showing the physical requirements of the job if they are not already in the record.

Once all needed information has been received the CE should compare the requirements of the job to the medical evidence of record. If necessary, the District Medical Advisor (DMA) should be consulted to supply an opinion on the claimant's ability to "return to duty". The CE should prepare a recommendation to the SCE as to whether the claimant could perform the job held at

the time of injury. The SCE or higher-level authority must make this determination; it may not be delegated to anyone subordinate to the SCE.

7. Establishing Annual Pay for Life Insurance. Annual pay for life insurance purposes is the annual rate of pay as fixed by law or regulation. However, this does include all of the elements that may comprise basic pay for compensation purposes.

a. Elements Included in Basic Pay:

- (1) Locality-based comparability payment (locality pay) and interim geographic adjustments.
- (2) Premium pay for overtime inspectional service for customs officers.
- (3) Law enforcement officers' premium pay for standby duty and administratively uncontrollable overtime.
- (4) Night differential pay for wage-grade (WG) employees.
- (5) Environmental differential pay for employees exposed to danger or physical hardship.
- (6) Tropical differential pay for citizen employees in Panama.
- (7) Special pay adjustments for law enforcement officers.
- (8) Availability pay for criminal investigators.
- (9) Bonuses for physicians and dentists of the Department of Veterans Affairs.
- (10) Straight-time pay for regular overtime hours for firefighters.

b. Elements *Not* Included in Basic Pay:

- (1) Foreign post differential for WG employees. *Exception:* those wage employees in Guam who were recruited from outside Guam and are paid a recruitment and retention incentive.
- (2) Night differential or premium pay not listed in paragraph 7a.
- (3) Foreign and non-foreign post differential pay of GS employees.
- (4) Bonus, allowances, overtime, holiday, and military pay not listed in paragraph 7a.
- (5) Premium pay for certain air traffic controllers.
- (6) Lump-sum payments for accrued leave.
- (7) Supervisory differentials.

(8) Retention allowances.

(9) Physicians' comparability allowances.

8. Making Deductions. This paragraph describes enrollment codes, rates, beginning and ending dates, as well as how to make deductions in various situations. ACPS withholds LI premiums based on data entered into the payment processing system.

a. Basic Life Insurance: Basic Life premiums are based on the annual "base salary" of the claimant used to calculate disability compensation. The base salary should then be rounded up to the nearest \$1,000, and an additional \$2,000 added to that figure, to arrive at the claimant's annual salary for basic life insurance purposes.

(1) The U.S. Postal Service (USPS) pays the entire cost of Basic life insurance for their employees. If a claimant remains an employee of the USPS, they are eligible for basic life insurance at no charge. USPS employees are automatically enrolled in Basic unless they waive the coverage.

(2) As of 1999, OPM regulation changes removed the cap on the value of Basic Life Insurance. There is no longer a "maximum" amount of basic pay.

(3) Premiums for basic life insurance must be manually calculated, and that dollar amount keyed into the ACPS. Although the calculation is for a bi-weekly premium, ACPS will automatically double the amount for the amount for the four-week/28 day deduction. To enter the premium in ACPS, the record *MUST* be deleted and re-entered in ACPS. There is no adjustment capability for Basic Life Insurance in ACPS.

b. Post-Retirement Basic Life Insurance: Premiums for Post-Retirement must be manually calculated, and that dollar amount keyed into the ACPS. Although the calculation is for a bi-weekly premium, ACPS will automatically double the amount to arrive at the four-week or 28 day deduction amount. At the payment system prompt, the claims examiner should key in the Post-Retirement code ("C"), and then enter the appropriate dollar amount.

c. Optional Life Insurance. In addition to the Basic Life Insurance described above, claimants are also entitled to Optional Life Insurance (OLI).

(1) Processing Optional Life Insurance. Exhibit 1 lists the codes corresponding to various kinds of LI coverage. The codes should be provided by the employing agency when certifying a Claim for Compensation (Form CA-7) submitted by the claimant, and used in entering data into the payment processing system. If the code is missing from the CA-7 form, the claims examiner should contact the employing agency directly to determine what LI coverage may apply. The employing agency should be requested to provide a copy of the claimant's most recent SF-50 form, where the FEGLI code can be found (in Box 27).

(2) Employee Eligibility Beyond Age 65. If the claimant begins receiving compensation benefits *after* his or her 65th birthday, he or she remains entitled to the life insurance eligibility held

during employment. Claimants are not required to "freeze" their coverage or elect Post-Retirement coverage until they have either retired or been separated by the employing agency. In essence, the "age 65" limitations or reductions do not begin to take effect until the claimant is no longer an employee for life insurance purposes.

d. "Freezing" Optional Life Insurance Coverage: OLI coverage reduces in value for Options B and C, once the enrollee reaches age 65. Benefits reduce 2% per month, until they are reduced to zero after 50 months (four years and two months). Although DFEC withholdings for LI stop at age 65, coverage does continue, on a decreasing scale. However, under new OPM regulations, claimants are presented with the option to continue coverage beyond the usual limits after age 65. Claimants are now allowed to continue (or "freeze") their Option "B" and Option "C" coverage indefinitely, without further reduction.

(1) Election. To notify claimants of their entitlement to the "freeze", the National Office will issue letters two months before their 65th birthday, advising them of this option. The claimants will then have 30 days from their 65th birthday in which to send their election directly to OPM. Once certified, OPM will inform the National Office of the election, and the National Office will make the necessary calculations to determine the claimant's 28-day premium deductions. Once calculated, the National Office will then inform the appropriate District Office of the necessary deductions that must be made from the claimant's compensation payments.

(2) Keying Freeze Deductions. In order to deduct the premiums for the coverage, an Accounts Receivable (A/R) entry must be established in ACPS to deduct the premiums from the claimant's compensation payments. Each A/R should contain the following information in the address field, so that the deductions can be identified as Option B premiums rather than another type of A/R deduction:

(2)Line 1 - Claimant Name

(3)Line 2 - "Option B/C Freeze"

(4)Line 3 - Number of Multiples Elected for Each

(5)Line 4 - Effective Date of Election (the date of the claimant's 65th birthday)

(3) Ongoing Deductions. The term "freeze" regarding Option B and C life insurance applies only to principle of maintaining the rate of coverage, by not allowing it to reduce after age 65. However, the premiums charged for this coverage are NOT "frozen", and are subject to the applicable age band rates. See Exhibit 1.

e. Life Insurance Rates. The premiums deducted from compensation benefits are based on the claimant's age and salary, and what various multiples of life insurance have been elected. Rates will increase as the claimant ages, even though the actual coverage does not increase. This is due to the fact that the claimant moves into a higher "age band" as they age. The increased premiums for a new age band will begin during the first pay period following the pay period in which the birthday occurs. When the LI rates or age bands change, OPM notifies the National Office. In turn, the National Office advises OWCP district offices of the changes via FECA bulletin. Current and previous rates are shown in Exhibit 1.

f. Beginning Dates. OWCP starts to deduct LI premiums on the 29th day of compensation. At that time withholdings are made retroactive to the date compensation began. The amounts of the withholdings are determined by the compensation period:

- (1) Up to 3 days: no withholdings.
- (2) 3 - 14 days: bi-weekly rate.
- (3) Over 14 days: twice bi-weekly (28-day) rate.

g. Ending Dates. When compensation stops, LI also stops. If the claimant was paid on the periodic roll, DFEC deducts for insurance from the last four-weekly check. The period of compensation is not a factor in determining LI withholdings. If compensation and the LI enrollment do not end at the same time, the LI enrollment must be retroactive to the date compensation ended.

ACPS automatically stops all life insurance deductions once the claimant reaches age 65 unless the claimant has elected either Post-Retirement Basic Life Insurance or an Option B/Option C freeze of benefits. This increase in net compensation is realized on the first full payment cycle after the claimant's 65th birthday.

h. Schedule Awards. Where a schedule award is being paid, the claimant is usually working or receiving an OPM annuity. If the claimant is receiving payment from either of those sources, the agency or OPM will withhold premiums.

i. Lump Sum Payment. If a lump sum has been paid and the claimant asks to continue LI coverage, OWCP will obtain the premium from the claimant for the forthcoming year of coverage at the beginning of the year. When the premium is received, it will be deposited into the Compensation Fund Account and recorded into the ACPS history file. The funds will be reported to OPM on the Automated RITS/OPM Monthly LI Adjustment (ARMAPAS). The National Office will transmit the data to OPM via Form SF-2812 and SF-2812A as though the claimant was actually receiving compensation and the funds were being reported to the carrier. The two ACPS actions will cancel one another in the chargeback process.

j. Benefits Insufficient to Make Deductions. Sometimes compensation payments do not cover the amount of the deduction for LI because the amount of compensation is very small. OWCP should continue to carry the claimant on the rolls and arrange for the claimant to submit premiums at the beginning of each year to continue coverage. The payment should be received from the claimant and credited as described in paragraph 8i.

9. Changes in Existing Coverage. Claimants do not have the ability to increase their LI coverage while DFEC is making the withholdings. However, they may cancel or reduce coverage at any time, unless the coverage is subject to an assignment. OPM must be notified directly of any changes that effect life insurance eligibility. Any such cancellation or reduction of life insurance coverage must be sent to OPM in writing and have an original signature by the insured claimant. The request should be sent to: OPM, Retirement Operations Center, P.O. Box

45, Attn: Life Insurance, Boyers, PA 16017-0045. The claimant must specify what action he or she wishes to take concerning his or her coverage. OPM determines the effective date of the change, and will notify DFEC of the change to withholdings and sends DFEC verification of the new level of insurance. NOTE: Once coverage has been voluntarily canceled or reduced, it cannot be reinstated while the claimant receives compensation benefits.

10. Third Party Credits. This paragraph describes the LI actions needed when a third party credit exists. If the claimant is entitled to compensation, LI coverage may remain in effect, using either of two methods to obtain the premiums.

a. The beneficiary may pay the premiums for each year of coverage at the beginning of the calendar year. See Paragraph 8i concerning ACPS transactions.

b. The beneficiary may be placed on the periodic roll, with the expiration date equal to the date the surplus should be depleted. Withholdings for LI should be entered, along with the third party "A/R" entry. The "total amount due" should be the amount of the surplus, and the "periodic deduction" should be the net amount of the benefits payable plus an extra \$500 to cover future cost-of-living increases (CPIs). This method allows for electronic reporting of LI coverage and premiums to OPM.

11. Overpayment and Underpayments. This paragraph describes LI actions needed when either an overpayment or underpayment exists. LI withholdings can be credited to the overpayment, thus reducing the total amount due. The payment confirmation should show the status of LI withholdings and whether a credit can be applied. The following examples address various possibilities:

a. Return to Work.

(1) If the employee returned to work with no LWEC, the amount deducted for LI should be applied to the overpayment.

(2) If the employee returned to work with an LWEC, the course of action will depend on whether reemployment is with the federal government or in the private sector:

(a) If federal employment, LI deductions should be terminated as these withholdings are now based on the actual salary being paid to the enrollee.

(b) If private employment, LI deductions should not be applied to an overpayment period after the LWEC determination was made.

(3) If forfeiture is involved, and entitlement ceased on the first day of the overpayment period, and no eligibility for further compensation exists, LI for the overpayment period should be credited to the compensation and manually reported to OPM. At the same time, the LI enrollment must be canceled effective the same date that entitlement ceased.

(a) If it is later determined that the claimant is entitled to ongoing compensation from the ending date of the forfeiture period, retroactive LI deductions must be made from the beginning date of the overpayment period. This may occur in cases where the Employees' Compensation Appeals Board reverses a prior decision denying ongoing entitlement to compensation.

(b) If compensation continues beyond the forfeiture period, LI is not credited to the overpayment of compensation. The overpayment is computed on the gross amount paid.

b. Underwithholding of Premiums. If it is discovered that there has been an underwithholding of premiums, the entire amount is deemed an overpayment of compensation.

(1) Declaring an Overpayment. Any overpayment declared in connection with an underwithholding should be treated in the same manner as all other overpayments of compensation. This includes the waiver provisions in 5 USC 8129, as well as all other statutes and regulations relative to overpayments and collection of debts.

(2) Reporting to OPM. An underwithholding of premiums results in a two-tiered liability. The claimant owes the agency the underwithheld funds, and similarly the agency owes the insurance fund/OPM. If this occurs OWCP must make OPM whole, and remit the entire amount of the underwithholding, even if the debt is eventually waived. This is to be accomplished immediately upon discovery via ARMAPAS process.

c. Underpayment. In the event that a claimant is owed a refund due to an excess deduction of life insurance premiums, the claims examiner must compute the amount owed. The refund should be issued via the ACPS Payment Option 03 screen, in order to insure that the agency chargeback is not adversely affected.

12. Reporting Premiums to OPM. The reporting of premium deductions is accomplished by the Automated RITS/OPM Monthly LI Adjustment (ARMAPAS). This electronic form is used to record supplemental LI withholdings made from manual or direct payments. This data is then included in the monthly RITS adjustment process conducted by the National Office to transmit the appropriate funds to OPM for all DFEC LI coverage.

a. Form Elements.

(1) Case File Number. Nine digits must be entered for the case number, without a dash or letters. Space(s) or "X" can be used as the first two positions for old case file numbers.

(2) Employee Premiums. There is a separate field for each type of life insurance coverage. Enter the dollar amounts for each type of coverage in the respective field(s). A dash (-) should be used for negative amounts.

b. Entering Data in PrHealth.

(1) Adding Data. To add new data go to the first blank row and click on the "Case File Number" field. Enter the file number and use the "Enter" key to move one field to the right. Repeat for each field until the entire row is filled. Data must be entered in every field of the row.

(2) Editing Existing Data. To edit a previously entered data field, go to the "Case File Number" field of the appropriate row. Use the "Enter" key to move across the row and enter any new value(s).

(3) Deleting Existing Entries. To delete an entry the entire row must be highlighted, and the "delete" key must be used. Click on the "Save" button to make the delete permanent and remove the blank row.

c. End of Month Processing. The Month End Processing must be completed on the first workday after the 20th of the month. Clicking on the "Month Clear" button on the form will create the monthly file ("limon") that needs to be sent to the National Office. This also clears the data from the form so that new data can be entered during the course of the next month.

(1) Once the monthly file has been created, it should be sent as an e-mail attachment to the National Office. The National Office will complete the transmission to OPM for each district office.

(2) If there is more than one "limon" file for the district office, they must be combined on a single master file in order to transmit the data to the National Office. To copy individual files to the master file, open the file and highlight all the rows to be copied. Once copied, paste the file on the first blank row of the master file. Repeat this process until all the individual files are copied to the master file. Once all have been copied to the master file, save the contents and transmit to the National Office as described above.

d. Month Recover. This action restores the monthly file to a daily file, which can be edited. The Month Recover button should be used after the end of month processing is done, and before any data for the current period is entered. When restoring an old month any new data that has been entered will be lost.

Exhibit 1: Optional Life Insurance Coding Structure

OPTIONAL LIFE INSURANCE CODING STRUCTURE

OPTION

A
 OPTION - STANDARD - \$10,000 in coverage
 B - ADDITIONAL - Up to 5 times the annual salary
 OPTION - FAMILY COVERAGE

C

CLASS EXPLANATION OF CODE

A A0 Ineligible
 B B0 Basic

C	C0	Post - Retirement Basic Life Insurance
D	D0	Basic + Option A
E	E1	Basic + Option C (1X)
	E2	Basic + Option C (2X)
	E3	Basic + Option C (3X)
	E4	Basic + Option C (4X)
	E5	Basic + Option C (5X)
F	F1	Basic + Option A + Option C (1X)
	F2	Basic + Option A + Option C (2X)
	F3	Basic + Option A + Option C (3X)
	F4	Basic + Option A + Option C (4X)
	F5	Basic + Option A + Option C (5X)
G	G0	Basic + Option B (1X)
H	H0	Basic + Option A + Option B (1X)
I	I1	Basic + Option B (1X) + Option C (1X)
	I2	Basic + Option B (1X) + Option C (2X)
	I3	Basic + Option B (1X) + Option C (3X)
	I4	Basic + Option B (1X) + Option C (4X)
	I5	Basic + Option B (1X) + Option C (5X)
J	J1	Basic + Option A + Option B (1X) + Option C (1X)
	J2	Basic + Option A + Option B (1X) + Option C (2X)
	J3	Basic + Option A + Option B (1X) + Option C (3X)
	J4	Basic + Option A + Option B (1X) + Option C (4X)
	J5	Basic + Option A + Option B (1X) + Option C (5X)
K	K0	Basic + Option B (2X)
L	L0	Basic + Option A + Option B (2X)
M	M1	Basic + Option B (2X) + Option C (1X)
	M2	Basic + Option B (2X) + Option C (2X)
	M3	Basic + Option B (2X) + Option C (3X)
	M4	Basic + Option B (2X) + Option C (4X)
	M5	Basic + Option B (2X) + Option C (5X)
N	N1	Basic + Option A + Option B (2X) + Option C (1X)
	N2	Basic + Option A + Option B (2X) + Option C (2X)
	N3	Basic + Option A + Option B (2X) + Option C (3X)
	N4	Basic + Option A + Option B (2X) + Option C (4X)
	N5	Basic + Option A + Option B (2X) + Option C (5X)
O	90	Basic + Option B (3X)
P	P0	Basic + Option A + Option B (3X)
Q	Q1	Basic + Option B (3X) + Option C (1X)
	Q2	Basic + Option B (3X) + Option C (2X)
	Q3	Basic + Option B (3X) + Option C (3X)
	Q4	Basic + Option B (3X) + Option C (4X)
	Q5	Basic + Option B (3X) + Option C (5X)
R	R1	Basic + Option A + Option B (3X) + Option C (1X)
	R2	Basic + Option A + Option B (3X) + Option C (2X)
	R3	Basic + Option A + Option B (3X) + Option C (3X)

	R4	Basic + Option A + Option B (3X) + Option C (4X)
	R5	Basic + Option A + Option B (3X) + Option C (5X)
S	S0	Basic + Option B (4X)
T	T0	Basic + Option A + Option B (4X)
U	U1	Basic + Option B (4X) + Option C (1X)
	U2	Basic + Option B (4X) + Option C (2X)
	U3	Basic + Option B (4X) + Option C (3X)
	U4	Basic + Option B (4X) + Option C (4X)
	U5	Basic + Option B (4X) + Option C (5X)
V	V1	Basic + Option A + Option B (4X) + Option C (1X)
	V2	Basic + Option A + Option B (4X) + Option C (2X)
	V3	Basic + Option A + Option B (4X) + Option C (3X)
	V4	Basic + Option A + Option B (4X) + Option C (4X)
	V5	Basic + Option A + Option B (4X) + Option C (5X)
W	W0	Basic + Option B (5X)
X	X0	Basic + Option A + Option B (5X)
Y	Y1	Basic + Option B (5X) + Option C (1X)
	Y2	Basic + Option B (5X) + Option C (2X)
	Y3	Basic + Option B (5X) + Option C (3X)
	Y4	Basic + Option B (5X) + Option C (4X)
	Y5	Basic + Option B (5X) + Option C (5X)
Z	Z1	Basic + Option A + Option B (5X) + Option C (1X)
	Z2	Basic + Option A + Option B (5X) + Option C (2X)
	Z3	Basic + Option A + Option B (5X) + Option C (3X)
	Z4	Basic + Option A + Option B (5X) + Option C (4X)
	Z5	Basic + Option A + Option B (5X) + Option C (5X)

Exhibit 2: Basic Life Insurance Page 1BASIC LIFE INSURANCEBI-WEEKLY RATES

Effective January 1, 1990:	\$ 0.185 for each \$1,000 of coverage
Effective January 10, 1993:	\$ 0.165 for each \$1,000 of coverage
Effective April 25, 1999:	\$ 0.155 for each \$1,000 of coverage
Bi-Weekly Rates Effective January 12, 2003:	\$ 0.150 for each \$1,000 of coverage

PLEASE NOTE: To enter Basic Life Insurance in ACPS, the record *must* be deleted and re-entered in ACPS, since there is no adjustment capability for Basic Life Insurance. The premiums must be manually calculated and then the bi-weekly premium is entered. ACPS will double the amount for the four week deduction.

Premiums are only withheld until age 65. Premiums are calculated using the "BASE" pay on which compensation is computed. This amount is rounded-up to the nearest \$1,000 and an additional \$2,000 is added.

Exhibit 2: POST-RETIREMENT Basic Life Insurance Page 2POST-RETIREMENT BASIC LIFE INSURANCEBi-Weekly Rates Prior to December 1988

75% Reduction in Coverage:	No Cost
50% Reduction in Coverage:	\$ 0.30 for each \$1,000 of coverage
NO Reduction in Coverage:	\$ 0.81 for each \$1,000 of coverage

Bi-Weekly Rates Effective December 1988

75% Reduction in Coverage:	No Cost
50% Reduction in Coverage:	\$ 0.24 for each \$1,000 of coverage
NO Reduction in Coverage:	\$ 0.78 for each \$1,000 of coverage

Bi-Weekly Rates Effective April 25, 1999

75% Reduction in Coverage:	No Cost
50% Reduction in Coverage:	\$ 0.27 for each \$1,000 of coverage
NO Reduction in Coverage:	\$ 0.94 for each \$1,000 of coverage

Bi-Weekly Rates Effective January 12, 2003

75% Reduction in Coverage:	No Cost
50% Reduction in Coverage:	\$ 0.60 for each \$1,000 of coverage
NO Reduction in Coverage:	\$ 1.83 for each \$1,000 of coverage

PLEASE NOTE: Premiums are based on the per annum salary of the claimant at retirement. OPM must advise OWCP of the coverage, and will provide the effective date and the per annum salary. Calculation of the premiums is a manual process. The bi-weekly amount is entered in ACPS, and the premiums continue for life.

Exhibit 2: Basic Life Insurance Page 3

BI-WEEKLY OPTIONAL LIFE INSURANCE RATES

EFFECTIVE JANUARY 12, 2003

OPTION A: Standard - \$10,000

Under	\$
35	
35 -	0.30
39	0.40
40 -	0.60
44	0.90
45 -	1.40
49	2.70
50 -	6.00
54	
55 -	

59
60 -
65

OPTION B: Additional up to 5x salary; per \$1,000 of coverage

Under	\$
35	
35 -	
39	
40 -	
44	
45 -	0.03
49	0.04
50 -	0.06
54	0.09
55 -	0.14
59	0.28
60 -	0.60
64	0.71
65 -	1.03
69	1.43
70 -	1.83
74	
75 -	
79	
80 -	
over	

OPTION C: Family - premium per contract

Under	\$
35	
35 -	
39	
40 -	0.27
44	0.34
45 -	0.46
49	0.60
50 -	0.90
54	1.45
55 -	2.60
59	3.00
60 -	3.40
64	4.50
65 -	6.00
69	
70 -	
74	

75 -
79
80 -
over

Rates for deduction past age 65 are only applicable in the iFECS system, but can be used for manual calculations.

Exhibit 2: Basic Life Insurance Page 4

BI-WEEKLY OPTIONAL LIFE INSURANCE RATES

EFFECTIVE APRIL 25, 1999

OPTION A: Standard - \$10,000

Under 35	\$	0.30
35 - 39		0.40
40 - 44		0.60
45 - 49		0.90
50 - 54		1.40
55 - 59		2.70
60 and over		6.00

OPTION B: Additional up to 5x salary; per \$1,000 of coverage

Under 35	\$	0.03
35 - 39		0.04
40 - 44		0.06
45 - 49		0.10
50 - 54		0.15
55 - 59		0.31
60 and over		0.70

OPTION C: Family - premium per contract

Under 35	\$	0.27
35 - 39		0.34
40 - 44		0.46
45 - 49		0.60
50 - 54		0.90
55 - 59		1.40
60 and over		2.60

In ACPS, premiums will change pay cycle following the age event (i.e. the claimant's birthday when they move into a new age bracket for life insurance). If the enrollee elects to "freeze" coverage after age 65, premiums will continue for life. ACPS has not yet been modified to

accommodate this requirement, but an A/R should be entered into DMS to account for the deductions from compensation benefit payments.

Exhibit 2: Basic Life Insurance Page 5

BI-WEEKLY OPTIONAL LIFE INSURANCE RATES
EFFECTIVE JANUARY, 1993

OPTION A: Standard - \$10,000

Under 35	\$	0.40
35 - 39		0.50
40 - 44		0.70
45 - 49		1.10
50 - 54		1.80
55 - 59		3.00
60 and over		7.00

OPTION B: Additional up to 5x salary; per \$1,000 of coverage

Under 35	\$	0.04
35 - 39		0.05
40 - 44		0.07
45 - 49		0.11
50 - 54		0.18
55 - 59		0.30
60 and over		0.70

OPTION C: Family - premium per contract

Under 35	\$	0.30
35 - 39		0.31
40 - 44		0.52
45 - 49		0.70
50 - 54		1.00
55 - 59		1.50
60 and over		2.60

For this period, and employee is considered to have attained age 35, 40, 45, 50, 55, or 60 as of the first pay period beginning on or after January 1 of the subsequent year. For example, a claimant that turns 40 on March 15, 1992 would have a rate change on the first pay period after January 1, 1993.

There are no withholdings past age 65 during this period.

Exhibit 2: Basic Life Insurance Page 6BI-WEEKLY OPTIONAL LIFE INSURANCE RATES
EFFECTIVE AUGUST 3, 1986OPTION A: Standard - \$10,000

Under 35	\$	0.40
35 - 39		0.50
40 - 44		0.80
45 - 49		1.30
50 - 54		2.20
55 - 59		4.50
60 and over		7.00

OPTION B: Additional up to 5x salary; per \$1,000 of coverage

Under 35	\$	0.04
35 - 39		0.05
40 - 44		0.08
45 - 49		0.13
50 - 54		0.22
55 - 59		0.45
60 and over		0.85

OPTION C: Family - premium per contract

Under 35	\$	0.30
35 - 39		0.31
40 - 44		0.52
45 - 49		0.70
50 - 54		1.10
55 - 59		1.75
60 and over		2.80

For this period, and employee is considered to have attained age 35, 40, 45, 50, 55, or 60 as of the first pay period beginning on or after January 1 of the subsequent year. For example, a claimant that turns 40 on March 15, 1992 would have a rate change on the first pay period after January 1, 1993.

There are no withholdings past age 65 during this period.

Exhibit 2: Basic Life Insurance Page 7BI-WEEKLY OPTIONAL LIFE INSURANCE RATES
EFFECTIVE MAY 17, 1984

OPTION A: Standard - \$10,000

Under 35	\$	0.55
35 - 39		0.70
40 - 44		1.00
45 - 49		1.60
50 - 54		2.70
55 - 59		6.00
60 and over		7.50

OPTION B: Additional up to 5x salary; per \$1,000 of coverage

Under 35	\$	0.04
35 - 39		0.05
40 - 44		0.08
45 - 49		0.16
50 - 54		0.27
55 - 59		0.60
60 and over		0.95

OPTION C: Family - premium per contract

Under 35	\$	0.30
35 - 39		0.31
40 - 44		0.52
45 - 49		0.72
50 - 54		1.10
55 - 59		2.00
60 and over		3.00

For this period, and employee is considered to have attained age 35, 40, 45, 50, 55, or 60 as of the first pay period beginning on or after January 1 of the subsequent year. For example, a claimant that turns 40 on March 15, 1992 would have a rate change on the first pay period after January 1, 1993.

There are no withholdings past age 65 during this period.

Exhibit 2: Basic Life Insurance Page 8

BI-WEEKLY OPTIONAL LIFE INSURANCE RATES
EFFECTIVE APRIL 23, 1981

OPTION A: Standard - \$10,000

Under 35	\$	0.60
35 - 39		0.80
40 - 44		1.40

45 - 49	2.20
50 - 54	3.20
55 - 59	7.50
60 and over	9.00

OPTION B: Additional up to 5x salary; per \$1,000 of coverage

Under 35	\$	0.05
35 - 39		0.07
40 - 44		0.12
45 - 49		0.20
50 - 54		0.30
55 - 59		0.60
60 and over		0.95

OPTION C: Family - premium per contract

Under 35	\$	0.50
35 - 39		0.60
40 - 44		0.70
45 - 49		0.90
50 - 54		1.30
55 - 59		2.00
60 and over		3.00

For this period, and employee is considered to have attained age 35, 40, 45, 50, 55, or 60 as of the first pay period beginning on or after January 1 of the subsequent year. For example, a claimant that turns 40 on March 15, 1992 would have a rate change on the first pay period after January 1, 1993.

There are no withholdings past age 65 during this period.

Chapter 5-0700, Chargeback

1. Purpose and Scope. Costs incurred under the Federal Employees' Compensation Act (FECA) for most injuries and deaths are billed to the agencies on an annual basis through a mechanism known as chargeback. The purpose of this chapter is to describe how the chargeback system works.

2. Statutory Provisions. The authority for the chargeback process is found in Section 8147 of the FECA.

a. Coverage. Each employing agency is responsible for the total cost of benefits paid from the Employees' Compensation Fund during the previous fiscal year for injuries or deaths occurring after December 1, 1960. Costs for injuries and deaths which occurred before then are not billed back to the employing agencies; rather, Congress appropriates them directly. Costs for certain other kinds of cases (e.g., non-Federal law enforcement officers, or LEO cases) are also appropriated directly by Congress.

b. Administrative Expenses. Each agency which is not funded (or only partly funded) from Congressional appropriations is required to pay an additional amount to the OWCP as its "fair share" of administrative expenses each year. Examples of such agencies are the U.S. Postal Service and the Tennessee Valley Authority.

c. Billing. By August 15 of each year, the OWCP is required to send each agency a statement and bill which summarizes its total costs for the prior chargeback year. The FECA chargeback year begins on July 1 and ends on June 30, and all checks issued by the U.S. Treasury between those dates will be shown on the chargeback listing. The agency must include the amount shown on the chargeback billing in its budget for the following fiscal year.

3. Agency Codes. The OWCP assigns each agency one or more four-digit agency codes which are used for chargeback purposes. The agency decides which of its departments or facilities are to be assigned separate codes. National Office (NO) staff assign these codes, which are listed in the Sequent System Case Management Users' Guide. NO staff also prepare FECA Circulars as changes or additions occur.

A two-digit suffix identifier is appended to the four-digit code. This two-digit code identifies the geographical location of the reporting office. The district offices assign these two-digit codes for all agencies except Department of Defense. The code will be either two letters of the alphabet (such as DC) or the numbers 00. Cases created prior to 1978 may only have the four-digit code, as the suffix code was not listed on the case summary until that time.

4. Transfer to Another Agency. If an agency (in whole or in part) or any of its functions is transferred to another agency, the costs of benefits paid for employees of the transferred agency or function are transferred to the receiving agency. The agency should advise the NO of the reorganization and provide a list of the employees affected and the OWCP agency code applicable to the gaining organization. The NO will furnish this information to district offices as soon as it is available.

Generally, such organizational changes affect only the codes for new injury cases. The codes for cases created before the transfer or reorganization remain unchanged in the data base and are adjusted by group change in the automated system.

By contrast, the chargeback code does not change when an employee transfers from one agency to another, but the function does not transfer. When an employee files a Notice of Recurrence with an agency other than the one at the time of injury, the chargeback code for that case should generally not be changed.

5. Determining Amounts Charged. The amount charged for any case is the sum of compensation and medical payments made over the course of the chargeback year.

a. Compensation Payments. When a payment is made through the Automated Compensation Payment System (ACPS), the system records the payment automatically using agency codes maintained in the Case Management File (CMF).

Adjustments to these payments such as check cancellations, cash receipts, CPI increases, and third party settlements (compensation portion) must be made through the ACPS using screen 02, Adjustment Input. The part of any third party settlement to be applied against compensation payments made must be entered as a Cash Receipt adjustment in the ACPS.

However, there are certain adjustments which, though they must be made part of the ACPS history, should be entered using screen 03, Payment/Cash Receipt Refund/Offset, so they do not affect the amount to be charged back. Examples of these adjustments include health benefits refunds and excess accounts receivable.

b. Medical and Other Bills. When a payment is made through the Bill Processing Subsystem (BPS), the system records the payment automatically using agency codes maintained in the CMF.

Adjustments to these payments, as well as bills paid manually or through fund transfers, must be entered into the BPS using screen 02, Adjustment Input. The part of any third party settlement to be applied to bill payments must be entered as a Cash Receipt adjustment into the BPS.

6. Agency Requests for Adjustment. In addition to funding the compensation program, the chargeback system serves as a management tool for agencies. The agencies actively monitor chargeback information provided by OWCP to control compensation costs and evaluate the effectiveness of their compensation programs. Because accurate chargeback data is crucial to their interests, an agency will sometimes request that a case believed to belong to another agency be removed from its report or bill.

a. Advice to Agencies. After the case is created, the OWCP sends a notice (Form CA-801) showing the case number generated by the ADP system to the claimant and the agency. Also, each agency receives a quarterly report showing a breakdown of cases and costs for which charges will appear on that year's chargeback bill.

b. Identification of Potential Errors. To ensure accurate chargeback data, OWCP encourages agencies to identify potential errors at the earliest possible time. No documentation is required for an agency to bring an error to the attention of the district office within 60 days of receipt of Form CA-801. Requests for changes based on review of the quarterly chargeback report should be made to the district office within 90 days of receipt of the report. The request should be accompanied by appropriate documentation, such as copies of an SF-50, job record card, or response from the Federal Records Center.

c. Action by District Office. Upon request by the agency, the district office will review the disputed case and any supporting evidence to determine whether a keying or coding error occurred.

(1) If the evidence does not support the agency's request, the district office must send the agency a copy of Form CA-1 or CA-2 from the case file with an explanation of why a change is not justified.

(2) If the evidence shows that the disputed case belongs on another agency's account, the district office must notify the new agency and forward a copy of Form CA-1 or CA-2 from the case file. A copy of this letter should be sent to the agency that brought the error to the office's attention.

(3) Before changing the agency code in the CMF, the district office should allow the new agency 60 days to respond in the event that it disputes ownership of the case. If at the end of that period no evidence has been received to alter the district office's finding, the Systems Manager should be asked to change the agency code for the case.

d. Intra-Agency Changes. Occasionally an agency will request that the chargeback code for a case be changed to reflect a different section of the same agency. If such a change is requested, the district office should ask the agency to send a representative to the office to review the disputed case and resolve the matter. No letter to the agency or 60-day waiting period is required before making an intra-agency correction of a chargeback code.

e. Adjustments to Bills. A request for an adjustment to the yearly chargeback bill must be forwarded to the NO for response. The request should be accompanied by documentation that the disputed charge was not for an employee of the agency, or by a complete explanation of the basis for the agency's objection.

Requests for adjustments of the chargeback bill will be considered only when the request involves a transfer of costs from one agency to another. A transfer of charges from one organization to another on the same bill will not be made.

7. Error Reports. Several kinds of reports are available to verify chargeback information and detect errors and omissions.

a. Case Not in CMF. Each time the disability and death roll programs are executed, a report is generated which lists cases having invalid CMF pay/adjudication status codes. Occasionally a case appears on this list with an indication that it is not contained in the CMF. When this happens, the case is not captured for chargeback purposes and thus is erroneously included with nonchargeable cases. The case must be reviewed for correction of erroneous codes and addition of the case to the CMF.

b. Payments and Agency Codes. The NO frequently provides district offices with lists of cases containing errors which affect chargeback. The error lists include cases for which payments were made in the chargeback period but which do not appear on the CMF, and cases that require correction of erroneous or nonexistent agency codes. District offices are required to take prompt

corrective action to ensure that the costs associated with these cases are charged to the appropriate agency.

c. High-Cost Cases. District offices receive quarterly listings of cases with particularly high medical or compensation costs. The lists of high-cost cases are to be used for review of possible payment discrepancies, and to ensure that the payment and cost transactions are correct when they appear in the final chargeback listings. The district office will review the lists and take any actions necessary to correct payment history records.

8. End-of-Year Adjustments. The steps required to ensure the accuracy of the chargeback bill are described below.

a. Preliminary Bill and Error Reports. At the end of June, the NO produces a preliminary chargeback bill. The NO also produces error reports as described in paragraph 7 above and sends them to the district offices with instructions to make corrections by a specified date. Unless the corrections are made by that date, they will not appear on the final chargeback bill run at the end of July.

b. Updates. The cutoff date for taking action on error reports also applies to updates to history for transactions occurring before July 1. Updates to reflect manual payments, check cancellations and cash receipts for the recently ended chargeback year must be processed prior to the cutoff date. When the final bill is produced at the end of July, it will reflect any updates entered during the "window" period for transactions occurring prior to July 1.

FECA Part 6 - Debt Management: Addresses identification of overpayments under the FECA, issuance of preliminary and final decisions, and collection actions.

Chapter 6-0100, Introduction

1. Purpose and Scope. This chapter provides a summary of the overpayment process in general terms and the instructions fundamental to implementing the provisions of 5 U.S.C. § 8129 of the Federal Employees' Compensation Act (FECA) as well as debt collection and management arising in connection with the FECA.

Detailed information pertaining to Identifying and Calculating an overpayment can be found in PM 6-0200. Initial Overpayment Actions can be found in PM 6-0300. Specific information regarding Final Overpayment Determinations is outlined in PM 6-0400. PM 6-0500 details procedures for Debt Liquidation.

An overpayment occurs when a claimant or beneficiary receives more compensation than that to which he or she is entitled. The Claims Examiner (CE) is responsible for properly identifying and calculating the overpayment, making initial determinations including administrative termination and fault findings, issuing Preliminary and Final Overpayment Determinations, and liquidating the debt, if applicable.

Debts may also be created when an entity such as a medical provider receives a duplicate payment in excess of the amount authorized under the fee schedule or payment that the Secretary determines is not appropriate under the FECA. Such debts are also subject to collection by the Office of Workers' Compensation Programs (OWCP). The fiscal handling of such debts can be found in Part 5, Benefit Payments, as well as in FECA Bulletin 17-05 (May 8, 2017), OWCP ADMINISTRATIVE PROCESS TO COLLECT IMPROPER BILLINGS THROUGH THE DEBT COLLECTION ACT.

2. Legislative Authority and Regulatory Provisions. The instructions in this chapter and the other chapters of Part 6 are derived from the following regulations and authorities:

a. 5 U.S.C. § 8129 authorizes the Secretary of Labor to recover overpayments because of an error of fact or law, except when an incorrect payment has been made to an individual who is without fault and the adjustment or recovery would defeat the purpose of the Act or would be against equity and good conscience. With respect to recovery, the FECA authorizes the OWCP (as designee of the Secretary of Labor) to collect overpayments from accrued compensation and continuing benefit payments.

b. Public Law 89-508, Federal Claims Collection Act of 1966 (80 Stat. 308), amended by Public Law 101-552 (1990), 31 U.S.C. § 3711(g)(1), assigns the Secretary responsibility for the collection of debts arising from the activities of the Department. It also provides the authority to compromise, terminate, or suspend collection action on debts not in excess of \$100,000. In such cases, there must be no indication of fraud, and it must appear that no person liable for the claim has the present or prospective financial ability to pay any significant amount of the debt, or that the cost of collection is likely to exceed the amount of recovery. The Departmental Manual at 924(d) provides that debt collection and settlement functions are delegated to agencies with accounting and settlement procedures that are consistent with the standards outlined in PM 5-700, the Department's Manual of Administration, and procedures that are approved by the Assistant Secretary for Administration and Management.

c. Public Law 97-365, Debt Collection Act of 1982, amended several statutes, including the Federal Claims Collection Act of 1966. The Debt Collection Act authorizes Federal agencies to collect certain charges on outstanding debts, to use salary offset or administrative offset to collect claims and to use the services of private collection agencies. (Note: The Federal Claims Collection Act of 1966, as amended by the Debt Collection Act of 1982, has been codified as 31 U.S.C. 3711-3720.)

d. Public Law 104-134, Debt Collection Improvement Act of 1996, also amended several statutes, including the Debt Collection Act of 1982. See 31 U.S.C. 3711(g)(1). The Debt Collection Improvement Act provides that any non-tax debt or claim owed to the United States that has been delinquent for a period of 180 days shall be turned over to the Secretary of the Treasury, who will determine whether to collect or terminate collection actions on the debt or claim. The 'Digital Accountability and Transparency Act of 2014' (DATA Act) now requires federal government agencies to refer debts within 120 days. PUBLIC LAW 113-101. See 31 U.S.C. § 3716 (c)(6)(A).

e. 31 CFR Part 900-904 (Federal Claims Collection Standards) describes standards for the collection and compromise of debts, termination of agency collection, and referral of civil claims to the Department of Justice. In particular, 31 CFR 903.1(b) provides that the authority to suspend or terminate uncollectible claims in excess of \$100,000, exclusive of interest, penalties and administrative costs "rests solely with the Department of Justice." Consequently, even if the OWCP believes that suspension or termination of recovery of such a debt is appropriate, the matter must be referred to the Department of Justice for determination.

f. In 29 CFR Part 20, Subparts A through D include the regulations governing credit reporting, administrative offset against funds owed to a debtor by the United States (other than salary), the FECA assessment and collection of charges, and salary offset when the debtor is a current employee of the United States. Although the Department of Labor's salary offset regulations may be applied to debts resulting from FECA overpayments, it is preferable to refer such debts to the Department of the Treasury through the National Office for resolution.

g. 20 CFR §§10.430-441 includes the regulations applicable to overpayments of compensation.

h. 31 CFR Part 285 includes the provisions for transferring delinquent debt to the Department of the Treasury for cross-servicing. Additional information is also available on the Treasury website.

i. In a case involving criminal fraud on the part of the debtor or any other party having an interest in the claim, instructions regarding compromise or termination do not apply. As provided by 31 CFR 900.3(a), only the Department of Justice has authority to compromise or terminate collection action on such claims.

j. In cases referred to the Office of Inspector General (OIG) or the U.S. Attorney for reasons other than collection of the debt, the OIG should be advised before collection action is initiated in order to evaluate whether collection action would jeopardize an ongoing investigation or a legal action in progress.

k. The Supreme Court ruling in the case of Califano v. Yamasaki, 442 U.S. 682 (1979) required that the Social Security Administration defer any measures to recover an overpaid benefit until the claimant had been notified of the overpayment, told of the right to seek reconsideration, and given an opportunity for an oral hearing on the issues of fault and waiver. Because the wording of the Social Security Administration waiver provision is similar to that in the FECA, the OWCP also provides the right to a pre-recoupment hearing to compensation claimants under the FECA. *Dorothy F. Ellis*, 41 ECAB 296 (1989) (OWCP determined that the holding of the Supreme Court in *Califano v. Yamasaki* was applicable to the recovery of overpayments under the FECA).

3. Basic Chronology of an Overpayment. The following is a typical sequence of events when an overpayment occurs:

a. The Overpayment is Identified. Once it has been determined that a claimant or beneficiary has received more compensation than that to which he or she was entitled, an overpayment is identified and a CE is assigned the debt for proper handling. An overpayment can be identified by Claims Office (Office) staff upon review of the compensation history or case file, or from information received from outside parties, such as the claimant, employing agency, the Office of Personnel Management (OPM), the Department of Veterans Affairs (VA), the Social Security Administration (SSA), etc.

b. The Overpayment is Calculated. After the overpayment is identified, the CE will calculate the difference between what the individual was paid and what the individual should have been paid to determine the final overpayment amount. Any worksheets or calculations that are used as the basis for the overpayment should be placed in the case file and attached (and explained) with any overpayment decision. For additional guidance, see PM 6-0200.

c. Administrative Termination of Debt Collection.

(1) Less than \$300. Debt collection actions on overpayments of less than \$300 may be administratively terminated at any time after the overpayment has been identified, with no requirement to complete any of the "due process" actions described elsewhere in this chapter or the other chapters of Part 6, if the cost of further collection action would exceed the recovery

expected. This action may be applied to any type of debt except those not covered by 5 U.S.C. 8129, which include:

- (a) Refunds due OWCP under 5 U.S.C. § 8132 as a result of a third party settlement.
- (b) Money owed OWCP as a result of a beneficiary's election of OPM retirement benefits in lieu of previously paid compensation, where the debt can be recovered from the retroactive portion of the annuity held by OPM.

If the administrative termination is in posture, the CE should prepare a memorandum to the file explaining its basis. See PM 6-0300.3 for more detailed information.

(2) Between \$300 and \$1,000. If the overpayment calculates to an amount less than \$1,000 (but more than \$300), the CE should determine whether it can be administratively terminated. This can only be done after a formal Preliminary Overpayment Determination has been issued, a decision has been made that the costs of collection are likely to exceed the amount recoverable and the overpaid individual has not requested a pre-recoupment hearing. If an administrative termination is in posture, the CE should prepare a memorandum to the file explaining its basis. See PM 6-0300.3 for more detailed information.

d. Preliminary Overpayment Determinations. Overpayments greater than \$300 (and overpayments under \$300 not covered by paragraph (c)(1) above) should be formally declared and a preliminary finding of overpayment issued shortly following declaration.

(1) The Preliminary Overpayment Determination includes a finding as to whether the overpaid individual was with fault or without fault in the creation of the overpayment. It should clearly explain how the overpayment was calculated, the reason the overpayment occurred and the basis for the fault finding.

(2) The Preliminary Overpayment Determination should be released using Form CA-2201 (with fault), Form CA-2202 (without fault), or equivalents.

(3) The Preliminary Overpayment Determination affords the overpaid individual 30 days to either request that the Office issue a final decision based on the evidence of record or request a pre-recoupment hearing with the Branch of Hearings and Review (H&R). If the overpaid individual requests a pre-recoupment hearing, a Final Overpayment Determination will be issued by H&R rather than the Office CE. The preliminary determination also provides an option to pay the overpayment in full or, if unable to pay in full, completion of Form OWCP-20, or equivalent, so that a fair repayment method can be determined. Further guidance on Preliminary Overpayment Determinations can be found in PM 6-0300.5.

e. Final Overpayment Determinations. Once 30 days have passed since the issuance of the Preliminary Overpayment Determination, in order to determine the next course of action, the CE should review the case file and debt management system to see if payment has been made towards the debt or if the overpaid individual has submitted a response to the preliminary determination.

(1) The CE should consider all information submitted since the release of the preliminary determination.

(a) If the overpaid individual repaid the debt in full, the CE should issue a letter advising the individual that the debt is closed. No Final Overpayment Determination is necessary.

(b) If the overpaid individual has submitted less than a full payment or has submitted no payment at all and has not requested a pre-recoupment hearing, the CE should issue a Final Overpayment Determination considering waiver, compromise and collection. Any administrative termination is based upon the initial balance of the debt, not any subsequent balance following a partial payment. As such, a final decision should be issued even if the individual submits partial payment resulting in a remaining debt balance of \$1,000 or less.

(2) A Final Overpayment Determination carries the right to appeal to the Employees' Compensation Appeals Board (ECAB). If the decision determines that a collectible overpayment exists, it should advise that a referral to the Department of the Treasury may occur. The decision should explain the due process requirements as outlined by the Department of the Treasury. Detailed information concerning Final Overpayment Determinations can be found in PM 6-0400.5.

(3) The Final Overpayment Determination should be released using Form CA-2223/4, Form CA-2225, Form CA-2226, Form CA-2227, or equivalents.

(a) Where the decision is made to collect the overpayment, the Final Overpayment Determination is also the first demand for payment.

(b) A second demand letter (Form CA-9001 or equivalent) should be issued after the 30th day following the Final Overpayment Determination, unless the debt has been resolved or is being collected under an established repayment schedule.

(c) If proper resolution of the debt is not achieved, a third demand letter (Form CA-9002 or equivalent) should be issued after the 30th day following the second demand letter.

(d) All of the demand letters should include the appropriate due process language required by the Department of the Treasury to avoid delays in the referral of the debt to the Department of the Treasury and to facilitate collection of the debt.

(e) Further information regarding debt liquidation can be found in PM 6-0500.

(4) After the 30th day following the third demand letter, if the debt has not been resolved, the debt should generally be evaluated for the possibility of implementing OPM offset, compromise or referral to the Department of the Treasury.

Chapter 6-0200, Identifying and Calculating an Overpayment

1. Identifying an Overpayment. When information is received which establishes that benefits have been overpaid, the OWCP is responsible for ensuring that an overpayment exists, that it is formally identified, and that compensation is adjusted accordingly (if applicable). Some of the most common reasons that an overpayment occurs include, but are not limited to:

a. Return to work with no wage loss or partial wage loss. The claimant is in receipt of compensation on the periodic roll and the Office receives notification after the cutoff date that he/she returned to work with no/partial wage loss. J.V., Docket No. 15-0140 (issued November 25, 2015) ("As he received full-time wages for an eight-hour position job for the period August 6 to 23, 2014, he was not entitled to disability compensation from OWCP for this same period. Therefore, appellant received an overpayment of compensation.") The CE will usually receive notification through correspondence or by phone from the claimant, the employing agency (such as by Form CA-3), and/or the Field Nurse or the Vocational Rehabilitation Counselor. Once confirmed, the CE should delete the claimant from the periodic roll and enter the return to work date (first date of non-entitlement). The overpayment will then be automatically calculated.

(1) If only partial wage loss exists, the CE should not rely on the automatically generated amount for determination of the overpayment amount. Rather, the CE should calculate the difference between what was paid and what should have been paid given partial wage loss in order to determine the final overpayment amount.

b. Incorrect pay rate. A compensation payment(s) was made using a higher pay rate than the claimant was entitled to receive. The CE will usually identify this type of overpayment upon review of case file documents, the compensation history, or upon receipt of updated pay rate information from the employing agency. J.S., Docket No. 14-977 (issued September 24, 2014)(ECAB affirmed fact and amount of overpayment as the record reflected that OWCP paid the incorrect recurrence pay rate when it calculated appellant's schedule award).

c. Improper deductions or no deductions for health benefits insurance (HB) or life insurance (LI). The CE will usually identify this type of overpayment upon review of case file documents, notification from the claimant or the employing agency, or receipt of correspondence from OPM. N.G., Docket No. 15-48 (issued May 22, 2015) (an overpayment occurred as his health and life insurance payments were not recovered when appellant's compensation was reinstated). In some instances, the CE may determine that there is conflicting information in the case file regarding the proper HB or LI deductions to take. Clarification to resolve the conflicting information should be sought prior to declaring the overpayment.

(1) The most common reasons for overpayments to occur due to improper HB or LI deductions are as follows:

(a) Incorrect code or no code. Where premium deductions were made for the wrong HB/LI code, and the correct HB/LI code carries higher premiums than the premiums previously deducted, or if no HB/LI code was entered but should have been.

(b) Incorrect deduction dates. Where HB/LI premiums were not deducted for the appropriate dates of total disability.

(c) Changes in marital or family status resulting in attainment of a family health insurance plan or an increased life insurance policy which results in higher premiums than previously deducted.

(d) Open season change as notified by fiscal personnel. Each year OPM announces changes in rates and coverage in health benefit plans. Claimants may change plans which may result in higher premiums than those previously deducted.

(e) OPM Form RI 76-10 reports a higher annual salary for life insurance than the pay rate salary resulting in higher premiums than those previously deducted.

d. Payment of augmented compensation (75 percent). The claimant was paid at the augmented 75 percent rate but lost a sole eligible spouse due to death, divorce, etc.; or lost eligible dependency status due to a sole dependent child's change in student status, age, marriage, etc. In these situations, compensation has to be retroactively adjusted to the 66 2/3 percent rate to which the claimant was entitled for the same period. The CE will usually identify this type of overpayment upon receipt of a death certificate or marriage license, the student dependency form, Form CA-1032, or by correspondence/phone call from the claimant. L.J., Docket No. 15-695 (issued May 26, 2015) (ECAB affirmed OWCP's determination on the fact of overpayment as appellant's grandson is not an eligible dependent for purpose of determining entitlement to augmented (3/4) disability compensation). See J.K., Docket No. 17-142 (issued December 1, 2017) (Overpayment occurred as daughter properly found no longer a student under FECA once she completed four years of education beyond the high school level).

e. Improper compensation period. Compensation has been paid for a period in which there was no entitlement. The CE will usually identify this type of overpayment upon receipt of a Form CA-7 or documentation/information received from the claimant or the employing agency.

(1) The most common reasons for an overpayment to occur due to payment for an improper compensation period include:

(a) The CA-7/CA-7a and/or leave analysis form(s) reported wage loss for date(s)/hour(s) previously paid for which no wage loss actually exists.

(b) The CE incorrectly entered date(s)/hour(s) of wage loss to which the claimant was not entitled.

(c) Wage loss compensation was paid for less than 14 days, but waiting days were not withheld.

(d) The claimant was paid sick/annual leave by the employing agency for the same date(s)/hour(s) that wage loss compensation was paid.

(e) The claimant has more than one claim and was paid wage loss compensation under each claim for the same date(s)/hour(s).

(f) The claimant received separation pay and under 5 U.S.C. 8116 and 20 CFR 10.421 (c), the claimant is not entitled to receive disability compensation and separation pay concurrently.

f. Incorrect Schedule Award. A schedule award may have been issued improperly. M.G., Docket No. 14-252 (issued May 20, 2014) (OWCP issued a schedule award for five percent binaural hearing loss. It later found that the schedule award was issued in error, as a claimant is only entitled to a schedule award for tinnitus if there is also a ratable hearing loss. As appellant did not have a ratable hearing loss, he was not entitled to a schedule award for tinnitus. ECAB held that OWCP correctly determined that appellant was not entitled to a schedule award, and that the entire amount of the schedule award constituted an overpayment of compensation.). The CE will usually identify this type of overpayment upon review of case file documents, the compensation record, notification from fiscal personnel, notification from the claimant, or correspondence received from the VA.

(1) Overpayments due to improper schedule award payments usually occur for one or more of the following reasons:

(a) Incorrect pay rate or effective pay rate date. Where an incorrect pay rate or effective pay rate date was used to pay the award, an overpayment may exist between the schedule award paid and the schedule award that should have been paid using the proper pay rate or effective pay rate date.

(b) Incorrect MMI date. Where an improper MMI date was used to process the schedule award, and CPI's were applied when they should not have been, an overpayment exists between the schedule award paid using an incorrect MMI date and what should have been paid using the correct MMI date.

(c) Incorrect percentage of impairment. Where the percentage of permanent partial impairment paid is greater than that to which the claimant is entitled, an overpayment exists between the schedule award paid at a higher percentage of impairment and the lower percentage of the actual impairment entitlement. This may occur if the actual percentage of impairment was erroneously entered at the time of the initial award or if new evidence is subsequently received demonstrating improvement in the claimant's condition (resulting in a lesser percentage of impairment than previously paid). L.F., Docket No. 15-489 (issued May 11, 2015) (ECAB affirmed OWCP's decision on the issues of fact and amount of overpayment and the issue of (without) fault where a schedule award decision establishes a lesser impairment after a greater award has been paid).

(d) Incorrect part of the body. The body part determined to be permanently partially impaired dictates the number of weeks/days compensation is paid, as outlined in the schedule table. (See PM 2-0808 Exhibit 1). Where payment was made based upon an incorrect body part which resulted in a higher schedule award than that to which the claimant is entitled, an overpayment exists between the number of weeks/days of compensation paid and the number of weeks/days of compensation that should have been paid.

(e) Incorrect compensation rate. Where the claimant was incorrectly paid at the augmented 75 percent rate, an overpayment exists between erroneous schedule award entitlement at the 75 percent rate versus the actual entitlement at the 66 2/3 percent rate.

(f) Prior impairment was not subtracted. Where a new schedule award is being issued for the same/similar body part as previously awarded, the percentage that was already paid should be subtracted from the total percentage of impairment. See PM 2-0808.7.a(1)(a). If this was not done, an overpayment exists.

(g) If a lump sum payment of the schedule award was issued and payments for temporary total disability were paid during the period covered by the lump sum, an overpayment exists.

(h) VA benefits were paid for the same injury. Where the VA has already paid the claimant for a previous impairment to the same member, an election will be required if the VA has awarded or increased the percentage payable due to the injury in civilian employment. See PM 2-808.7.a(1)(b).

(i) Where the OWCP has paid a schedule award as a result of an injury sustained in civilian employment, and the VA has paid an award due to military service for disability to which the civilian employment/injury caused or contributed, and no election was made, an overpayment exists.

(ii) Similarly, where an increase in the veteran's service-connected disability was brought about by an injury sustained in civilian duty, an overpayment exists if no election was made between the VA percentage increase (related to the civilian employment/injury) and the OWCP schedule award benefits (to which the claimant is entitled to as a result of the accepted civilian employment/injury alone).

(i) Schedule award payments continued after the expiration date. Where the claimant receives compensation for a schedule award beyond the award's expiration date, an overpayment exists for the dates paid beyond entitlement.

g. OPM/VA Election. The claimant has elected OPM or VA benefits in lieu of FECA benefits, but compensation was paid beyond the election date. N.P., Docket No. 15-1799 (issued January 11, 2016) ("As appellant elected FERS retirement benefits retroactive to a period already covered by FECA compensation payments, the Board finds that she did in fact receive an overpayment of compensation for the entire amount. Her election of retirement annuity benefits from OPM, retroactive to May 20, 2013, created a prohibited dual benefit under section 8116 of FECA."). The overpayment is between what was paid by the OWCP and what should have been paid by OPM or the VA. The CE will usually identify this type of overpayment upon receipt of correspondence from OPM or the VA, or by notification from the claimant or employing agency. Upon confirmation, the CE will enter the election date (first date of non-entitlement) into the compensation system and the overpayment will be automatically calculated.

h. FERS/SSA offset. Compensation was not reduced by the FERS/FECA offset amount. Since the SSA will not report an offset amount until after SSA benefits are received, an overpayment

will almost always occur and will need to be calculated for each period in which the offset was not withheld from compensation. The CE will usually identify this type of overpayment upon receipt of documentation from the SSA or upon review of the Form CA-1032. R.B., Docket No. 15-0192 (issued August 6, 2015) (The portion of SSA benefits he earned as a federal employee as part of his FERS retirement package and the receipt of benefits under FECA and FERS benefits concurrently is a prohibited dual benefit. SSA provided information regarding appellant's applicable SSA rates and their effective dates. ECAB reviewed OWCP's calculations of the dual benefits appellant received and found that OWCP properly determined the overpayment.). See also S.C. Docket No. 17-1567 (December 22, 2017) (Overpayment of \$47,003.18 created when claimant received both compensation for total disability and SSA retirement benefits attributable to federal service).

i. A surviving spouse under age 55 remarried without advising the OWCP, and compensation due as a result of the previous spouse's death continued to be paid after the date of remarriage. The CE will usually identify this type of overpayment upon receipt of Form CA-12. Under Section 8135(b), if a lump sum payment was made to a spouse who remarried before reaching age 55 (or 60, depending on the date of remarriage), an overpayment of the entire lump sum award can occur if the remarriage later proves to be void or voidable. See PM 2-0700.7b.

j. Forfeiture. A claimant knowingly failed to report earnings or underreported earnings under § 8106(b) of the FECA, and a forfeiture decision has been issued. The amount forfeited is an overpayment. The CE will usually identify this type of overpayment upon receipt of an Investigative Memorandum.

k. Death of claimant or survivor. When a claimant or survivor dies, compensation paid after the date of death is not considered an overpayment but is still a debt to the Government. The CE will usually identify this type of debt upon receipt of a death certificate or notification from the claimant/survivor's family or the employing agency. See PM 6-0500.16 for guidance on the routine handling of these types of debts.

2. Calculating the Overpayment. Once an overpayment has been identified, and information or documentation is received that corrects the improper data element(s), the CE may need to determine the difference between what was paid and what should have been paid in order to calculate the final overpayment amount. This comparison should be documented in the case file.

In some instances, no comparison is necessary because the claimant is entitled to zero compensation. For example, if the claimant returned to full-time work with no wage loss, zero compensation is payable from the date of the return to work forward. Similarly, if the claimant elected OPM benefits, there is zero entitlement from the date of the election forward. In these situations, the entire amount paid during the non-entitled period is the final overpayment amount.

In other instances, a comparison is necessary:

a. Example 1 – Return to Part-Time Work. The claimant was paid on the daily roll for temporary total disability (TTD) in the amount of \$1047.43 (after benefit deductions) for 15 days. On day 3, the claimant returned to part-time work, which reduced the amount of wage loss incurred.

The employing agency advised that the claimant worked 4 hours each day for 13 of the 15 days. Compensation for the period of disability is calculated using the Shadrack formula. For the purposes of this example, assume the Shadrack calculation determines that the claimant was entitled to \$579.15 for those 13 days. No HB or LI premiums should have been deducted from compensation for the days that the claimant worked since deductions were taken by the employing agency. A calculation for two days of TTD reveals that the claimant was entitled to \$139.66 ($[\$1047.43/15] \times 2$). Therefore, the final overpayment amount is \$328.62 ($\$1047.43 - \$579.15 - \$139.66$).

b. Example 2 – HB/LI change. The claimant had a self only HB plan with premium deductions of \$175.64 each 28 days (e.g. the periodic roll period). The claimant got married and changed to a family HB plan with premium deductions of \$409.96 each 28 days. This plan became effective on the 22nd day of the 28 day payment period. Therefore, 7 days of the 28 day period were under-deducted for health benefits resulting in an overpayment.

For the purposes of this example, assume that the premiums that should have been deducted were $\$409.96/28 = \$14.64$ per day $\times 7$ days = \$102.48 for the family plan. However, only \$43.89 was deducted for the self only plan ($\$175.64/28 = \$6.27$ per day $\times 7$ days). Since only \$43.89 was deducted, HB premiums were under-deducted by \$58.59 ($\$102.48 - \$43.89$), which is the final overpayment amount. Since this amount is less than \$250, the overpayment should be administratively terminated per PM 6-0100.3c and PM 6-0300.3.

c. Example 3 – FERS/SSA Offset. The SSA reported that the claimant was in receipt of their benefits for 2 years, but no offset for old age or death had occurred under 5 U.S.C. 8116 (d)(2). The first year, the 28 day FERS offset was \$206.49 or \$7.37 each day and the second year, it was \$211.29, or \$7.55 each day.

Since there are 365 days in a year, the first year the overpayment calculates to $365 \times \$7.37 = \$2,690.05$ and the second year it calculates to $365 \times \$7.55 = \$2,755.75$ for a final overpayment amount of \$5445.80 ($\$2,690.05 + \$2,755.75$).

3. System Coding. When an overpayment is identified, a debt record should exist in order to monitor and track the debt. In some instances, such as when a claimant's receipt of compensation on the periodic roll is terminated, the system will automatically create the debt record. In other instances, the CE will have to create the debt record.

a. The date that the debt record is created is the date it is automatically generated in the debt application or the date that the CE opens the debt record.

b. The date of the overpayment identification is the date the Office was notified of the event that caused the overpayment (e.g. the date of the phone call from the employing agency advising that the claimant returned to work, the date the claimant advised that his or her spouse died, etc.).

c. Other items to record in the debt record include the name of the debtor (usually the claimant), the debt amount, the debt period, the debt type, the primary debt reason and the assigned debt CE.

d. When an adjustment to the debt record is needed, updates will most likely be made to: the debt identification date, debt amount, debt period, debt type, and/or the primary debt reason. This will usually be necessary when the overpayment was automatically created, but may be necessary at other times as well. The most common reasons that a debt may need to be adjusted are as follows:

(1) The termination date of the periodic roll was entered incorrectly.

(2) The claimant did not return to full-time work with no wage loss, but rather sustained partial wage loss, reducing the amount of the overpayment.

(3) The claimant returned to full-time work, but still sustained wage loss due to loss of premium pay or lost time due to medical treatment.

(4) The Branch of Hearings and Review (H&R) or the Employees' Compensation Appeals Board (ECAB) rules that the overpayment amount should be changed.

(5) The claimant made a partial payment towards the overpayment prior to the Final Overpayment Determination, thus reducing the amount.

e. Voiding the debt. On rare occasions, a debt may need to be voided. This may occur, for example, if a debt record was created, but it was later determined that no debt exists. The primary debt reason, the amount of the debt, and the reason(s) for voiding the debt should be recorded in the debt application. A debt should only be voided by a Supervisory Claims

6-0300, Initial Determinations in an Overpayment

1. Purpose and Scope. This chapter explains the procedures for making initial determinations in an overpayment after it has been identified and calculated, including assessment for administrative termination, making rationalized fault determinations and issuing Preliminary Overpayment Determinations.

2. Regulatory Provisions.

a. 20 CFR §10.430 addresses how the Office of Workers' Compensation Programs (OWCP) notifies an individual of payments that are made:

(1) In addition to providing narrative descriptions to recipients of benefits paid or payable, the OWCP includes on each periodic roll check a clear indication of the period for which payment is being made. A form is sent to the recipient with each supplemental check which states the date

and amount of the payment and the period for which payment is being made. For payments sent by electronic funds transfer (EFT), a notification of the date and amount of payment appears on the statement from the recipient's financial institution.

(2) By these means, the OWCP puts the recipient on notice that a payment was made and the amount of the payment. If the amount received differs from the amount indicated on the written notice or bank statement, the recipient is responsible for notifying the OWCP of the difference. Absent affirmative evidence to the contrary, the beneficiary will be presumed to have received the notice of payment, whether mailed or transmitted electronically. For EFT payments, the OWCP is entitled to presume receipt and acceptance of that payment once a recipient has had an opportunity to receive a statement from their financial institution.

b. 20 CFR §10.431 provides the basic rules for what the OWCP does when an overpayment is identified where administrative termination is not in posture. Before seeking to recover an overpayment or adjust benefits, the OWCP will advise the beneficiary in writing that:

(1) The overpayment exists and the amount of overpayment;

(2) A preliminary determination shows either that the individual was or was not at fault in the creation of the overpayment;

(3) He or she has the right to inspect and copy Government records relating to the overpayment; and

(4) He or she has the right to present evidence which challenges the fact or the amount of the overpayment, and/or challenges the preliminary finding that he or she was at fault in the creation of the overpayment. He or she may also request that recovery of the overpayment be waived.

c. 20 CFR §10.435 provides the basic guidelines for whether an individual is responsible for an overpayment that resulted from an error made by the OWCP or another Government agency:

(1) The fact that the OWCP may have erred in making the overpayment, or that the overpayment may have resulted from an error by another Government agency, does not by itself relieve the individual who received the overpayment from liability for repayment especially if the individual also was at fault in accepting the overpayment.

(2) However, the OWCP may find that the individual was not at fault if failure to report an event affecting compensation benefits, or acceptance of an incorrect payment, occurred because the individual relied on misinformation given in writing by the OWCP (or by another Government agency which he or she had reason to believe was connected with the administration of benefits) as to the interpretation of a pertinent provision of the FECA or its regulations.

3. Administrative Termination of Debt Collection

The Federal Claims Collection Standards (FCCS), 31 CFR §902.2(a)(3) states that a claim may be compromised if the "cost of collecting the debt does not justify the enforced collection of the

full amount." 31 CFR §903.3(a)(3) states that agencies may terminate collection activity when the "costs of collection are anticipated to exceed the amounts recoverable."

In a decision issued on September 29, 1986, the Comptroller General concluded that these standards extend to the collection of debts from Federal employees, and that agencies may establish "minimum debt amounts" and realistic "points of diminishing returns" in their debt collection activities. The term "minimum debt amounts" refers to the designation of categorical thresholds beneath which collection action need not be initiated, because the amount of the debts in that class are so small in relation to the costs of attempting collection efforts.

"Diminishing returns" refers to an agency's designation of debt collection efforts the agency initiated, but will discontinue, when it appears that the costs of additional collection actions would exceed the amounts likely to be recovered. Termination of collection by Offices usually occurs only as directed by the Department of the Treasury, the Department of Justice, or the Solicitor's Office when it has been determined that collection of the debt is unlikely. Further, the Comptroller General instructed that agencies may, on a case-by-case basis, take the anticipated costs of required administrative hearings into consideration when determining whether to compromise or terminate collection action.

Although the General Accounting Office's role in collecting debts owed to the United States has been redefined, current Department of the Treasury guidelines continue to follow the September 29, 1986 opinion of the Comptroller General.

a. Less Than \$300. Debt collection actions on overpayments less than \$300 should be administratively terminated after the overpayment has been identified with no requirement to complete any of the "due process" actions described in paragraph 2 of this chapter. This is because the cost of further collection action would exceed the recovery expected. The only exceptions to this rule are noted in subparagraph (1) below.

(1) This action may be applied to any type of debt except those not covered by 5 U.S.C. §8129, which include:

(a) Refunds due to the OWCP under 5 U.S.C. § 8132 as a result of a third party recovery.

(b) Money owed to the OWCP as a result of a beneficiary's election of Office of Personnel Management (OPM) retirement benefits in lieu of previously paid compensation, where the debt can be recovered from the retroactive portion of the annuity held by OPM.

(2) For each administrative termination of debt collection action, the CE must prepare a brief memorandum to the file. The memorandum should:

(a) Identify the amount of the overpayment.

(b) Describe the reason(s) that the overpayment occurred.

(c) State that the debt is not covered by 5 U.S.C. § 8129.

(d) Discuss the reasons for terminating collection action, advising that the anticipated costs of collection would exceed the expected recovery.

(3) Once the memorandum to the file is complete, the existing debt record should be terminated. No notice of the overpayment to the overpaid individual is required.

b. Between \$300 and \$1,000. For overpayments of this amount, a Preliminary Overpayment Determination must be issued. See paragraph 5 below. In follow up to such a finding for a debt greater than or equal to \$300 and less than \$1,000, the CE will consider on a case-by-case basis whether the debt can be administratively terminated.

(1) When considering administrative termination, the CE will evaluate the following:

(a) The potential costs of pursuing collection and whether those costs will likely exceed the amount owed.

(b) Whether the debtor can be located.

(c) The likelihood of collection based upon knowledge of the individual overpaid, i.e. financial status, ability to pay, etc.

(d) The outcome of any previous overpayment the individual had. Amounts still owed from previous overpayments should be considered in the decision. However, separate overpayment occurrences involving the same beneficiary, if due to differing circumstances and potentially requiring expenditure of differing costs to pursue, may be considered separately.

(e) The circumstances that resulted in the creation of the overpayment or the overpaid individual's actions, such as willful attempts to mislead or engage in obvious avoidance of the reporting responsibilities.

(2) If the overpaid individual requests waiver on a debt less than \$1,000, a formal decision must be made on the waiver and notification sent.

(a) The debt record should then be updated with the waiver transaction before the debt is administratively terminated. See PM 6-0300.6 for more detailed information.

(3) If the overpaid individual requests a hearing with the Branch of Hearings and Review (H&R) on a debt less than \$1,000, the debt must be referred to H&R for handling.

(a) The debt record should reflect a suspended status upon learning that the claimant has requested a pre-recoupment hearing.

(b) The H&R Representative will apply the factors detailed in PM 6-0300.4, as well as conduct a routine analysis of overpaid cases, and consider whether to terminate recovery.

(c) If the H&R Representative elects to terminate the overpayment, the parties will be so advised and the case will be returned to the Office with a detailed discussion of the basis for compromise or termination of the debt.

(d) The Office will follow up with any necessary actions commensurate with the hearing decision.

(4) The status of an overpaid individual on Federal compensation or retirement rolls, or in current employment with the Federal government, shall not preclude OWCP from considering administrative termination. However, if a claimant is being paid compensation on the periodic roll or an annuity from OPM, or is due accrued benefits from either the OWCP or OPM, and does not respond to the Preliminary Overpayment Determination, a final decision should be issued and the debt should be recovered from such benefits as quickly as possible. Proper regard to due process requirements should be given before actually commencing the offset of ongoing benefits.

(5) When terminating collection of a debt under \$1,000, the case file should contain:

(a) a brief memorandum to the file on behalf of the District Director that outlines the reasons for termination including stating that the debt is not covered by 5 U.S.C. 8129, and that the cost of the collection action would exceed the expected recovery.

(b) a letter to the claimant and the employing agency advising that the debt has been terminated and stating the reasons for termination.

(6) Once the debt is terminated, the CE should update the debt record to show that the debt has been administratively terminated.

(7) Administrative terminations of debts less than \$1,000 do not necessarily forgive these debts, as they can be collected from future compensation paid, if proper due process is afforded with a Preliminary and Final Overpayment Determination.

4. Fault Findings. If a debt is \$300 or more (or is less than \$300 but not eligible for administrative termination), a Preliminary Overpayment Determination should be issued. In this decision, the CE assigned to the debt is responsible for making a finding as to whether the overpaid individual was with fault or without fault in the creation of the overpayment.

a. Each overpayment should be handled separately in relation to the fault finding. When there is more than one overpayment identified in the same claim, the CE should consider each overpayment separately because in terms of fault finding, the circumstances that led to the creation of one overpayment may be different than the circumstances that led to another, possibly resulting in a different fault finding for each. William D. Beard, Docket No. 05-221 (issued December 20, 2005) (ECAB remanded the case to OWCP for the separate handling of the two overpayments: "The Office should issue new preliminary determinations for each overpayment that address how the overpayments were calculated, whether appellant was at fault in the creation of the overpayment and if so, the reasons for the finding of fault.").

b. Fault applies only to the individual who has received a payment in his or her name or on behalf of a beneficiary. Although the OWCP may have erred in creating the overpayment, this does not relieve the beneficiary of making a refund. B.G., Docket No. 14-850 (issued September 17, 2014) (On appeal, appellant noted that the overpayment was the result of a mistake by OWCP. ECAB held that although OWCP may have erred, this does not relieve the overpaid individual of the obligation to repay the overpayment if he or she was at fault in accepting the overpayment).

c. The CE should carefully consider all variables in the case when making a fault finding. Generally, if the evidence shows either a lack of good faith or failure to exercise a reasonable degree of care in reporting changes in circumstances that may affect either entitlement or the amount of benefits awarded, an individual may be found with fault. However, in situations where an equally valid argument can be made for both "without fault" and "with fault," a finding of without fault should usually be made.

d. When evaluating the degree of responsibility expected of an individual, the OWCP should consider both the complexity of the circumstances surrounding the overpayment and the capacity of the particular individual to realize that he or she was being overpaid. Reference: Neill D. Dewald, 57 ECAB 451 (2006); Ralph P. Beachum, Sr., 55 ECAB 442 (2004) (reasonable person test).

(1) In considering the complexity of the circumstances surrounding the overpayment, the following factors should be evaluated with regard to the overpaid individual:

- (a) Understanding of reporting requirements;
- (b) Any agreement to report events affecting payments;
- (c) Knowledge of events that should have been reported;
- (d) Efforts to comply with the reporting requirements;
- (e) Opportunities to comply with the reporting requirements;
- (f) Understanding of the obligation to return payments to which he or she was not entitled; and
- (g) Ability to comply with reporting requirements.

(2) In considering the capacity of the particular individual to realize that he or she was being overpaid, the OWCP should apply the reasonable person test, considering such factors as:

- (a) Age;
- (b) Intelligence and/or comprehension;
- (c) Education;

(d) Demonstrated degree of familiarity with the compensation system;

(e) Consistency of actions;

(f) Physical and mental condition(s); and

(g) Clarity of correspondence and/or telephone advice received from the OWCP or the employing agency.

e. With Fault. An individual is found to be with fault if the overpayment resulted from:

(1) An incorrect statement as to a material fact made by the beneficiary that he or she knew, or should have known, to be incorrect;

(2) Failure of the recipient to furnish information that he or she should have known to be material; or

(3) Acceptance of payment(s) that the overpaid individual either knew, or should have known, was incorrect. See 20 CFR §10.433(a).

f. Without fault. An individual is found to be without fault if failure to report an event affecting compensation benefits or acceptance of an incorrect payment occurred because of one or both of the following:

(1) The individual relied on misinformation given in writing by the OWCP (or by another Government agency which he or she had reason to believe was connected with the administration of benefits) as to the interpretation of a pertinent provision of the FECA or its regulations. See: Andy Wdowiak, Docket No. 01-622 (issued July 23, 2002) (ECAB affirmed the finding of fault holding that although appellant indicated that he talked to someone at the OWCP about the matter, there was no evidence that appellant relied on misinformation given in writing).

(a) The case file should contain documentation to substantiate that this misinformation was actually communicated to the overpaid individual.

(b) There should be no evidence in the case file that demonstrates that the individual knew, or should have known, the proper course of action to be followed.

(2) The OWCP erred in calculating cost-of-living increases, schedule award length and/or percentage of impairment, pay rate(s), loss of wage-earning capacity, and/or improperly deducted health benefit or life insurance premiums. An exception would occur when it is shown that the individual had actual knowledge of the calculation error.

g. The following are some common circumstances and corresponding appropriate fault findings:

(1) Return to work: Overpayments most commonly occur because a claimant returns to work and receives wages concurrently with compensation for temporary total disability (TTD). In such cases, a reasonable person should know that both cannot be received simultaneously.

Both the initial acceptance letter and the periodic roll placement letter advise that the OWCP expects the claimant to monitor statements from his or her financial institution and if EFT deposits were made for any periods that the claimant also worked, to advise the OWCP so that the overpayment can be collected. However, simply receiving an EFT payment to which the claimant was not entitled is not enough to establish fault in creating the overpayment. The claimant will generally not be found at fault for EFT payments transmitted and received within 60 days of the claimant's return to work, unless the record contains clear evidence to show that the claimant was made aware of the erroneous deposit. Per R.S., Docket No. 20-0177 (Issued: September 3, 2021) "[...] in cases where a claimant receives compensation through direct deposit, OWCP must establish that at the time a claimant received the direct deposit in question that he or she knew or should have known that the payment was incorrect. The Board has held that an employee who receives payments from OWCP in the form of a direct deposit may not be at fault for the first incorrect deposit into his or her account since the acceptance of the overpayment, at the time of receipt of the direct deposit, lacks the requisite knowledge. Because fault is defined by what the claimant knew or should have known at the time of acceptance, one of the consequences of electronic fund transfers is that the claimant lacks the requisite knowledge at the time of the first incorrect payment. Whether or not OWCP determines that an individual is at fault with respect to the creation of an overpayment depends on the circumstances surrounding the overpayment. It is not appropriate, however, to make a finding that a claimant has accepted an overpayment through direct deposit until such time as a reasonable person would have been aware that this overpayment had occurred. This awareness could be established either through documentation such as a bank statement or notification from OWCP or where a reasonable period of time has passed during which a claimant could have reviewed independent confirmation of the incorrect payment."

The letters also advise that if compensation is issued via paper check and the claimant worked any portion of the period indicated on the check, payment should be returned to the OWCP. Reference: D.E., Docket No. 09-240 (issued July 23, 2009) (ECAB found that appellant was with fault in the creation of the overpayment. She returned to full-time work on July 6, 2008 and OWCP continued to pay compensation for total disability through August 2, 2008. Fact of overpayment is established. Appellant received a letter outlining the conditions under which she would receive compensation which advised her to notify them "immediately" when she went back to work and to return any payment if she worked any portion of the period covered thereby. Appellant did not notify OWCP that she returned to work for over three weeks: "Appellant did not exercise a high degree of care in reporting events which affected her entitlement to or the amount of benefits. Therefore, under the circumstances, the Office properly found her to be at fault."). See K.M., Docket No. 16-0802 (issued November 23, 2016) (overpayment was created where claimant continued to receive benefits after they were terminated: "The fact that OWCP may have been negligent in issuing the payments does not mitigate this finding.")

Examples:

(a) A paper check has been received. Since the check prints the period of payment and the amount paid, the claimant should reasonably know that the payment is incorrect because the dates overlap with a period he or she worked. All situations involving paper checks should result in a “with fault” finding unless extenuating circumstances exist.

In the case of Wanda G. Berdyck, Docket No. 89-391 (Mar. 31, 1989), an overpayment occurred when the claimant returned to duty on April 27, 1987, but was paid compensation for total disability until July 4, 1987. The OWCP noted that the claimant had received Form CA-1049 advising her to "Return to us any compensation check received after you return to work." Also, the OWCP noted that the compensation checks issued to the claimant showed, on the face of the checks, the dates being paid. Accordingly, the claimant was found to be with fault in creating the overpayment. In upholding the decision of the OWCP, the Employees' Compensation Appeals Board (ECAB) concluded that under this circumstance the claimant knew, or should have known, that she was not entitled to the checks she received after returning to work. R.A., Docket No. 14-539 (issued June 24, 2014) (ECAB stated "OWCP includes on each periodic check a clear listing of the period for which payment is being made. OWCP places the recipient on notice that a payment was made and the amount of the payment. This, together with the strongly worded November 8, 2012 OWCP letter, establishes that appellant should have known that he was not entitled to accept wage-loss compensation for total disability for any period after he returned to work.").

(b) The deposit was by EFT and over 60 days has elapsed between the EFT deposit and the date the claimant returned to work, allowing ample time for the claimant to receive and review a statement from his or her financial institution that outlines the details of the improper payment. Such situations should result in a “with fault” finding unless extenuating circumstances exist.

The ECAB has focused on EFT transfers in making fault determinations, differentiating between checks and EFTs, and has found that awareness of an incorrect EFT can be established either through documentation such as a bank statement or notification from the OWCP or where at least 60 days have passed since the claimant has returned to work, during which a claimant could have reviewed independent confirmation of the incorrect payment, such as several incorrect payments. In A.H., Docket No. 07-1036 (issued August 14, 2007), the ECAB found the claimant to be with fault because he received compensation checks through direct deposit which involved a series of payments over several months with clear knowledge that the payments were incorrect. J.B., Docket No. 24-0359 (Issued: May 28, 2024) (ECAB noted that the claimant was overpaid from April 12 – May 20, 2023 through a series of two periodic roll payments issued following the claimant's successful return to work, but could not be found at fault in the creation of the overpayment as, "[g]iven the short period of time following appellant's return to work, there is no documentation to demonstrate that appellant had knowledge at the time his bank received direct deposits from OWCP on April 22 and May 20, 2023 that the payments were incorrect.")

(c) The claimant was given specific notice in advance of the EFT deposit that (1) the forthcoming payment is incorrect, (2) the requisite action that must be taken and (3) over 14 days have elapsed between the EFT deposit and the date the Preliminary Overpayment Determination is issued (such that the claimant is afforded an opportunity to take action). Such situations should result in a “with fault” finding unless extenuating circumstances exist.

(d) If the claimant notifies the Office of a return to work in advance, specific notice must still be provided to the claimant of the improper EFT forthcoming and the requisite action that should be taken as noted in paragraph (c) above. If the file is so documented, the claimant should be found with fault if over 14 days have elapsed between the EFT deposit and the date the Preliminary Overpayment Determination is issued. If the claimant is not formally notified, then he or she should be found without fault as good faith and exercise of reasonable care were exercised in reporting a change in circumstance that affects benefit entitlement.

(2) Where the claimant's compensation rate changes from 75 percent to 66 2/3 percent due to the death of a spouse, divorce, change in eligible dependency status, etc., and the claimant promptly notifies the Office of such a change, he or she should be found without fault. However, if notice is not provided within 90 days of such a change, the claimant is with fault because he or she has knowingly continued to receive compensation at the augmented compensation rate when he or she had no eligible dependents.

However, the CE should review the case file for any extenuating circumstances.

In the case of Marcia L. Wright, 37 ECAB 435 (issued March 28, 1986), a married claimant received compensation on the periodic roll at the augmented rate. For several years she reported her spouse as a dependent on Form CA-1032. In July 1985, she returned a Form CA-1032 and reported that she had no dependent. When asked for additional information by the OWCP, the claimant replied that she had been recently divorced. The claimant was overpaid from the date of her divorce until the date that the OWCP adjusted her compensation. The claimant stated that Form CA-1032 correctly indicated that she no longer had dependents and that it had been sent within 15 days of her divorce becoming final. She said that she would have sent the notification sooner, but she was hospitalized for surgery two days after the divorce. The OWCP found that she was with fault because she knew, or reasonably should have known, that she was to immediately report any change in her dependency status. ECAB found that given the extenuating circumstances, the claimant's actions in reporting her change in status were both timely and reasonable and concluded that the claimant should be found without fault.

(3) Incorrect pay rate. In cases where the claimant's pay rate was incorrect, the claimant should be found without fault unless the evidence of record clearly establishes that they should have known that the weekly pay rate used by the Office was incorrect. For example, if a claimant with a salary of \$1,000 per week receives notification via Form CA-1049 (or equivalent) that his or her pay rate was established at \$3,000 per week, he or she should reasonably know that the forthcoming compensation payment is incorrect.

(4) Dual Benefits

(a) The claimant receives benefits from the Social Security Administration (SSA) as part of an annuity under the Federal Employees' Retirement System concurrently with disability/wage loss compensation. See 5 U.S.C. 8116 (d) (2). In such cases, the claimant should be found without fault unless there is evidence on file that the claimant was aware that the receipt of full SSA benefits concurrent with disability/wage loss compensation was prohibited.

(b) The claimant receives an inappropriate dual benefit from OPM.

(i) If the claimant elects OPM benefits and the Office is unable or otherwise fails to stop compensation benefits timely, the same rules as referenced for return to work in subparagraph (1) above apply.

(ii) If the claimant begins receiving OPM benefits without obtaining an election and this is later discovered by the Office, a finding of with fault may only be made if there is evidence on file that the claimant was aware, or should have been aware, that the receipt of OPM benefits concurrent with disability/wage loss compensation was prohibited.

(iii) Where the claimant elects OPM benefits for a date in the past and has received OWCP disability/wage loss compensation beyond the election date, the claimant is without fault because he or she was entitled to FECA benefits at the time he or she accepted the payments (which was prior to his or her retroactive election of OPM benefits). Because there is no evidence to support that the claimant should have known that the FECA compensation payment was improper when he or she accepted the payment, a without fault finding should be made. D.M., Docket No. 14-548 (issued on February 20, 2015) (reversing a finding of fault as the claimant was entitled to FECA benefits at the time she accepted the payments prior to her retroactive election of OPM benefits); M.R., Docket No. 14-844 (issued November 21, 2014) (as there was no evidence that the claimant should have known that the September 21, 2013 compensation payment was incorrect when he accepted that payment, the Board found that the record did not support OWCP's finding of fault). However, reference L.S., Docket No. 14-1690 (issued December 5, 2014) (a claimant who makes an election of benefits between FECA and OPM may be charged with knowledge that subsequent dual payments are incorrect).

(iv) During the period of exhaustion of the third party surplus, the beneficiary is not considered to be in receipt of compensation; consequently, an election of OPM benefits while the surplus is being exhausted does not constitute a prohibited dual benefit. See Chapter 2-1100.10(b)(1).

(5) The claimant was advised through OWCP correspondence that a lump-sum payment pursuant to the schedule award would represent the only compensation he or she would receive for the period covered by the award even if he or she sustained a recurrence of total disability. However, compensation for wage loss was paid for the same period. In such situations, a finding of with fault is appropriate.

In K.O., Docket No. 07-816 (July 13, 2007), the claimant signed a statement that he understood and agreed that the lump sum payment represented full and final settlement of his schedule award for the period in question and that he was not entitled to any further compensation for the duration of his schedule award. He subsequently claimed and accepted periodic payments for wage loss after he had received a lump-sum settlement under the schedule award. The ECAB found the claimant with fault in the creation of the overpayment as he received wage loss compensation payments after receiving the lump sum payment of \$58,784.19 which he should have known was incorrect.

(6) Schedule Awards. Where the office neglected to terminate a schedule award upon its expiration, and no recent (less than a year) notification of expiration (Form CA-1051 or equivalent) of the period of the award stating the end date (Form CA-181) had been provided, the claimant is without fault because it would not be established that the claimant should have been aware of the date the award would expire and that any date subsequent to that expiration date was incorrectly paid. However, if Form CA-1051 (or equivalent) was sent, or if the claimant was recently advised as to the length of the schedule award (on Form CA-181 or equivalent) it can be concluded that the claimant should have been aware of the expiration date and should be found with fault.

Overpayments as the result of improper pay elements when computing a schedule award generally result in findings of without fault unless extenuating circumstances apply.

(7) Cost-of-Living Adjustments. It is unrealistic to expect a claimant to know the effective date of a cost-of-living increase, whether this increase should be applied, or even the amount of such an increase. As such, resulting overpayments are generally without fault unless extenuating circumstances apply.

(8) Insurance Deductions. It is unrealistic to expect a claimant to know the specific premium deduction made during an OWCP payment cycle (or benefit coding that corresponds to their type and level of coverage). As such, resulting overpayments are generally without fault unless extenuating circumstances apply.

(9) Rescissions. Where the original acceptance of a claim is rescinded and all compensation paid is declared an overpayment, the claimant is generally found without fault unless it can be proven that he or she was aware that the acceptance of the claim was erroneous. C.B., Docket No. 12-1849 (issued January 13, 2014) (ECAB found that OWCP met its burden of proof in rescinding appellant's claim on the ground that she was not injured in the performance of duty. ECAB further found that OWCP properly found an overpayment of compensation, and that appellant was without fault. ECAB further found that OWCP properly denied waiver of recovery of the overpayment); and Troy D. Watts, Docket No. 05-184 (issued on July 27, 2006).

(10) Exhaustion of Surplus. An overpayment may occur where a FECA beneficiary who has paid the required refund from a third party recovery receives FECA compensation while a surplus is being absorbed. Claimants are typically informed that a surplus exists and the effect of that surplus, so they know or should know that they should not be receiving benefits. As such, claimants should generally be found with fault absent extenuating circumstances.

5. Preliminary Overpayment Determinations. Where the debt is \$300 or more (or not eligible for administrative termination), a Preliminary Overpayment Determination should be issued within 30 days of debt identification. If the overpaid individual is determined to be with fault, Form CA-2201 or equivalent should be issued. If the overpaid individual is determined to be without fault, Form CA-2202 or equivalent should be issued.

Each decision should contain a memorandum outlining the specific circumstances of the case and the existence of the overpayment.

a. The content of the memorandum should:

(1) state the period and the amount of the benefit overpaid and whether or not the claimant was with or without fault in its creation;

(2) describe the reason(s) that the overpayment occurred;

(3) specifically detail how the overpayment was calculated so that it is clear to the overpaid individual how the final overpayment amount was determined; and

(4) state whether the overpaid individual is with or without fault in the creation of the overpayment and explain how the fault determination was made. To support the position, excerpts from decisions from the ECAB may be referenced.

b. Actions the overpaid individual may take in response to the Preliminary Overpayment Determination should also be outlined and include:

(1) Repayment of the full overpaid amount if in agreement with the debt.

(2) The right to request waiver of recovery of the overpayment if the overpaid individual is found without fault.

(3) The right to inspect and copy case file documents with respect to the debt and to dispute any information contained in those records.

(4) The right to contest the overpayment and to submit any evidence or argument that he or she believes will affect the preliminary findings.

(5) The right to request that the Office issue a final decision based on the written evidence only.

(6) The right to request a pre-recoupment hearing with the Branch of Hearings and Review.

c. Form OWCP-20, Overpayment Recovery Questionnaire, or equivalent, should be attached to the decision for completion in order to properly address fault and/or waiver or to determine a reasonable method for collection, if applicable.

d. The overpaid individual is afforded 30 days to submit a response to the Preliminary Overpayment Determination.

6. System Coding. When a Preliminary Overpayment Determination is issued, or an administrative termination memorandum is completed, the debt record should be updated with the action taken. In most instances, the debt record should have already been created, but if not it will need to be.

a. Administrative Terminations. At the time an administrative termination is processed, the debt record should usually be in a pending status. The CE should modify the debt record to document

that the action taken was termination of the debt. Once the record is properly saved, the debt will be terminated.

b. Preliminary Overpayment Determinations. At the time a Preliminary Overpayment Determination is issued, the debt record should usually be in a pending status. The CE should modify the debt record to establish a preliminary record and to document the fault finding made. Once the record is properly saved, the status should show that the debt is in its preliminary stages.

c. Any updates needed to the debt identification date, debt amount, debt period, debt type, and/or the primary debt reason should also be made at this time.

6-0400, Final Overpayment Determinations

1. Purpose and Scope. This chapter explains the procedures for making a final determination in an overpayment following the issuance of the Preliminary Overpayment Determination. This includes situations where payment towards the debt is received; the overpaid individual provides a response to the Preliminary Overpayment Determination; and/or the overpaid individual fails to provide a response to the Preliminary Overpayment Determination. This chapter also discusses evaluating a debt for waiver and issuing a Final Overpayment Determination.

2. Regulatory Provisions:

a. 20 CFR §10.432 explains how an individual can present evidence to the Office of Workers' Compensation Programs (OWCP) in response to a Preliminary Overpayment Determination.

The individual may present this evidence to the OWCP in writing or at a pre-recoupment hearing. The evidence must be presented, or the hearing requested, within 30 days of the date of the written notice of overpayment. Failure to request the hearing within this 30-day time period shall constitute a waiver of that right.

b. 20 CFR §10.433 outlines the circumstances under which the OWCP can waive recovery of an overpayment.

(1) The OWCP may consider waiving an overpayment only if the overpaid individual was not at fault in accepting or creating the overpayment. Each recipient of compensation benefits is responsible for taking all reasonable measures to ensure that payment(s) he or she receives from the OWCP are proper. The recipient must show good faith and exercise a high degree of care in regard to receipt of their benefits. Such care includes reporting events which may affect entitlement to (or the amount of) benefits, including reviewing their bank accounts and related

statements (including electronic statements and records from their financial institutions involving EFT payments). A recipient who has done any of the following will be found to be at fault with respect to creating an overpayment:

- (a) Made an incorrect statement as to a material fact which he or she knew, or should have known, to be incorrect; or
- (b) Failed to provide information which he or she knew, or should have known, to be material; or
- (c) Accepted a payment which the recipient knew, or should have known, to be incorrect. (This provision applies only to the overpaid individual.)

(2) Whether or not the OWCP determines that an overpaid individual was at fault with respect to the creation of an overpayment depends on the circumstances surrounding the overpayment. The degree of care expected may vary with the complexity of those circumstances and the individual's capacity to realize that he or she was being overpaid.

c. 20 CFR §10.434 details what criteria is used to decide whether to waive recovery of the overpayment if the OWCP finds that the recipient was not at fault.

(1) If the OWCP finds that the recipient of an overpayment was not at fault, repayment will still be required unless:

- (a) Adjustment or recovery of the overpayment would defeat the purpose of the Federal Employees' Compensation Act (FECA); or
- (b) Adjustment or recovery of the overpayment would be against equity and good conscience.

d. 20 CFR §10.437 defines the circumstances under which recovery of an overpayment would be against equity and good conscience.

(1) Recovery of an overpayment is considered to be against equity and good conscience when any overpaid individual would experience severe financial hardship in attempting to repay the debt.

(2) Recovery of an overpayment is also considered to be against equity and good conscience when any overpaid individual, in reliance on such payments or on notice that such payments would be made, gives up a valuable right or changes his or her position for the worse. In making such a decision, the OWCP does not consider the individual's current ability to repay the overpayment.

(a) To establish that a valuable right has been relinquished, it must be shown that the right was in fact valuable, that it cannot be regained, and that the action was based chiefly or solely in reliance on the payment(s) or on the notice of payment(s). Donations to charitable causes or gratuitous transfers of funds to other individuals are not considered relinquishments of valuable rights.

(b) To establish that an individual's position has changed for the worse, it must be shown that the decision made would not otherwise have been made but for the receipt of benefits, and that this decision resulted in a loss. *B.R.*, Docket No. 15-1247 (issued October 26, 2015) (ECAB held that appellant “submitted no evidence to show that she gave up a valuable right or changed her position for the worse in reliance on anticipated compensation payments. Thus, she has not shown that if required to repay the overpayment, she would be in a worse position after repayment than if she had never received the overpayment at all. OWCP properly found that appellant was not entitled to waiver on the grounds that recovery would be against equity and good conscience.”)

e. 20 CFR §10.438 outlines the requirements of the overpaid individual to submit additional financial information.

(1) The individual who received the overpayment is responsible for providing information about income, expenses and assets as specified by the OWCP. This information is needed to determine whether or not recovery of an overpayment would defeat the purpose of the FECA, or be against equity and good conscience. This information will also be used to determine the repayment schedule, if necessary.

(2) Failure to submit the requested information within 30 days of the request shall result in denial of waiver, and no further request for waiver shall be considered until the requested information is furnished. *P.C.*, Docket No. 14-860 (issued August 18, 2014) (Appellant requested waiver but did not return the questionnaire or otherwise provide any financial information. ECAB stated: “Under the implementing regulations, OWCP could not determine whether recovery of the overpayment would defeat the purpose of FECA or be against equity and good conscience. As appellant failed to submit the requested information, as required by section 10.438 of its regulations, she is not entitled to waiver. The Board finds that OWCP properly denied waiver of recovery of the overpayment of compensation.”)

f. 20 CFR §10.439 advises what is addressed at a pre-recoupment hearing. At a pre-recoupment hearing, the OWCP representative will consider all issues in the claim on which a formal decision has been issued. Such a hearing will thus fulfill OWCP's obligation to provide pre-recoupment rights and a hearing under 5 U.S.C. §8124(b). Pre-recoupment hearings shall be conducted in exactly the same manner as provided in 20 CFR §§10.615 through 10.622.

g. 20 CFR §10.440 details how the OWCP communicates its final decision concerning recovery of an overpayment, and the appeal rights that accompany it.

(1) The OWCP will send a copy of the Final Overpayment Determination to the individual from whom recovery is sought; his or her representative, if any; and the employing agency.

(2) The only review/appeal of a Final Overpayment Determination is via the Employees' Compensation Appeals Board (ECAB). The provisions of 5 U.S.C. §8124(b) (concerning hearings) and 5 U.S.C. §8128(a) (concerning reconsiderations) do not apply to such a decision. The pendency of an appeal with ECAB has no effect on the finality of the order being appealed;

in the event ECAB reverses the Final Overpayment Determination, any monies collected will be restored to the beneficiary.

Note: Although no reconsideration is available as a matter of right, in the event of a changed circumstance (such as a life event that would affect the beneficiary's ability to repay the overpayment once finalized - such as the death of a spouse whose income was included in assessing the beneficiary's ability to repay), the beneficiary can submit evidence of the changed circumstance and request that the Director reopen the case on his/her own motion.

3. Actions following the Preliminary Overpayment Determination. Once 30 days have passed following the issuance of the Preliminary Overpayment Determination, the CE assigned to the debt should review the case to determine the next appropriate action.

a. If no response is received.

(1) If no response to the Preliminary Overpayment Determination is received, and the overpaid individual is not receiving compensation benefits, the CE should proceed with a Final Overpayment Determination that pursues collection in full.

(2) If no response to the Preliminary Overpayment Determination is received, and the overpaid individual is receiving disability/wage loss compensation benefits on the periodic roll, the CE should proceed with a Final Overpayment Determination that sets the rate of repayment at 25% of the 28 day net compensation amount until the balance of the overpayment is paid in full.

(3) If no response to the Preliminary Overpayment Determination is received, and the overpaid individual is due disability/wage loss compensation on the daily roll (either immediately or in the near future), the CE should proceed with a Final Overpayment Determination that either pursues collection in full or sets the rate of repayment at 25% of the net compensation amount, depending on the amount of compensation payable in the case.

b. If payment is submitted towards the debt, the action taken will depend on whether full payment or partial payment was made. The case file should contain documentation that the payment(s) was received.

(1) Where full payment has been made and there is evidence that the payment has been received, the CE should issue a letter to the overpaid individual (with a copy to the employing agency and representative, if applicable) advising that the debt has been paid in full and is considered closed. The CE should also update the debt record to a final status and indicate that payment has been made in full.

(2) Where partial payment has been made, the CE will need to thoroughly evaluate the documentation in the case file to determine whether a repayment plan is necessary or whether payment should be requested in full. The CE should request payment in full unless evidence substantiates that the overpaid individual is financially unable to do so. To make this determination:

(a) The CE should review the responses on the Form OWCP-20 and the overpaid individual's income, assets, and ordinary and necessary living expenses, in a manner similar to the waiver considerations as described in paragraph 4, below. If the evidence supports that the overpaid individual's income and assets are insufficient to repay the overpayment in full, the highest reasonable rate of repayment should be established to collect the debt as quickly as possible while minimizing any hardship on the overpaid individual.

(b) As each case is unique, the specific financial circumstances of the overpaid individual should be evaluated when devising a repayment plan to ensure that the rate of repayment is reasonable. See PM 6-0500 for further details.

c. Request for a Hearing. If the overpaid individual requests a pre-recoupment hearing from the Branch of Hearings and Review (H&R), no Final Overpayment Determination will be issued by the Office. Rather, the case will be transferred to H&R and the H&R Representative assigned to the case will schedule and conduct the hearing, accept any evidence submitted, and closely evaluate the testimony provided.

(1) Upon careful consideration of the facts:

(a) If the H&R Representative determines that the amount of the debt is significantly larger than that outlined in the Preliminary Overpayment Determination, the case should be returned to the Office for a new Preliminary Overpayment Determination, which will then give the overpaid individual full appeal rights concerning the increased debt amount.

(b) Otherwise, the H&R Representative will prepare a Final Overpayment Determination either affirming or modifying the amount of the overpayment and/or the Office's preliminary finding of fault.

(c) If the overpaid individual is found to be without fault, the H&R Representative will also address the question of waiver in the Final Overpayment Determination.

(2) When a hearing has been requested, the CE should suspend the debt record until the H&R Representative issues the Final Overpayment Determination. When the case is returned to the Office, the CE should then update the debt record to reflect that a final determination has been made, as indicated.

d. The CE determines that a conference is needed. The CE has the sole discretion to conduct a conference following the Preliminary Overpayment Determination if he or she determines that it is beneficial for resolving an outstanding issue. Examples of situations where a CE may decide to conference a case include where the financial data in the file is not adequate for a decision on waiver or repayment, where fault is in question, or where no possible offset for recovery exists and compromise is possible.

e. Request that the Office issue a Final Overpayment Determination. If the overpaid individual requests that the Office issue a decision based on the written evidence only, the CE should ensure that a completed Form OWCP-20 and supporting evidence or documents are on file. The

CE should then thoroughly review and consider all pertinent evidence and issue a Final Overpayment Determination. See paragraph 5 below for additional details.

4. Waiver of Recovery.

If the overpaid individual is without fault in the creation of the overpayment, and adjustment or recovery would defeat the purpose of the FECA or would be against equity and good conscience, collection of the overpayment will be waived in whole, or in part, depending on the financial circumstances of the case. T.S., Docket No. 08-1604 (issued March 13, 2009)("a finding that appellant was without fault does not automatically result in waiver of the overpayment."). A partial waiver may be granted if total recovery would impose a financial hardship, but partial recovery would not. However, a fault finding must be made in every overpayment before waiver may be considered. If the overpaid individual is found to be with fault in the creation of the overpayment, adjustment or recovery may not be waived. Waiver can only be considered when the overpaid individual is found to be without fault. W.Z., Docket No. 15-1526 (issued October 28, 2015) (ECAB held that the overpayment recovery questionnaire was irrelevant to the issues on appeal, because appellant was at fault, and therefore she was not eligible for consideration of waiver: "OWCP and the Board therefore have no occasion to review whether adjustment or recovery of the overpayment would defeat the purpose of FECA or whether adjustment or recovery of the overpayment would be against equity and good conscience."); Ehrman S. Eldridge, 49 ECAB 263, 266 (issued January 5, 1998)("no waiver of an overpayment is possible if the claimant is with fault in helping to create the overpayment.")

5 U.S.C. §8129(b) states "Adjustment or recovery by the United States may not be made when incorrect payment has been made to an individual who is without fault and when adjustment or recovery would defeat the purpose of this subchapter or would be against equity and good conscience." The clause "defeat the purpose of this subchapter" means defeat the purpose of benefits under the FECA. The purpose of the FECA is to provide at least a subsistence income for beneficiaries. See 20 CFR §10.436. The test is whether the individual has income or financial resources sufficient for more than ordinary needs or is largely or solely dependent upon current benefit payments for the necessities of life. R.O., Docket No. 14-1329 (issued September. 1, 2015)("According to his overpayment recovery questionnaire, appellant had over \$500 in discretionary monthly income and assets that exceeded the established resource base. Either one of these, standing alone, is sufficient to find that recovery will not defeat the purpose of the FECA."); E.C., Docket No. 14-1467 (issued July 2, 2015) (ECAB held that appellant had not established that recovery of the overpayment would defeat the purpose of the FECA because she has not shown both that she needs substantially all of her current income to meet ordinary and necessary living expenses and that her assets do not exceed the allowable resource base). This clause applies only to claimants/beneficiaries who are, or were, entitled to benefits. If an individual was never entitled to benefits, the overpaid individual's financial condition would be considered under the "against equity and good conscience" clause. For example, if a claim was accepted and compensation was awarded, but it is later determined that the claimant was not a civil employee, the "defeat the purpose of this subchapter" clause would not apply.

a. Financial Hardship Criteria. Recovery of an overpayment will "defeat the purpose of the FECA" if recovery would cause hardship by depriving a presently or formerly entitled

claimant/beneficiary of income and resources needed for ordinary and necessary living expenses under the criteria set out in this section. Recovery will defeat the purpose of the FECA if:

- (1) The overpaid individual from whom recovery is sought needs substantially all of his or her current net income (including FECA benefits) to meet current ordinary and necessary living expenses; and
- (2) The overpaid individual's assets do not exceed the resource base of \$6,200 for an individual or \$10,300 for an individual with a spouse or one dependent, plus \$1,200 for each additional dependent. This base includes all of the overpaid individual's assets not exempted from recoupment in subparagraph b (3) below. The first \$6,200 or more, depending on the number of the overpaid individual's dependents, is also exempted from recoupment as a necessary emergency resource.
- (3) An overpaid individual is deemed to need substantially all of his or her current net income to meet current ordinary and necessary living expenses if monthly income does not exceed monthly expenses by more than \$50. *Desiderio Martinez, 55 ECAB 245 (2004)*. Thus, the amount of monthly funds available for debt repayment is the difference between current income and adjusted living expenses (i.e. ordinary and necessary living expenses plus \$50).

All of the conditions in (1), (2), and (3) above must be met to defeat the purpose of the FECA. If an overpaid individual has disposable current income or assets in excess of \$50, a reasonable repayment schedule can be established over a reasonable, specified period of time. It is the overpaid individual's burden to submit evidence to show that recovery of the overpayment would cause the degree of financial hardship sufficient to justify waiver.

b. To determine whether financial hardship is met, the CE or H&R Representative should thoroughly review and analyze the overpaid individual's income, expenses, and assets.

(1) Income. An individual's total income includes any funds which may reasonably be considered available for his or her use, regardless of the source. A spouse's income is considered available to the individual if the spouse was living in the household both at the time the overpayment was incurred and at the time waiver is considered. Income to be considered includes, but is not limited to:

- (a) Government benefits, such as Black Lung, Social Security, Railroad Workers' Compensation, Department of Veterans Affairs, and Unemployment Compensation.
- (b) Wages and self-employment income.
- (c) Regular payments received, such as rent or pension.
- (d) Investment income.
- (e) Alimony or child support payments.

(2) Ordinary and Necessary Living Expenses. An individual's ordinary and necessary living expenses include:

(a) Fixed living expenses, such as food and clothing; furniture; household and personal hygiene supplies; rent; mortgage payments; utilities (including natural gas, water and sewer, electric, a basic, unadorned cell phone or landline telephone, basic cable, satellite, or television streaming service, and basic internet service); maintenance; burial plot or prepaid burial contract; taxes; vehicle insurance (one or two allowable); life, accident and health insurance; expenses for one or two vehicles (loan payments, gas and oil, maintenance); and commuting expenses not included under vehicle expenses.

(b) Medical, hospitalization and other similar expenses not reimbursed by insurance or other sources.

(c) Expenses for the support of others for whom the individual is responsible, such as dependent child day care, child support, elder care or alimony.

(d) Church and charitable contributions made on a regular basis. This does not include large one-time gifts made after receipt of the Preliminary Overpayment Determination.

(e) Miscellaneous expenses (i.e. haircuts) not to exceed \$60 per month.

A finding that a type of expense is ordinary and necessary does not mean that the amount is ordinary and necessary. The burden is on the overpaid individual to show that the expenses are reasonable and needed for a legitimate purpose. If the CE or H&R Representative determines that the amount of certain expenses is not ordinary and necessary, he or she must state in writing the reasons for the determination. The determination should be supported by rationale, which may include utilizing statistics from the Bureau of Labor Statistics that show that the overpaid individual's expenses exceed that of the range for the general population.

The CE or the H&R Representative should be careful to avoid counting an expense twice when totaling the overpaid individual's ordinary and necessary living expenses. For example, if the overpaid individual's credit card debt is already calculated as a fixed and miscellaneous living expense, the credit card expense(s) should not be added again as consumer debt expense. If the amount is added again, it would result in an excessive total for the overpaid individual's ordinary and necessary living expenses, and would make the individual appear less able to repay his or her overpayment than would actually be the case.

Furthermore, the CE or the H&R Representative should ensure that the monthly expense used for each credit card reflects only the minimum payment required by the creditor. The minimum amount should be verified, if necessary, by requiring the overpaid individual to submit copies of his or her monthly billing statement(s).

(3) Assets. An individual's assets include:

(a) Liquid Assets, such as cash on hand, the value of stocks, bonds, savings accounts, mutual funds, certificates of deposit, etc.

(b) Non-Liquid Assets, such as the fair market value of an owner's equity in property such as a camper, boat, second home and furnishings/supplies, vehicle(s) above the two allowed per immediate family, retirement account balances (such as Thrift Savings Plan or 401 (k)), jewelry, artwork, etc.

(c) Assets do not include the value of household furnishings (primary residence), apparel, one or two vehicles, family burial plot or prepaid burial contract, a home which the person maintains as the principal family domicile, or income-producing property, if the income from such property has been included in comparing income and expenses.

Form OWCP-20 is designed to obtain this information and should be enclosed with Form CA-2201, Form CA-2202, or equivalents. Extensive documentation of assets and expenses in support of the statements made on the Form OWCP-20 is requested by both Forms CA-2201 and CA-2202. If adequate documentation is not supplied, the CE may elect to conference the case and/or request that additional documentation be submitted (or the H&R Representative should request additional documentation at the hearing).

Example 1 – TThe OWCP finds that an overpayment of \$2,500 occurred due to an incorrect pay rate. The overpaid individual submits evidence to show that he has income of \$2,000 per month consisting of his FECA benefits and benefits from the Social Security Administration, and assets consisting of an \$800 bank account and \$1,000 in a mutual fund. He also submits evidence showing that he has fixed monthly living expenses of \$1,000 for rent, \$300 for a vehicle loan, \$250 for utilities, \$300 for food, and a \$75 minimum credit card payment. He also has \$50 in miscellaneous expenses. Thus, the ordinary and necessary living expenses are determined to be \$1,975 per month and his assets do not exceed the resource base of \$6,200 for an individual.

An individual is deemed to need substantially all of his or her current net income to meet current ordinary and necessary living expenses if monthly income does not exceed monthly expenses by more than \$50. The difference between the individual's income of \$2,000 and his ordinary and necessary living expenses of \$1,975 is only \$25. Recovery of the overpayment in this case would "defeat the purpose of the FECA" because recovery would cause hardship by depriving the overpaid individual of income and/or resources needed for his ordinary and necessary living expenses under the criteria set out in this section.

c. Against Equity and Good Conscience. If the overpaid individual is not entitled to waiver under the "defeat the purpose of this subchapter" clause, the "against equity and good conscience" clause should be considered. Even if the overpaid individual does not raise "equity and good conscience" reasons in the claim for waiver, the CE or H&R Representative must address the issue in the Final Overpayment Determination, stating whether or not this clause pertains to the specific circumstances of each case. Robert E. Wenholz, 38 ECAB 311, 315 (1986) ("In support of his request for waiver of the overpayment, appellant submitted cancelled checks to the Office which showed that he used the award money he received to repay personal loans, settle a property dispute with his ex-wife, and assist his daughter in the payment of school expenses. At

the hearing appellant testified that he entered into these transactions relying upon the compensation that he received and that he was unable to repay the overpayment as a result. Accordingly, the case must be remanded to the Office for further development on this claim. On remand the Office should determine whether the evidence is sufficient to waive the overpayment under the "against equity and good conscience" clause of the Act.") This clause is divided into three parts: financial hardship, lack of knowledge of the overpayment, and detrimental reliance.

(1) Financial Hardship. Recovery will be found to be "against equity and good conscience" when an overpaid individual would experience severe financial hardship in attempting to repay the debt. The factors to consider in making this hardship determination are the same as those considered under the "defeat the purpose of this subchapter" clause.

(2) Lack of Knowledge. Recovery will also be found to be "against equity and good conscience" when the overpaid individual derived no personal gain from the incorrect payment(s) and had no knowledge of the compensation benefits that were paid.

A case where an individual is not aware of an overpayment is rare, but when this occurs, since the individual had no knowledge of compensation paid to him/her, the overpayment is waived; there is no reason to consider finances.

For example, the Eighth Circuit Court of Appeals ruled in *Groseclose v. Bowen*, 809 F.2d 502 (8th Cir. 1987), that the Secretary of Health and Human Services had applied an "unreasonably narrow" definition of the "against equity and good conscience" test, because the Secretary failed to interpret this phrase in a manner reflecting its commonly-understood meaning. The appellant had been charged with a Social Security overpayment and waiver was denied by the Social Security Administration (SSA) when benefits were incorrectly paid directly to one of his minor children who was living in another state. The appellant was not even aware that his child was receiving benefits.

The Court of Appeals reversed the SSA and found that recoupment of the overpayment from appellant "would be against equity and good conscience as that phrase is commonly understood." The Court stated, "We find it difficult to imagine a more unfair or unjust situation than requiring a person who is without fault to repay overpaid benefits when that person had no knowledge of the overpayments." See R.L., Docket No. 10-2412 (Issued August 23, 2011) (ECAB found recovery would not "defeat the purpose of [FECA]" nor be against "equity and good conscience." Retirement funds available for withdrawal may be considered for waiver determinations and the evidence of record indicated that appellant had significant assets in excess of the established limit. Appellant also cited *Groseclose* a case which involved Social Security benefits and an "equity and good conscience" clause where a claimant who was not aware that one of his minor children was receiving Social Security benefits in error and the Court of Appeals found recoupment of the overpayment would be against equity and good conscience. ECAB found *Groseclose* factually distinguishable and found OWCP properly denied waiver in this case.)

(3) Detrimental Reliance. Recovery is considered to be inequitable and against good conscience when a person, in reliance on such payment(s) or on notice that such payment(s) would be made, relinquished a valuable right or changed his or her position for the worse.

When the overpaid individual states that he or she has relinquished a valuable right, it must be demonstrated that:

- (a) the right was, in fact, valuable;
- (b) the individual is unable to get it back; and
- (c) his or her action was based primarily or solely on reliance of such payment(s) or notice of payment(s).

When an overpaid individual has changed his or her position for the worse, it must be shown that:

- (a) he or she made a decision that would not otherwise have been made, but for the receipt of benefits, and
- (b) this decision resulted in a loss.

The overpaid individual must show that if required to repay the overpayment, he or she would be in a worse position after repayment than he or she would have been the case if the benefit(s) had never been received in the first place. Conversion of the overpayment into a different form, such as food, consumer goods, real estate, etc., from which the overpaid individual derived some benefit is not to be considered a loss. J.B., Docket No. 15-1043 (issued August 6, 2015)(ECAB stated: "the money appellant spent on a car, pistol, magazines, snow blower, and bathroom fixtures is not considered a loss. He did not change his position for the worse. Rather, appellant simply converted his assets from one form to another. He purchased tangible property from which he derived some benefit." Converting the overpayment into a different form for the benefit of another person (such as a child or relative), however, may be considered as a loss if the overpaid individual retains no ownership interest in the proceeds and has no ability to reclaim the proceeds); G.W., Docket No. 12-1171 (issued October 25, 2012) (the claimant argued that he relied on the overpaid compensation to help relatives financially, to pay for his daughter's wedding, and to make purchases, such as a new car, a swimming pool, appliances, and electronics. ECAB found, however, that the claimant did not qualify for waiver under the principle of detrimental reliance because there was no evidence he gave up a valuable right or changed his position for the worse); Ronald L. Berente (claiming as son of John M. Berente), Docket No. 89-624 (issued September 19, 1989) (Appellant stated that he put the money into his daughter's savings account. ECAB noted: "waiver of the overpayment might be considered if appellant had put the money in an account in which he had no ownership and had no call on the money. He commented, however, that recovery of the overpayment would result in a loss because he would have to take money out of his daughter's savings account. This statement shows that appellant is able to withdraw money from his daughter's savings account. He therefore has not relinquished any valuable rights which would lead to waiver of recovery of the overpayment on the ground that it would be against equity and good conscience.")

If detrimental reliance occurred, the individual's present ability to repay the overpayment is not considered and the overpayment should be waived.

The following are examples of application of the detrimental reliance principle:

Example 1: A surviving spouse and a son were receiving death benefits. After the son dropped off the rolls in 2012 at age 18, the surviving spouse's benefits were recomputed. An error was made in the re-computation of cost-of-living adjustments, resulting in a difference in payment of \$50 per month. When the error was detected in 2014, the surviving spouse applied for waiver of the overpayment, stating that she quit her job in 2012 based on the expectation of continuing compensation and was unable to regain her job. In this situation, it is likely that waiver would not be granted on grounds of detrimental reliance. The surviving spouse would have to show that she relied on the difference between benefits actually received and entitled benefits when deciding to retire, and that if she had been receiving correct benefits, she would not have retired. Proving this will be very difficult due to the small difference between benefits actually received and the correct benefits, i.e. \$50 per month. Also, the surviving spouse would have to show that she cannot go back to work.

This outcome does not conflict with OWCP's responsibility to carefully investigate, evaluate, and make a determination on all of the overpaid individual's contentions concerning waiver. Since the overpaid individual is in possession of the facts, she is in the best position to show that her assertions have merit, and the burden of setting forth the argument is generally on the party with the best access to the facts. OWCP must provide the individual with the opportunity to present additional argument and prove her assertions. Furthermore, OWCP must clearly explain to her the basis for waiver and what she would need in order to qualify.

If the benefit which is now declared an overpayment is a large one, the OWCP will compare the amount the overpaid individual was receiving against the amount she would have received without the overpaid benefit(s) to determine whether there may have been detrimental reliance. For example, if the surviving spouse's entire benefit was paid in error, the Office would have to consider whether she might have given up her job if she were getting no FECA benefit(s) at all. Even in this case, she might have been entitled to an OPM annuity or other pension, sufficient to prompt her to resign.

Therefore, consideration must also include the financial hardship in the case. If detrimental reliance is not demonstrated, waiver might still be granted on financial hardship alone.

Example 2: A claimant received a large schedule award for her hearing loss. Later it was discovered that the claimant's hearing loss was not noise-induced and the entire award was declared to be an overpayment. The claimant contended that she had changed her position for the worse, as she used the entire award to make a down payment on a larger home. The claimant has not met her burden in showing that she changed her position for the worse, since she has not shown that she suffered any loss. She simply converted the money into a different form and did not lose it. Conversion of a liquid asset into real or personal property does not constitute a loss.

While the claimant may have made the expenditure in reliance upon the award, she must also establish a financial loss before it will be inequitable to recoup the overpayment. Of course, the CE must still compare the claimant's income and expenses under the second part of the "against equity and good conscience" test, i.e., financial hardship.

By contrast, if the surviving spouse relied on such benefits to pay her daughter's college tuition, this would not be a conversion of the money into anything for her own use. Therefore, she would be worse off if recoupment is made rather than if she never received the benefits.

Example 3: A claimant was notified that he was entitled to a \$20,000 schedule award for his hearing loss. Upon receipt of the money, the claimant bought a farm with a \$2,500 down payment and took a ten-year mortgage from the owner. The first payment was not due until six months after the down payment. Before the first payment was due, the claimant was notified that the entire award was an overpayment. As a result, the claimant put all of the remaining money into the bank, failed to make the first payment, and forfeited the down payment. Since the claimant would not have entered into the contract to purchase the farm but for his receipt of benefits, it would be inequitable to recoup the entire \$20,000 overpayment, as the claimant clearly suffered a loss in the amount of \$2,500.

This example indicates that partial waiver is a legitimate action. The claimant did not suffer a \$20,000 loss, but merely a \$2,500 loss. The claimant did not have the money to buy a farm and had no intention of doing so until he received his award. Thus, the claimant detrimentally relied upon the OWCP's action and it would be inequitable to recover the overpayment to the extent of his reliance (i.e. \$2,500). It would not be inequitable, however, to recoup the part of the overpayment that the claimant deposited in the bank. If the claimant was faced with additional expenditures arising out of the forfeiture, those expenses should also be deducted from the overpayment.

d. Waiver of Interest Only. The Debt Collection Act of 1982 and the Federal Claims Collection Standards (31 CFR Part 900-904) provide that interest shall be assessed on all debts due the United States Government unless specifically exempted or waived under established regulations. When recovery of an overpayment is waived in full, the overpayment never becomes a "debt" and, therefore, interest is not applied.

However, whether or not waiver of recovery is requested, an overpaid individual may request that interest be waived. In an overpayment case where the overpaid individual specifically requests that interest be waived and waiver of recovery of the overpayment is not granted in full, the Final Overpayment Determination must address the request for waiver of interest. If waiver of interest is denied, the decision must include a discussion of the rationale as to why the circumstances in the case do not meet the criteria for waiving interest.

Interest may be waived after the Final Overpayment Determination is issued under the following circumstances:

(1) If the principal is repaid in full within 30 days of notification that charges are applicable. This may be extended for one additional 30-day period (for a total of 60 days) on a case-by-case basis for good cause shown. Acceptable reasons for the 30-day extension include, but are not limited to, situations where the overpaid individual needs the additional time to liquidate assets or arrange financing in order to pay the debt, or where the individual does not receive the Final Overpayment Determination in a timely manner (e.g., because of absence from home due to hospitalization).

(2) If the full amount of the principal is paid after charges have accrued and the additional cost of recovering the charges is greater than the amount of the accrued charges.

(3) Where the overpaid individual is without fault in the creation of the debt and a repayment agreement has been established, if the monthly payment is so small that it does not cover the interest, or there is so little left after interest that the debt will not be paid off within the lifetime of the overpaid individual (as determined by actuarial tables).

Waiver of interest is determined by using the Waiver/Compromise application to create a Waiver of Charges/Compromise of Principal Worksheet. See Exhibit I. When interest is waived under any of the three above criteria, the overpaid individual should be informed by letter. If waived pursuant to item (c), the letter should advise that charges will again be applied if the overpaid individual defaults on the debt.

In the case of Marie D. Sinnett, 40 ECAB 1009 (1989), the claimant agreed to repay an overpayment through deductions of \$100 from her continuing compensation checks. While she did not request waiver, she did request that the assessment of interest be waived. The OWCP refused to waive the interest amount and the claimant appealed. The Board ruled that the case was not in posture for a decision on the issue of the OWCP's refusal to waive the imposition of interest on the overpayment debt because "...the Office hearing representative failed to specify the circumstances of the appellant's case which denies the Office authority to waive interest and he failed to explain why the agreed repayment schedule precludes waiver of interest under the applicable regulations."

e. Waiver of additional charges, Administrative and/or penalty charges must be waived if the overpaid individual is without fault in the creation of the overpayment and the application of charges will extend the period of indebtedness beyond the individual's life expectancy. The Waiver/Compromise application can be used to create a Waiver of Charges/Compromise of Principal Worksheet. See PM 6-0500.5 for additional information regarding additional charges.

5. Final Overpayment Determinations. If the overpaid individual has not repaid the debt in full and has not requested a pre-recoupment hearing with H&R, a Final Overpayment Determination should be issued by the Office using Forms CA-2223-2227 or equivalents. Correspondence Library contains shell letters to serve as a guide in writing the Final Overpayment Determination and should be tailored to the specific circumstances of the case. When any Final Overpayment Determination is issued, a copy should be sent to the employing agency and any authorized representative.

a. Entitlement issues that affect an overpayment should be addressed by the Office before a Preliminary Overpayment Determination is issued, when possible. Entitlement decisions carry greater appeal rights than those afforded in a Final Overpayment Determination. In some instances, an entitlement issue will be raised after the Preliminary Overpayment Determination is issued. If raised and not previously addressed, the CE or the H&R Representative should issue an entitlement decision, with appropriate appeal rights, before the Final Overpayment Determination is issued. This difference may be especially important in the context of pre-recoupment review or hearing where the overpaid individual contests the fact of the overpayment

and the CE or the H&R Representative must determine whether the overpaid individual's objections actually involve an issue of entitlement. The CE or the H&R Representative should then take appropriate action with regard to the overpayment issues of fault, waiver and/or recovery, and issue a Final Overpayment Determination.

(1) For example, an overpayment is created as a result of the OWCP's decision that compensation had been paid at an incorrect pay rate. If the claimant presents evidence in support of the argument that the original pay rate used by OWCP was correct and that the decision changing the pay rate was improper, the issue of entitlement should be addressed and a formal decision with appropriate appeal rights should be issued prior to the Final Overpayment Determination.

(2) On the other hand, if the overpaid individual questions the amount of the overpayment based solely on the correctness of the OWCP's mathematical computations, no issue of entitlement is raised in connection with the overpayment and only a Final Overpayment Determination is necessary. The CE should discuss the evidence of record that supports modification, show how the amount was modified and include any recalculations with as much detail as done in a Preliminary Overpayment Determination. See FECA PM 6-0300.5.

b. Most Final Overpayment Determinations will not involve entitlement determinations, and therefore, may be issued after considering all evidence received in response to the Preliminary Overpayment Determination.

(1) No response to the Preliminary Overpayment Determination, With Fault.

(a) If the overpaid individual is found with fault and did not respond to the Preliminary Overpayment Determination, proper due process was afforded, and he or she is being paid compensation from the OWCP on the periodic roll (or is due accrued benefits from the OWCP or the OPM), a Final Overpayment Determination should be issued using Form CA-2223 or equivalent. If the overpaid individual is due accrued benefits from the OWCP or the OPM for past entitlement, the overpayment should be recovered in full by a single deduction from compensation, when possible. Where compensation is being paid on the periodic roll, the debt repayment rate should be set at 25% of the net compensation amount until the balance of the overpayment is paid in full.

(b) If there is no ongoing compensation or accrued benefits upon which to collect the debt, a Final Overpayment Determination should be issued using Form CA-2223 (or equivalent) and repayment of the debt demanded in full. If financial documentation is received at a later date reflecting the inability to repay the debt in full, a reasonable repayment plan can be appropriately determined at that time.

(2) Response to the Preliminary Overpayment Determination, With Fault.

(a) If the overpaid individual is found with fault and provided a response to the Preliminary Overpayment Determination, the response should be thoroughly reviewed along with any

evidence submitted to determine if the overpaid individual remains to be found with fault in the overpayment.

(b) If the evidence received was irrelevant or insufficient to overturn the with fault finding, a Final Overpayment Determination should be issued using Form CA-2223 or equivalent. If no financial documentation is on file, the debt should be recovered in accordance with paragraph (1) (a) or (b) above.

(c) If the Preliminary Overpayment Determination's finding of with fault is overturned and the overpaid individual is determined to be without fault in relation to the overpayment, the CE must decide if there is sufficient information on file to grant a waiver of recovery as described in paragraph 4 of this chapter.

(3) No response to the Preliminary Overpayment Determination, Without Fault.

(a) If the overpaid individual is found without fault, did not provide a response to the Preliminary Overpayment Determination, and proper due process has been afforded, a Final Overpayment Determination should be issued in accordance with paragraphs (1) (a) or (b) above. If the CE determines that a conference is necessary to actuate a fair and equitable repayment plan, it is at the sole discretion of the CE to arrange one.

(4) Response to the Preliminary Overpayment Determination, Without Fault.

(a) If the overpaid individual is found without fault and responded to the Preliminary Overpayment Determination and requested a waiver but did not request a hearing, the CE should thoroughly review the evidence submitted and make a determination regarding waiver of recovery in accordance with paragraph 4 of this chapter. If the CE determines that a conference is necessary to properly address waiver of recovery, it is at the sole discretion of the CE to arrange one.

(b) If full waiver of recovery is granted, the CE will issue a Final Overpayment Determination using Form CA-2227 or equivalent.

(c) If partial waiver of recovery is granted, the CE will issue a Final Overpayment Determination using a modified version of Form CA-2225 (or equivalent) and recover the debt in accordance with paragraph (1) (b).

(d) If no waiver of recovery is granted, the CE will issue a Final Overpayment Determination using Form CA-2225 (or equivalent) and determine a reasonable rate of repayment for debt recovery based on the financial documentation on file.

(5) If a retroactive schedule award is immediately payable or payable in the near future, and full waiver has not been granted, 100% of the award can be taken towards the balance of the overpayment (regardless of whether financial information has been received or not) and a Final Overpayment Determination should be issued fully explaining the recovery.

c. The Final Overpayment Determination should contain the following:

(1) Notification of due process that the delinquent debt may be referred to the Department of the Treasury, administrative costs may be assessed if this occurs, and it is reportable to credit bureaus.

(a) The Debt Collection Improvement Act of 1996 created a new Federal Debt Collection system for delinquent debts. Delinquent debts are cross-serviced by the Department of the Treasury and are required to be referred to them for collection action when the debts are more than 180 days delinquent.

(b) Notification of due process must be given at least 60 days prior to referral for cross-servicing. All final decisions that require repayment of a debt (Forms CA-2223 through CA-2225, or equivalents) contain the necessary due process language.

(2) Notification that the overpaid individual has a right to inspect and request copies of debt records, to enter into a mutually agreeable repayment plan, and to request a review of the debt determination.

(3) Notice of the right to appeal to the ECAB.

(4) A memorandum to the file that includes:

(a) The Issue under consideration, specifically that the Preliminary Overpayment Determination be finalized or overturned, and either the overpayment recovered or waived.

(b) The Background of the case, including the reason(s) the overpayment occurred, a summary of the findings made in the Preliminary Overpayment Determination and the evidence received in response.

(c) The Discussion, including the rationale for the final fault finding, regardless of whether or not it changed from that declared in the Preliminary Overpayment Determination; a summary of any conference held and conclusions drawn from it; consideration of waiver of recovery where the overpaid individual is found without fault; and, if the overpayment is recoverable, an appropriate collection plan.

(d) The Basis for the Decision, explaining the reason(s) for the final determination made on fault finding and waiver (if applicable).

(e) The Conclusion, finalizing the Issue and the action(s) to be taken.

d. Representative Payees. A representative payee may be held responsible for repaying an overpayment. Compensation payments are often sent to a representative payee, a party other than the individual on whose behalf the benefits are payable. The representative payee is legally obligated to use the funds for the advantage of the claimant/beneficiary. The representative payee may be a legally appointed guardian, a trustee, or other fiduciary.

This commonly occurs in death cases, where a surviving spouse or legally appointed guardian receives payments on behalf of the decedent's surviving children. It is less common in disability cases, occurring chiefly where claimants are unable to handle their financial affairs for various reasons, such as being declared legally incapable of handling financial matters or suffering from a grave illness.

A finding will be made regarding the representative payee's fault in creation of the overpayment. If the representative payee is without fault, waiver of the overpayment will be considered using established standards. The issues of fault and waiver are determined individually for the claimant/beneficiary and for the representative payee. Therefore, either the representative payee or the claimant/beneficiary would be liable for an overpayment, or both could share the liability if neither met the standards for waiver. The regulatory authority for representative payees appears at 20 CFR §10.424.

(1) A representative payee has a fiduciary responsibility. Consequently, the fact that an overpayment for a claimant/beneficiary must be repaid from the representative's funds is insufficient to justify waiver. If a representative payee is without fault, the waiver issue will be determined as it would be for a without fault claimant who received an overpayment on his or her own behalf (by applying the tests including equity and good conscience).

(2) The CE must provide representative payees with adequate written notification of the circumstances which may result in prohibited receipt of benefits and their responsibility in reporting requirements including the return of checks/funds received after an event that affects entitlement.

(3) Since a determination of fault depends heavily on whether the payee was informed of the reporting responsibility, both the representative payee and the claimant/beneficiary should be informed of this responsibility and asked to furnish information. Providing a claimant/beneficiary with copies of letters addressed to a representative payee is generally not sufficient to hold the claimant/beneficiary responsible for submitting information. A separate letter must be sent to each.

(4) Minors and those found legally incompetent to handle their own affairs, however, should not be asked to submit information. Requests for information and final decisions should be sent only to the representative payees.

(5) While a representative payee may do nothing more than endorse compensation checks to the claimant/beneficiary, this does not excuse the representative payee from liability or in any way diminish responsibility in the creation of an overpayment. An overpayment to a representative payee is handled according to regular overpayment procedures outlined in this chapter.

6. System Coding. When a Final Overpayment Determination is issued, the debt record should be updated accordingly to reflect the action taken.

- a. Full payment received. If full payment has been received towards the debt following the Preliminary Overpayment Determination, the debt record should be updated to reflect a zero balance and the record should be closed.
- b. Partial payment received. If partial payment has been received towards the debt following the Preliminary Overpayment Determination, the debt record should be adjusted to reflect the new overpayment amount less the payment received. The debt record should also be changed from a preliminary status to a final status to reflect that a Final Overpayment Determination has been issued. The debt record should also reflect any repayment plan set forth in the Final Overpayment Determination.
- c. No payment received. At the time the Final Overpayment Determination is issued, the debt record should be updated from a preliminary status to a final status. The debt record should also reflect any repayment plan set forth in the Final Overpayment Determination.
- d. Change in fault finding. At the time the Final Overpayment Determination is issued, the debt record should be updated to reflect a change in the case status from preliminary to final. If the Preliminary Overpayment Determination determined that the claimant was with fault, but that has subsequently changed with the issuance of the Final Overpayment Determination, the debt record should properly reflect this change. If waiver was granted, it should also be reflected in the debt record.

[Exhibit I – Waiver of Charges Worksheet](#)

6-0500, Debt Liquidation

1. Purpose and Scope. This chapter furnishes the information and instructions necessary to properly manage and liquidate debts by providing procedures for collection strategies, assessment of charges, compromise, and collection actions including recovery from the OWCP entitlement, various offset options, and termination (write-off) of collection efforts.

Debt referrals to the Departments of the Treasury and Justice are also addressed, as is the management of existing debts from a deceased debtor, compensation paid after death, and debts where a third party, fraud, or bankruptcy is involved.

2. Legislative Authority and Regulatory Provisions:

a. 20 CFR §10.441 explains how overpayments are collected:

(1) When an overpayment has been made to an individual who is entitled to further payments, the individual shall refund to the OWCP the amount of the overpayment as soon as the error is

discovered or his or her attention is called to the same. If no refund is made, the OWCP shall decrease later payments of compensation, taking into account the probable extent of future payments, the rate of compensation, the financial circumstances of the individual, and any other relevant factors, so as to minimize any hardship. Should the individual die before collection has been completed, collection shall be made by decreasing later payments, if any, payable under the FECA with respect to the individual's death. If no further benefits are payable with respect to the individual's death, the OWCP may also 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 Department of the Treasury.

(2) When an overpayment has been made to an individual who is not entitled to further payments, the individual shall refund to the OWCP the amount of the overpayment as soon as the error is discovered or his or her attention is called to the same. The overpayment is subject to the provisions of the Federal Claims Collection Act of 1966 (as amended) and may be reported to the Internal Revenue Service as income. If the individual fails to make such refund, the OWCP may recover the same through any available means, including offset of salary, annuity benefits, or other Federal payments, including tax refunds as authorized by the Tax Refund Offset Program, or referral of the debt to a collection agency or to the Department of Justice.

b. Minimum Collection Guidelines. The Federal Claims Collection Standards, published jointly by the Department of the Treasury and the Department of Justice, (31 CFR Parts 900 through 904) state that Government claims should be collected in full. If an installment plan is accepted, the installments should be large enough to collect the debt promptly.

(1) In cases where there is no entitlement to waiver and the overpaid individual's assets are insufficient to repay the overpayment in full, the CE or H&R Representative should evaluate the individual's financial information to establish the highest reasonable rate of repayment which will collect the debt promptly and at the same time minimize any hardship on the overpaid individual.

(2) Where the overpaid individual's ordinary and necessary living expenses approximately equal his or her income, a repayment schedule must still be established. In such cases, the rate of repayment should be set so that any hardship is minimized. The appropriate recovery rate must be established based on the circumstances of each case, taking into account the requirement to minimize (not necessarily eliminate) hardship on the individual.

3. Responsibility for the Collection and Settlement of Debts is delegated as follows:

a. The Office is responsible for establishing and maintaining debt records, pursuing collection of the debt, and monitoring debt records to determine if and when referral to the Departments of the Treasury or Justice or termination of collection action may be appropriate.

b. Quality Assurance and Mentoring Examiners or Journey-level CEs are authorized to compromise debts and to suspend or terminate collection action, subject to the approval of the District Director, on debts of \$1 to \$100,000, and to recommend referral of debts of more than

\$100,000 to the Director of Federal Employees' Compensation for possible referral to the Department of Justice.

(1) If there is any indication of fraud on the part of the debtor or any other party having an interest in the claim, the authority of the CE is limited to debts less than \$500. H&R Representatives have the same limitations with respect to compromising, suspending or terminating collection action on debt claims.

(2) A case involves fraud if an investigation is ongoing which is likely to lead to an indictment; if an indictment is pending; or if there has been a conviction in connection with the debt. Cases where the Department of Justice has declined to seek an indictment, where the criminal case has been dismissed, or where an acquittal has occurred, are not considered fraud cases.

c. The Director of Federal Employees' Compensation is authorized to compromise up to \$100,000 on claims and suspend or terminate collection action on claims not in excess of \$100,000, exclusive of interest, penalties, and administrative costs.

d. The authority to suspend or terminate collectible debts in excess of \$100,000 rests solely with the Department of Justice. Therefore, even if the OWCP believes that suspension or termination of recovery of such a debt is appropriate, the matter must be referred to the Department of Justice for determination. See 31 CFR 904-03.1(b).

e. An overpayment of compensation does not become a debt and is not subject to recoupment (except for overpayments not covered by 5 U.S.C. 8129 as discussed in PM 6-0300.3) until established due process procedures have been provided and a Final Overpayment Determination has been issued. Until that time, the OWCP may accept payment against the overpayment but may not assess any charges, take any action to collect from compensation owed, or issue requests for offset by the Office of Personnel Management (OPM) or other Federal agencies.

4. Collection Strategies Strategies for collection of a debt should generally be pursued in the following order:

a. Recovery of the entire debt from accrued compensation for which there is direct statutory authority under 5 U.S.C. §8129.

b. Voluntary prompt repayment of the debt in a lump sum;

c. Deduction of installment payments from periodic compensation;

d. Voluntary deduction of installment payments from retirement benefits;

e. Involuntary offset of retirement benefits or refund of retirement contributions;

f. Voluntary installment payments made directly by the debtor;

g. Referral to the Department of the Treasury (if the debt meets certain criteria);

- h. Agreement to compromise in consideration of partial payment;
- i. Salary Offset deducted by the Federal employer;
- j. Referral to the Department of Justice (if the debt meets certain criteria);
- k. Termination or suspension of collection action (write-off) after items a-j (above) have been exhausted.

5. Assessment of Charges. The Debt Collection Act of 1982 authorizes the assessment of interest, administrative costs, and penalties on delinquent debts.

- a. Charges are assessed on all debts where a final decision has been issued (except certain debts which are being repaid under a long-standing repayment agreement as noted in b. and c. below) beginning on the date the debtor was notified that charges may apply to the debt, or the date of the Final Overpayment Determination, whichever is later.
- b. Charges are not assessed on any debt being repaid under a repayment agreement in effect prior to October 25, 1982. The repayment agreement may have been oral or written. If the OWCP notified the debtor and began collections prior to October 25, 1982, and voluntary payments or offset payments have continued more or less regularly since that time, it may be assumed that an agreement exists.
- c. Charges are assessed on any debt being repaid under a repayment agreement which took effect between October 25, 1982 and March 26, 1986, unless the repayment agreement, as documented in the case file, stipulates that no charges will be assessed.
- d. If the repayment agreement took effect after March 26, 1986, charges apply regardless of what is indicated in the repayment agreement.
- e. In cases of court-ordered restitution, the Court Order takes precedence over the Debt Collection Act. Unless stipulated in the Court Order, charges may not be assessed on the part of the debt corresponding to the restitution amount set by the court. See PM 6-0500.19.
- f. Interest is assessed at the rate in effect on the date of the Final Overpayment Determination (or the date the debtor was notified that charges may apply to the debt), unless the debtor has defaulted, in which case the interest rate in effect on the date of the new agreement is used. Changes in the interest rate will be announced by OWCP Notice and DFEC directive. See Exhibit 1.
- g. Administrative costs are assessed when the debt is found to be delinquent. When a delinquent debt is referred to the Department of the Treasury for collection, a charge is added to the principal and interest as an administrative cost of collection.
- h. Penalties. At present, penalties are not being assessed.

6. Compromise to Limit the Repayment Period. Compromise is an administrative means of decreasing a debt by accepting a partial settlement after a debt has already been established. This is distinguished from full or partial waiver which is a formal decision that negates the overpayment, or the portion waived, before it becomes a debt. Additionally, the debtor has no legal right to settlement or compromise and need not be without fault for compromise to be considered.

Compromise is a contractual agreement on the part of the United States to be satisfied with partial repayment of the debt. Even if the debtor's circumstances change, such that the reasons for the compromise are no longer valid, the OWCP has officially forgiven the remainder of the debt and may not pursue additional repayment unless the debtor defaults on the repayment agreement. Only after the debtor's financial circumstances are known, should compromise be undertaken.

Compromise to limit the repayment period is considered to be due to hardship, as is compromise based on life expectancy.

The determination that the debt has been compromised does not carry the right to a hearing or to review by the Employees' Compensation Appeals Board.

a. Compromise of the principal reduces the principal amount of the debt where it is necessary to limit the repayment period so that it can be repaid within a reasonable time period.

b. Compromise of additional charges reduces the accrued charges applied in the debt to limit the repayment period at the time the repayment agreement (either initial or re-negotiated) is established.

c. A specific mathematical formula is used to determine whether compromise of accrued charges and/or principal is required.

(1) Three pieces of information are needed for the mathematical formula:

(a) the amount of the principal;

(b) the amount of the monthly payment; and

(c) the annual interest rate.

(2) To determine whether compromise is required, divide the current principal balance plus any accrued charges by the monthly payment and multiply the result by the annual interest rate. If the result is less than 5.5 no compromise is necessary.

(3) If the result is 5.5 or greater, the Compromise of Principal Worksheet must be completed in order to determine the amount, if any, to be compromised. This worksheet can be found using the Waiver/Compromise application.

(4) If the formula calculation eliminates compromising the debt, the CE should complete a memorandum to the file that includes a discussion as to how, with an attachment of the Compromise of Principal Worksheet showing the figures.

(5) If the formula calculation results in a compromise, the Final Overpayment Determination should include a discussion as to how, with an attachment of the Compromise of Principal Worksheet showing the figures. See paragraph g. below.

d. Compromise of the principal and/or accrued charges must be considered if the application of charges will increase the period of indebtedness by more than 35%.

(1) Example: The current principal of the debt is \$15,788.62. There are no accrued administrative, penalty, or interest charges. The annual interest rate is 1.00%. The monthly payment amount is \$54.16 and the debtor's current age is 60.

When inputting this information into the Waiver of Charges/Compromise of Principal application, the debt without charges would take 291.52 months to repay. 35% of this period is 102.03 months. Therefore, the debt with charges must be repaid within 393.55 months (291.52 + 102.03). So that the repayment period does not exceed the claimant's life expectancy, the accrued charges and principal must be compromised in order to reduce the payment period to 393.55 months. The application reveals that \$15,788.62 compromised by \$3,852.66 results in a new debt principal balance of \$11,935.96.

(2) The Office may have some cases in which a modest repayment amount was set years ago without a thorough review of the debtor's resources. While the debtor is repaying, interest will extend the schedule by more than 35%. In such cases, the OWCP should not proceed to compromise based on the scheduled amount. The CE should instead contact the debtor to discuss the schedule, point out that the application of interest will extend the schedule, and ask the debtor to consider an accelerated repayment schedule in order to resolve the debt earlier and reduce the total interest paid. If the debtor can provide financial information which supports an inability to pay more, the OWCP may then apply the compromise rule above.

e. If the principal or accrued charges must be compromised, and the principal amount (before compromise) is not more than \$100,000 where there is no indication of fraud, or not more than \$500 where there is such an indication, then the Compromise of Principal Worksheet should be certified by a second individual at the Quality Assurance and Mentoring Examiner level or higher and the compromise detailed in the Final Overpayment Determination.

(1) When a debt arises because of a third party recovery, any compromise may not result in a principal balance which is less than the amount of the Government's statutory right of reimbursement. (See paragraph 18 of this chapter.)

f. If the principal or accrued charges must be compromised, and the principal amount (before compromise) is more than \$100,000, or more than \$2,500 where there is an indication of fraud, then the Compromise of Principal Worksheet must be certified by a second individual at the

Quality Assurance and Mentoring Examiner level or higher and the case referred to the Director of Federal Employees' Compensation or designee for further action regarding the compromise.

g. The Final Overpayment Determination should include a discussion of compromise as follows:

- (1) The amounts specified for each component of the debt including principal, accrued administrative costs, accrued penalty, and accrued interest, as applicable;
- (2) The rationale for the determination that the debt cannot be waived;
- (3) The rationale for compromising the debt with a copy of the Compromise of Principal Worksheet attached;
- (4) The amount to be accepted in full settlement of each component of the debt, with separate amounts specified for principal, accrued administrative costs, accrued penalty, and accrued interest, as applicable;
- (5) The time and manner of payment;
- (6) A statement that the debt is not compromised or settled until full payment of the specified amount has been made; and
- (7) Notification that unless the compromise was for financial hardship, the compromised debt will be reported to the IRS as income because while the debtor does not actually receive money, compromise negates a debt that would have otherwise been paid, and the IRS considers this to have the same effect as receiving income. As such, the individual must pay taxes on it according to the proper income tax level.

7. Compromise in Consideration of Debt Disposal. Regardless of whether compromise is required under the provisions of Paragraph 6 of this chapter, compromise may be further considered as a means of disposing of debts where collection would be extremely difficult or expensive.

a. The debtor may propose that the OWCP be satisfied with partial recovery on the debt, or the OWCP may propose a compromise of partial repayment to the debtor. This might occur if the debtor reported a liquid asset that exceeded the resource base, but was insufficient to cover the debt, and otherwise had only enough income to meet expenses. The compromise would provide for recovery of the amount available and forgiveness of the remainder.

(1) In judging whether repayment would cause hardship, the OWCP should assess the debtor's income and assets according to the criteria provided in paragraph 6.400.4. The debtor should be required to submit a current financial report (OWCP-20) with supportive documentation if one has not been provided within the past six months.

b. Compromise with partial recovery of the debt should be considered if the Government cannot collect the full amount because the debtor is unable to pay it within a reasonable time, or the

debtor refuses to pay the claim in full and the Government is unable to enforce collection by court action within a reasonable time. The compromise limitations, as described in paragraph 6 of this chapter, also apply here. In determining inability to pay, the OWCP may consider:

- (1) The age and health of the debtor;
- (2) Present and potential income;
- (3) Inheritance prospects;
- (4) The possibility that assets have been concealed or transferred by the debtor to avoid recoupment; and
- (5) The availability of assets or income for enforced collection.

c. If it is determined that compromise is warranted, the CE should prepare a memorandum to the file which describes the inability to pay, the proposed compromise, and the factors that led to the compromise recommendation.

d. A claim may also be compromised if the Solicitor notifies the Office that significant doubt exists as to whether the Government could establish its claim in court, and the debtor has offered partial repayment. This may occur because of a dispute about the law or facts of the individual case. The Office should not make a judgment about legal enforceability without the Solicitor's specific advice after review of the case.

e. Once a compromise decision is released, and the agreed upon portion of the debt has been refunded to the OWCP, the debt is fully resolved.

(1) The debt management system should be annotated to reflect resolution by compromise and the amount repaid.

(2) A letter should be sent to the debtor confirming that the debt has been discharged. Unless the compromise was for reasons of economic hardship, the letter sent to the debtor should also advise that the amount compromised will be reported as income to the IRS and may be subject to taxation under IRS rules. In cases where the debt has been compromised for reasons other than economic hardship, at the end of each year the National Office files IRS Form 1099G, and a copy of the form is forwarded to the debtor's case file.

8. Recovery from Continuing OWCP Entitlement.

a. If compensation is owed to the overpaid individual, the debt should be recovered from compensation due after a Final Overpayment Determination has been issued. The payment of benefits due should not be delayed, since collection can be made from ongoing compensation.

(1) An exception to delay can occur if the delay will assist in collecting the debt. For example, if a schedule award is in posture to pay, and the debt should be recovered from the award but the

Final Overpayment Determination has not yet been issued, payment of the award can be delayed until the Final Overpayment Determination has been issued in order to sufficiently recover the debt.

b. If a sufficiently large lump sum payment of compensation is payable to the overpaid individual for a single period of past entitlement or for a schedule award, the debt should be recovered in full by a single deduction from compensation owed. The CE should explain the recovery method in the Final Overpayment Determination. *D.S., Docket No. 14-378* (issued June 11, 2014)(ECAB has held that OWCP may properly collect an overpayment from the amount of compensation owed a claimant through a schedule award).

c. If the beneficiary is receiving periodic payments, an appropriate payment amount should be deducted in order to recover the overpayment within three years. See 31 CFR § 901.8(b). Deductions can begin with the next periodic roll payment following the release of the Final Overpayment Determination, as long as the overpayment decision is released at least two weeks before the issuance of the first reduced compensation check. If the decision is not released at least two weeks before the next compensation check, the deduction should not be started until the following check cycle, to provide the claimant the required two week notice for reduction in net compensation.

(1) If no response to the Preliminary Overpayment Determination is received, the CE should set the rate of repayment at 25% of the 28 day net compensation amount until the balance of the overpayment is paid in full. If a completed response to the Preliminary Determination is received within one year, the financial information should be thoroughly examined and if adjustment of the 25% is warranted, the CE should set a reasonable rate of repayment with intent to recover the overpayment within three years. A final decision should be issued with appeal rights to the ECAB. (This is distinguishable from situations where a change in financial circumstances is requested and a review on the Director's motion is requested.)

(2) If a response to the Preliminary Overpayment Determination is received, the financial information received should be thoroughly examined and the CE should set a reasonable rate of repayment with intent to recover the overpayment within three years.

d. The debt record should be updated to reflect the debt recovery information, whether it be paid in full or payment installments arranged toward resolution of the debt.

e. The Final Overpayment Determination should advise the overpaid individual of the rate of offset and the date on which the debt will be liquidated.

9. Salary Offset. The Debt Collection Act of 1982 and Department of Labor regulations (29 CFR §20.74 et seq.) provide that a Federal agency may recover a debt owed to the OWCP, upon request, by regular installments from the employee's pay. Generally, the DOL salary offset process will not be utilized as Treasury referrals take precedence. If a CE receives a request for salary offset from the claimant, the CE should contact the National Office.

10. Administrative Offset from OPM benefits for retired debtors and debtors with contributions toward retirement.

a. The OWCP and the OPM have an agreement whereby offset may be made against amounts payable to retired debtors and debtors with contributions toward retirement from the Civil Service Retirement and Disability Fund. Generally, the OPM benefit offset process will not be utilized as Treasury referrals take precedence.

(1) The offset amount must be at least \$50.

(2) If there are accrued benefits which have not yet been paid to the debtor, because of a retroactive election of benefits under the Civil Service Retirement Act (CSRA) or the Federal Employees Retirement System (FERS), the OPM will reimburse the OWCP up to the amount of accrued benefits without certification of notice to satisfy due process.

(3) If a debt is to be collected by offset from continuing OPM payments (i.e. no accrued benefits due), the OWCP must provide notice to satisfy due process, and must certify to the OPM that the due process requirements were provided before offset can occur. Due process consists of a Preliminary and Final Overpayment Determination.

b. The Federal Claims Collection Standards provide that before applying to the OPM for offset, the Office must notify the debtor of the intention to proceed with collection by offset, offer the opportunity to review and copy records pertaining to the debt, and offer the debtor the opportunity to enter into a written agreement to repay the debt.

(1) Form CA-9003 (or equivalent) provides this notification and should be released to the debtor at least 30 days prior to actually requesting offset from the OPM. Failure to provide this 30-day notice will result in improper due process notification.

(2) The debtor can submit a written request to review and obtain copies of debt records. The debtor is entitled to the first copy of any case record material without charge, in accordance with the Privacy Act.

c. The OPM's regulations governing administrative offset are detailed in 5 CFR 550.1101-1110. If a person indebted to the OWCP is receiving or is entitled to OPM benefits, and the requirements for administrative offset have been met, the assigned fiscal personnel/CE should promptly complete and forward Form SF-2805 and OPM Form 1552, certifying that appropriate due process notice was offered and requesting offset.

(1) Where collection will be in installments, the amount requested must be specified as either a percentage of the net annuity or a specific dollar amount for each monthly installment.

(2) Generally, the monthly installments should be at least 10% of the net benefit and should not be less than \$50, unless a smaller amount is justifiable on financial hardship grounds or some other reasonable cause.

(3) The monthly installments may not be more than 50% of the net benefit, unless the debtor has consented in writing to collection of a larger amount.

(4) If possible, the installment amount should be large enough to liquidate the debt within three years.

(5) The OPM will continue deductions until the debt is resolved as long as an annuity is being paid. If interest accrues against the debt during this period, the CE should notify the OPM of the additional amount and of the additional period necessary to pay the interest well in advance of the last deduction that the OPM would make if paying off only the amount of the debt declared at the time the offset was requested. The OPM will not calculate the interest.

d. If the debtor is not receiving an annuity under the CSRA or FERS and has no accrued retirement contributions, the OPM will inform the Office that no possibility for offset exists and the CE will need to pursue other means for debt recovery.

e. If the debtor is not receiving an annuity under CSRA or FERS but has accrued retirement contributions, the OPM will notify the Office and retain the claim for future recovery. The CE should then pursue recovery through other means. If recovery is made through other means, the Office must notify the OPM so that the claim against future CSRA or FERS entitlement can be removed.

(1) If the OPM subsequently receives an application for an annuity or for refund of contributions within one year of the claim for offset, it will offset the amount stated in the claim, unless the claim specifies that interest is being charged, in which case it will first contact the Office to determine the current balance to be offset.

(2) If the application for an annuity or refund is received more than one year after the claim for offset, the OPM will contact the Office to determine the current debt balance before collecting from the amount to be offset.

(3) If the debtor advises the OPM that due process procedures were not followed, the OPM will notify the Office. The Office must send a letter signed by the District Director (or designee) certifying that notice sufficient to satisfy due process was provided. Copies of the Preliminary and Final Overpayment Determinations should be attached.

(4) If the OWCP has made an incomplete claim for offset, and the OPM receives an application for refund of contributions to the retirement system, the OPM will withhold the amount of the debt from the refund for 120 days, which upon request, may be extended an additional 60 days for a total of 180 days. If the OPM has not received certification of sufficient notice to satisfy due process by the end of the 180 day period, full refund will be made to the debtor.

f. A ten year statute of limitations on debt collection by administrative offset used to exist. The Debt Collection Act of 1982 (as amended by the Debt Collection Improvement Act of 1996) was amended on June 11, 2009 to conform with an amendment made by the Food, Conservation, and Energy Act of 2008 under 31 U.S.C. 3716(e).

(1) Prior to this change, administrative offset to debt collection was only available if the debt was delinquent for a period of less than ten years. The changes to this rule conform to the statutory language by removing the ten-year time limitation on the collection of nontax debt by administrative offset, including centralized salary offset, by explicitly stating that no time limitation shall apply, and by explaining that by removing the time limitation, all debts, including debts that were ineligible for collection by offset prior to the removal of the time limitation, may now be collected by administrative offset and centralized salary offset.

(2) The amendment to the law applies to any debt outstanding on or after the date of the enactment of the Act.

(3) To avoid any undue hardship, a requirement applicable to debts that were previously ineligible for collection by offset because they had been outstanding for more than ten years has been added. For these debts, creditors must certify that the notice of intent to offset was sent to the debtor after the debt became ten years delinquent. This is intended to alert the debtor that his debt may now be collected by offset and allows the debtor additional opportunities to dispute the debt, enter into a repayment agreement, or otherwise avoid offset. This requirement applies even in a case where notice was sent prior to the debt becoming ten years delinquent. This requirement applies only with respect to debts that were previously ineligible for collection by offset because of the time limitation. Form CA-9003 (or equivalent) provides this notification.

11. Recovery Where No Compensation or OPM Offset is Available. Where there are no compensation benefits, salary offset, or OPM offset benefits available to recover the debt from, the CE should outline the amount that the debtor needs to repay directly in the Final Overpayment Determination.

a. The debtor's resources for repayment should be evaluated at the time a Final Overpayment Determination is being issued. If detailed information on the debtor's financial status is not already in the case file, it may need to be obtained to negotiate an appropriate repayment plan with the debtor. This information may include:

(1) Form OWCP-20

(2) Overpayment Recovery Questionnaire

(3) The official transcript of any hearing

(4) Claim Form CA-7

(5) Form CA-1032

(6) Information provided by the Social Security Administration in response to Form CA-1036

b. The debt should be collected in one lump sum whenever possible. If the debtor is unable to pay the debt in full, payment may be accepted in regular installments. The size and frequency of

installment payments should be determined by the size of the debt and the debtor's ability to repay.

c. When considering the amount of installment payments, the CE should evaluate the debtor's financials to determine if there is appreciable income in order to recover the entire debt (including any interest or penalties) within three years, as recommended by the U.S. General Accounting Office (GAO). If so, the installment amount should be set so that the debt is paid in full in three years or less. If not, the installment amount should be set so that the debt is repaid as close to three years as possible.

d. If the debtor refuses to submit detailed financial information, or has not yet had time to reply to a request for such information due to extenuating circumstances, the Office may accept voluntary installment payments in an amount determined by the debtor, or the Office may determine a reasonable amount based on documentation in the case file, unless or until detailed financial information becomes available.

(1) If the debtor makes installment payments in an amount so small that the debt will never be repaid or will be repaid in an unreasonably long period (termed a "perpetual debtor"), and refuses to increase the payments or submit detailed financial information justifying the size of the payment, the Office should consider involuntary offset, referral to the Department of the Treasury, or referral to the Justice Department.

e. The CE should not enter into a formal agreement with the debtor, and should not consider waiver of charges (See PM 6-0400.4) or compromise of principal (see PM 6-0500.6), unless and until the debtor provides detailed financial information and agrees to installment payments in an amount which reasonably represents the maximum payment he or she is able to afford.

f. If the debtor offers to repay on a set schedule or requests a change in a schedule already established, the proposed repayment plan should be evaluated for reasonableness on the basis of the debtor's financial resources as documented in the case file.

(1) If the repayment plan is reasonable, the CE should obtain a signed statement from the debtor which specifies the terms of repayment, and the statement will constitute a legally enforceable agreement.

(2) If the repayment plan proposed by the debtor is not reasonable, the CE should conduct a conference to discuss an accelerated plan and then obtain a signed statement from the debtor agreeing to the revised plan.

(3) If the debtor has not agreed to a repayment plan and/or is not making reasonable payments, the CE should conference the case to discuss an accelerated plan and follow up with a written repayment plan for the debtor to sign. If the debtor cannot be reached for conferencing, or refuses conferencing, referral to the Department of the Treasury may be in posture for pursuit of collection.

g. The Final Overpayment Determination is considered the first demand for payment. The CE should follow up after 30 days to determine whether the overpaid individual has paid the debt in full or made an installment payment towards the balance of the debt. After any necessary conferencing, if no payment has been made, or if an unreasonable payment has been made towards the debt, the CE should follow up with two more demand letters at 30-day intervals.

(1) Forms CA-9001 and CA-9002 (or equivalents) include the notice to satisfy due process in demand for debt recovery. Form CA-9001 is issued 30 days following the Final Overpayment Determination and Form CA-9002 is issued 30 days following Form CA-9001, if applicable.

(2) The letters should advise the debtor of the amount of money owed, the rate at which applicable interest and penalties will accrue, the possibility of salary or administrative offset, and the potential for referral to credit bureaus, the Department of the Treasury, or for litigation by the Department of Justice, if no good faith effort is demonstrated on the part of the debtor.

(3) In most cases, however, after the 30th day following the third demand letter (when the debt is between 90 and 120 days delinquent), if no payment is received, if regular payments are not received, or if the payment is unreasonable to reduce the debt timely, the CE should refer the debt to the Department of the Treasury for debt collection or termination. See paragraph 12 of this chapter.

(4) If letters are returned because of an insufficient address, the Office should seek the correct address by contacting the employing agency, former employer, dependents, or the OPM; or by using the internet, telephone directories, city directories, Postmasters, motor vehicle records, credit agency skip reports, and/or credit bureaus. Depending on the nature and amount of the debt, if all efforts to locate the debtor are unsuccessful, further collection action should be terminated as provided in paragraph 14 of this chapter, or the debt should be referred to the National Office for possible litigation (as provided in paragraph 13 of this chapter).

12. Referral to the Department of the Treasury. The Debt Collection

Improvement Act (DCIA) of 1996 centralized the government-wide collection of delinquent debt and gave the Department of the Treasury new responsibilities.

When a non-tax debt is greater than 120 days delinquent the debt may be referred to the Department of the Treasury for collection or termination of collection actions as long as the debt is final and not covered by bankruptcy, already in private collection or in litigation, or with the Justice Department. The fact that a Final Overpayment Determination is on appeal to the ECAB does not affect the timing of referral—if the overpayment is reversed by the ECAB, the debt can be recalled from Treasury.

The Department of the Treasury oversees all collection activity on all referred debts. All debts related to the overpayment of benefits under the FECA will be referred for both the Treasury Offset Program (TOP) and Cross-Servicing.

The Financial Management System (FMS) is responsible for the implementation of the debt collection provisions of the DCIA. FMS sends demand letters to debtors on Treasury letterhead, and enters into repayment arrangements with debtors.

a. FMS uses the TOP to compare the names and taxpayer identifying numbers (TINs) of debtors with the names and TINs of recipients of Federal payments. If there is a match, the Federal payment is reduced, or "offset," to satisfy the overdue debt.

b. TOP has been expanded to incorporate other offset processes, particularly:

(1) the tax refund offset program, formerly operated by the Internal Revenue Service, was merged into TOP in January 1999;

(2) levies served by the IRS for the collection of delinquent tax debt in accordance with the Taxpayer Relief Act of 1997; and

(3) collection of state income tax debts by offset of Federal income tax refunds as mandated by the 1998 Internal Revenue Service Restructuring and Reform Act.

c. Cross-Servicing is the other primary debt collection tool operated by FMS. Cross-Servicing uses a variety of collection tools to encourage debtors to repay the Federal Government. Under the Debt Collection Act of 1982, debtors whose accounts become delinquent are subject to reporting to private credit reporting bureaus. FMS administers a contract with Private Collection Agencies who provide delinquent debt collection services and FMS refers debts to these Private Collection Agencies.

(1) The Department of the Treasury reports delinquent debtors to one or more credit bureaus. These bureaus maintain credit information on individuals and provide the information upon request to lenders. The possibility of credit reporting should be pointed out to individuals who refuse to cooperate in the debt collection process. This language is provided in Forms CA-9001 and 9002.

(2) If a debtor disputes the information in a credit bureau's file, the credit bureau will contact the Department of the Treasury to verify the information. The Department of the Treasury currently refers these inquiries to the Branch of Fiscal Operations in the FECA PROGRAM National Office. A failure to respond to the Department of the Treasury within a given time limit (generally 30 days) will result in the credit bureau accepting the debtor's version of the facts.

(3) Since the Department of the Treasury reports debt to all the credit bureaus, referred debts end up being reflected on the debtor's personal credit history report. Once the debt is satisfied, it isn't automatically removed from the debtor's credit report. The debtor must make a specific request to have it removed.

(4) Should a debtor contact the Office with a request to have a satisfied debt removed from his or her credit report, pertinent information should be forwarded to the National Office. National Office will research the matter to make sure the debt has in fact been satisfied, and will then

contact the Department of the Treasury directing them to remove the negative report. National Office will contact the debtor of the action taken, but it will be the debtor's responsibility to periodically check his or her credit report to confirm that the update occurred.

d. At least 60 days prior to referral to the Department of the Treasury, a debtor must be given notice that the referral for collection action is a possibility. As outlined in PM 6-0100.3e(3) and PM 6-0500.11g, Forms CA-9001 and CA-9002 include appropriate language to serve this purpose, and both must be issued at 30-day intervals after the Final Overpayment Determination to provide adequate due process notice. The Department of the Treasury will not accept debts where such notice has not been given. The notice must also include specific advice that the debtor can:

- (1) inspect and request copies of records about the debt;
- (2) enter into a mutually agreeable written repayment agreement; and
- (3) request review of the amount of the debt, its past-due status, and whether the debt is legally enforceable.

e. A referral to the Department of the Treasury should be made using established process. All documents pertaining to the debt (from calculation through the most recent demand letter) must be in the case file. The complete package should then sent to Fiscal Personnel in the National Office to confirm that referral to the Department of the Treasury is appropriate.

(1) Once the referral is received by the National Office, it will be reviewed to assure that all due process requirements have been met and that it is an appropriate debt for handling by the Department of the Treasury.

(2) The Debt Record should be updated to properly reflect that the debt was referred for treasury servicing.

(3) Once the referral is made, all questions regarding the debt should be referred to National Office until the debt is returned to the referring Office.

f. The Department of the Treasury may return a debt for a number of reasons. The debt may have been paid in full, found to be uncollectable, covered by a bankruptcy filing, or compromise may have been reached. When the Department of the Treasury returns a debt, it will be returned to the custodial Office for further action as noted.

13. Referral to the Justice Department. When the Office has exhausted all means to collect a debt, referral to the Justice Department for litigation should be considered. Department of Justice Nationwide Central Intake Facility (NCIF), P.O. Box 65720, Washington, D.C. 20035, is the central location at the U.S. Department of Justice (DOJ) where Federal agencies should refer civil debts for litigation and enforced collection.

a. Statutory time limitations exist for filing a civil action in the courts to enforce an administratively declared fine, penalty or forfeiture or to recoup overpayments.

(1) With respect to collection of debt resulting from a forfeiture determination, 28 U.S.C. 2462 provides a five-year limitation period to seek judicial enforcement of the forfeiture, starting from the date the OWCP issues its final decision on the forfeiture issue.

(2) With respect to filing suit to enforce collection of other debts, 28 U.S.C. §2415(a) provides that any such action shall be barred unless filed within six years after the right of action accrues or within one year after a final administrative decision has been rendered on the matter, whichever is later. The date the overpayment first occurred represents the date the "right of action accrues." However, 28 U.S.C. §2416(c) provides that as long as "facts material to the right of action are not known and reasonably could not be known by an official of the United States charged with the responsibility to act in the circumstances," the six-year period will be tolled.

The ECAB stated that the OWCP was not barred by the six-year period of limitations set forth in 28 U.S.C. §2415 from recovering an overpayment of compensation made more than six years before the Office determined there was an overpayment. The ECAB found that section 2415(d) applies only when the Government seeks to recover an erroneous payment in a civil action in a court of competent jurisdiction and it has no application to section 8129 of the FECA. The Board found this interpretation consistent with language of section 2415(d), with the legislative history of the section, with the position of the Comptroller General, with subsection(I) of section 2145, and with court decisions on the application of section 2415. Earl C. Poppell, 39 ECAB 1455 (1988); see also, John F. Dunleavy, 45 ECAB 891, 893 (1994) (ECAB held: "Neither the Act nor the implementing regulations place a period of limitation on the adjustment authorized thereunder. Accordingly, the Board finds that the Office is not barred from recouping the full amount of the overpayment that occurred in this case.")

b. If clear evidence exists for the potential recovery through litigation and the debt is greater than \$500, the case should be referred to the National Office by signature of the District Director. Legal action will require evidence that the debtor has assets that may be attached or that family income is sufficient to repay.

c. Any case referred for legal action must contain the following information, if known:

(1) Debtor's full name and current address, or a listing of prior known addresses and steps taken to locate debtor;

(2) Debtor's date of birth and SSN;

(3) Military serial or other identifying number;

(4) Statement detailing circumstances of the debt and computations pertinent to the amount of debt;

(5) Actions taken to collect or compromise the debt, specifying whether or not referral to a private collection agency was made;

(6) Credit data obtained within the past six months which shows ability to recover from the debtor.

(a) Regulations specify that credit information must exist in one of the following forms: a commercial credit report; an agency investigative report showing assets, liabilities, income and expenses; or the debtor's own financial statement executed under penalty of perjury. The Office may enlist an agency investigator to obtain this information.

(7) A Claims Collection Litigation Report (CCLR) prepared by the National Office, with assistance from the Office of the Solicitor (SOL);

(8) A Certificate of Indebtedness (COI) prepared by the National Office, with assistance from the SOL;

(9) Copies of correspondence with debtor;

(10) Any documents which establish the Government's position on issues raised by the debtor;

(11) Citations to applicable laws and regulations;

(12) Action taken toward recoupment through salary offset or OPM offset;

(13) Dates the debt first accrued and dates of partial payments, if any; and

(14) A description of the debtor's financial status.

If significant doubt exists about the financial hardship reported by a beneficiary, a Wage-Hour investigator may be asked to interview the beneficiary, verify unemployment, etc. The Department of Justice will also accept an OWCP-20 completed by the debtor.

d. If the credit information shows that the debtor has assets which may be recovered, the CE should prepare a memorandum recommending referral to the Director for Federal Employees' Compensation and forward it to the District Director (or designee) for certification.

(1) Upon receiving a referral recommendation, the District Director (or designee) should carefully review the file to verify that the finding of overpayment is supported, that due process rights were properly provided, and that the potential for enforced collection is documented in the file.

(2) The District Director (or designee) should consider the facts of the case including the pay rate used for compensation purposes and evidence regarding dependents.

(3) If the overpayment arose because the forfeiture provision in 5 U.S.C. §8106 was invoked, the reviewer should ensure that the only period at issue is the time period required by affidavit which was falsely provided and declared forfeit.

e. Upon receipt of a complete file, National Office staff will determine whether:

- (1) The overpayment actions taken were correct;
- (2) Due process rights were provided;
- (3) All possible collection actions were taken by the Office; and
- (4) All necessary information is present, or thorough efforts to obtain the information are documented.

Cases which do not meet the above criteria, or where the file does not document persistent and substantial efforts toward recovery, will be returned to the Office for further collection action or additional documentation.

f. At the time the referral is made, the debt record should be updated to properly reflect that the debt was referred to the Department of Justice.

g. Where the OWCP is collecting a debt under a Department of Justice agreement, the OWCP cannot charge interest or send billing notices.

14. Termination of Collection Action (Write-off). If the OWCP is not successful in its attempts to collect from the debtor, collection action may be terminated/written off. The Office may terminate collection activity on debts which do not exceed \$100,000, exclusive of interest, and which do not involve fraud.

a. When assessing debt termination, the OWCP should consider whether:

- (1) Any substantial amount can be collected;
- (2) The debtor can be located;
- (3) Assets exist which can be liquidated;
- (4) The applicable statute of limitations has expired, so that litigation will be unsuccessful;
- (5) Cost of further collection action will exceed recovery; and
- (6) The agency's claim has legal merit, or can be substantiated by the evidence.

b. Office management should periodically review debt management records to identify cases in which aggressive collection action has brought no result. Each case should be examined to

determine whether litigation would lead to collection of the debt. Circumstances where collection is not likely to be successful should be terminated. Those circumstances include:

- (1) where it appears that the debtor has no assets or income which could be attached by a court;
- (2) if the debtor's financial circumstances are such that hardship would result from recoupment; and/or
- (3) if the Solicitor or the U.S. Attorney states that the OWCP has a poor legal case against the debtor.

c. Where aggressive collection action has brought no result, a Termination of Collection Action memorandum to the file should be prepared by the CE. The memorandum should state:

- (1) the nature and amount of the debt;
- (2) the efforts made to collect the debt;
- (3) the financial circumstances of the debtor; and
- (4) an explanation why termination of collection action is warranted.

If the debt exceeds \$100,000, or involves an indication of fraud, the memorandum should be signed by the District Director and referred to the National Office with documentation of collection action(s) and a recommendation.

Debts of \$2,500 or less which cannot be collected by administrative means, including referral to the Department of the Treasury, must be written off, since the Department of Justice will not accept them.

d. Occasionally a debtor may ask that the debt be forgiven due to financial hardship.

- (1) The OWCP may suspend collection action because of financial hardship, but reserves the right to resume collection action in the event of future claims or a change in the debtor's circumstances.
- (2) If the debtor has failed to respond to requests or has refused to repay, the OWCP should place a memorandum in the file without corresponding with the debtor. If the debtor's circumstances change, or the OWCP receives different information at some later date, collection action may be resumed if no order compromising or forgiving the debt was issued.

e. When collection action is terminated, the debt record should be closed.

- (1) Termination of collection action, or the "write-off" of a debt, is an administrative action which is different from waiver or compromise.

(2) Termination of collection action does not forgive the debt since the OWCP may collect the debt at a later date. However, generally, once a debt has been written off, collection action will not be resumed.

(3) At the end of each year the National Office files IRS Form 1099G for cases where the debt has been written off for other than economic hardship reasons, and a copy of the form is forwarded to the case file. Once Form 1099G has been filed, the debt record should be closed, and the OWCP may not collect the debt at a later date.

15. Recovery of an Existing Debt from a Deceased Debtor's Estate. If the overpaid individual dies before an existing debt is completely recovered, the Office must quickly and efficiently obtain pertinent information about the estate and devise further collection strategies. Prompt action is essential because creditors who have not properly asserted a claim before the estate is closed are generally precluded from any recovery.

Many state statutes provide that an unsecured debt may not be collected from an estate one year after the death of the decedent. As many states require publication of a notice to creditors, a written claim against an estate should generally be presented within four months from the date of death.

If it appears that the claimant's surviving spouse will be entitled to compensation for death benefits under 5 U.S.C. § 8133 (b) from which the remaining overpayment balance can be collected under 5 U.S.C. § 8129 within a reasonable time, or similarly, that the claimant's surviving spouse has clear entitlement to OPM retirement benefits subject to offset and where it appears clear the remaining overpayment balance can be feasibly collected from these sources, the CE may seek the permission of the District Director to omit the estate collection process described below. Such permission should be documented with a memorandum to the file and a letter to the claimant's surviving spouse should describe the collection process contemplated.

Otherwise, the CE should take swift action to collect the balance of the overpayment from the estate as follows:

a. If only a Preliminary Overpayment Determination has been issued to the claimant at the time of death, a new Preliminary Overpayment Determination should be issued to the estate, followed by a Final Overpayment Determination. Generally, estates should be found without fault.

b. Conversely, if a Final Overpayment Determination has already been issued at the time of death, no Preliminary and Final Overpayment Determinations will be issued to the estate due to the strict timeframes associated with making a claim against the estate. Rather the CE should proceed with making a claim against the estate using the procedures outlined in PM 6-0500.16.

c. Should FECA death benefits be determined payable, the claimant's debt should be collected from any FECA benefits due to the deceased claimant's surviving spouse in accordance with the explicit authority set forth in 5 U.S.C. 8129(a).

d. Should non-death FECA benefits be determined payable, the claimant's debt should be credited with the amount entitled, reducing or eliminating the overpayment balance. In some instances, this may require delay in credit/payment of FECA benefits to ensure that proper overpayment due process has been afforded.

e. If the claimant recently passed away, the OWCP may refer the debt to FMS for offset of the deceased claimant's last Federal tax refund under the Treasury's Offset Program (TOP). 31 §CFR 285.2 if the death occurred in the prior year. The CE should follow the referral procedures set forth in PM 6-0500.12, including sending the complete referral package to the National Office for final review and forwarding to the FMS.

f. Upon learning that a claimant with an existing overpayment has died, the Office shall immediately contact the OPM to determine the availability of any OPM benefits payable at the time of death that may be administratively offset, e.g., basic employee death benefits, survivor annuity benefits, or lump sum refund of the deceased employee's retirement contributions (5 CFR §831.1805). If such OPM benefits are available for offset, the Office should refer to procedures set forth in PM 6-0500.10.

g. To initiate action against an estate for debt recovery, the Office should take the following steps:

(1) Immediately send a letter to the claimant's estate, in care of the individual most likely to be named the personal representative or executor of the estate (i.e., Attention: Michael Smith, Personal Representative of the Estate of John Doe). This letter will also serve as a Preliminary Overpayment Determination on the debt to the estate.

(2) The letter must state that the OWCP is making a claim against the estate for the amount of the overpayment and full payment is due within 30 days. In addition, the letter should request the name of the personal representative or executor for the estate and the name of the court where a probate estate case would be opened.

(3) The OWCP should further inform the estate representative in the letter that the estate has the right to: inspect/copy OWCP records relating to the overpayment debt, request that the overpayment be waived, and request a pre-recoupment hearing.

(4) The estate representative will generally be found without fault in the creation of the overpayment. If the estate requests a waiver determination or otherwise asks to be excused from the debt, financial information should be requested from the estate and a waiver determination should be prepared. However, in most situations waiver will be denied and collection will proceed if the estate's resources, after liabilities are established, allows for repayment of the overpayment.

(5) The OWCP should enclose a copy of its previously issued Final Overpayment Determination and a debt history report.

(6) After 30 days, the CE should send a final overpayment letter to the estate. This constitutes the first demand for payment. In the letter, the OWCP shall warn the estate that unless full payment is made within 15 days and the requested information provided, SOL will take legal action against the estate. In the event that the estate representative requests a waiver determination following the request for legal action, any information garnered in the SOL process should be considered in the waiver determination.

(7) After 15 additional days, a last demand letter should be issued to the estate.

h. After the Office sends the final overpayment letter to the estate and confirms that there are no OWCP or OPM benefits available for administrative offset, the debt should be referred to the Solicitor's Office of Federal Employees' and Energy Workers' Compensation Division (SOL/FEEWC).

Only debts of \$1000 or more should be referred to SOL/FEEWC. Outstanding debts under \$1000 should be administratively terminated if not collected following the development described in part (g) of this section.

SOL/FEEWC will take the following actions upon receipt:

(1) Determine whether a probate estate case is currently open and in which jurisdiction. Generally a probate estate is opened in the deceased claimant's county of legal residence or domicile. SOL/FEEWC will determine the appropriate county and contact its probate court. As a practical matter, if a claimant is married and holds assets jointly with a living spouse, an estate may not be opened where the assets are modest.

(2) If a probate estate case is open for the deceased claimant, SOL/FEEWC will file a claim against the estate for the amount of the outstanding debt.

(3) If a probate estate case is not open, SOL/FEEWC may file the preliminary and final overpayment letters and demand letter(s) with the probate court and request that the court open a case, appoint a personal representative, and provide an estate accounting report.

(3) If the overpayment is or becomes uncollectible, SOL/FEEWC will create a memorandum to the OWCP, recommending termination (write-off) of the debt in accordance with PM 6-0500.14. The OWCP will then terminate the debt record accordingly.

16. Compensation Paid After Death. It is not unusual for one or more FECA compensation payments to be issued after the death of a claimant. Sometimes checks continue to be cashed by the debtor's surviving spouse or child or paid by Electronic Funds Transfer (EFT) into the deceased's bank account shared jointly with a surviving spouse or child. Prompt action by the OWCP in identifying these continued payments after death is essential to any potential recovery.

a. Cashing checks or accepting money by EFT after the death of the debtor may constitute criminal conduct and cannot be considered overpayments. No waiver, hearing, or appeal rights

are available to the individual in these cases and no Preliminary or Final Overpayment Determinations should be issued by the OWCP.

b. Even though compensation paid after death is not an overpayment, it is still a debt owed the Government and tracked via the debt management system.

c. Upon learning of the death of a debtor, the CE should take the following steps:

(1) Immediately send a letter to the surviving spouse, child or other individual who cashed the checks or to the joint holder of the bank account requesting that the payments be returned within 15 days.

(2) This initial letter is considered a final decision and a first demand for payment.

(3) The CE should ensure that compensation has been terminated in the case, and that a debt record is created and appropriately updated with each action taken.

d. After 30 days from the date of the initial letter, the CE should pursue reclamation. Reclamation is a procedure used by FMS to recover Government benefit payments made to a deceased beneficiary's checking and/or savings account at a financial institution.

(1) Per 31 CFR §§ 210.9-14 the OWCP must initiate reclamation with FMS within 120 calendar days after the date it has actual or constructive knowledge of the debtor's death. Due to the 120-day time period, it is imperative that the Office act promptly in these cases. FMS will recoup the money from the financial institution that cashed the check or received the EFT and restore the funds to the OWCP.

(2) If no funds are received as a result of the initial letter, the CE should send a referral to the National Office Branch of Fiscal Operations requesting that reclamation be performed to recoup the money via the Department of the Treasury.

(3) In the case of EFT payments, only the full amount of the payment made after death can be reclaimed. This may result in funds being owed to the survivor(s) after a successful reclamation.

(4) In the case of reclaimed paper check payments, the actual amount owed can be reclaimed, avoiding any excessive recoupment. When requesting reclamation of funds paid by paper check, the CE should inform the National Office Branch of Fiscal Operations of the exact amount paid after death, to ensure that the correct amount is requested.

(5) The National Office Branch of Fiscal Operations will then submit the reclamation immediately to the Department of the Treasury using the on-line PACER application. Reclamations can take from 30 to 90 days to be processed by the Department of the Treasury, so it is important that they are requested promptly. Once notified by the Department of the Treasury, the National Office Branch of Fiscal Operations will then notify the CE of the reclamation results. The Notice of Reclamation (FMS-133) should be bronzed to the claimant's case file.

(6) Should the reclamation result in the return of excess funds, the CE should closely monitor the case for receipt of payments then expeditiously process any payment due to the debtor's survivors or estate.

e. If the Office receives notice of the debtor's death more than 120 days after the actual date of death, this is considered "late notice." When "late notice" occurs, the reclamation should be processed immediately, instead of waiting 30 days after the initial letter to the survivor(s) as noted above.

f. If monies were not received after the first payment demand, the Office should send a second demand letter at the time the reclamation is issued. The debt record should be updated to reflect this status once the letter is released.

g. Depending on the results of the reclamation, the Office should consider referring the case to any or all of the following agencies:

(1) SOL/FEEWC as described in PM 6-0500.15.

(2) FMS as described in PM 6-0500.12.

(3) OIG. If the facts of the case are sufficiently egregious, e.g., continued receipt of EFTs by a joint account holder for numerous months after the debtor's death, continued cashing of compensation checks of the deceased debtor, etc., the OWCP may refer the case to the deceased debtor's employing agency's Injury Compensation Specialist for investigation by its Office of Inspector General (OIG) into possible criminal conduct. The OWCP may also consider referral to DOL/OIG. Referral may lead to criminal charges and prosecution by the local U.S. Attorney's Office and/or State Attorney General's Office and the individual, if convicted, may be required to pay restitution to the OWCP.

h. If the compensation payments become uncollectible after one year from the date the OWCP has knowledge of the debtor's death, the OWCP may write-off the debt in accordance with PM 6-0500.14 and the debt record should be updated to reflect this status.

17. Bankruptcy. The CE may discover that the debtor has filed bankruptcy when reviewing the case for a Preliminary or Final Overpayment Determination or when so notified by the debtor.

a. When the CE learns of the bankruptcy, the Regional Solicitor or SOL/FEEWC must be immediately contacted, the OWCP must immediately cease all collection efforts, and any automatic deductions from the debtor's continuing compensation payments must be terminated. OWCP should not provide any legal or procedural advice to the FECA debtor regarding the bankruptcy.

Under the Bankruptcy Code, once the FECA debtor files a petition for bankruptcy relief, the recovery of an overpayment against the debtor for an overpayment that arose prior to the filing in bankruptcy is automatically stayed. See 11 U.S.C. §362. The stay applies regardless of whether

the overpayment will or will not be discharged. Therefore, any deductions being made from the debtor's compensation benefits for the recovery of an overpayment must stop immediately upon receipt of the notice in bankruptcy. In addition, any deductions made after the petition for bankruptcy was filed must be expeditiously refunded directly to the debtor in a Chapter 13 case or to the trustee in a Chapter 7 case. In the event that notice of the bankruptcy is received after the debtor receives his/her discharge, any deductions made after the petition was filed must be expeditiously refunded directly to the debtor under either bankruptcy chapter. The refund should not be made to the debtor's attorney or any other individual representing the debtor. Failure to stop deductions can subject the OWCP to damages and sanctions under the Bankruptcy Code even if the violation was not willful. See 11 U.S.C. §362. The date that the petition in bankruptcy is filed will appear on the notice and is the date that should be used to determine whether any refund must be made. The actual date that OWCP received the notice should not be used to calculate a refund.

Note that the automatic stay does not preclude the administrative redetermination of FECA benefits owed to the Debtor. See *In re Howell*, 4 B.R. 102 (M.D. TN 1980). The automatic stay precludes determinations regarding monies owed to the government. For example, the OWCP may not finalize a preliminary determination on an overpayment while the automatic stay is in effect.

b. If possible, the CE should request that any paperwork pertaining to the bankruptcy such as the bankruptcy petition, bankruptcy schedules and/or any order of the bankruptcy court in the case be submitted by fax from the debtor, as well as the location of the bankruptcy court involved (i.e. the bankruptcy court for the Southern District of Ohio), the bankruptcy case number and the name and contact information of the bankruptcy attorney representing the debtor.

c. In some instances, the bankruptcy court will request that a Proof of Claim form be completed. If such a request is received in the Office, e-mail communication should immediately ensue with the Regional Solicitor or SOL/FEEWC and the Proof of Claim form faxed so that it can be completed and timely filed with the bankruptcy court and transmitted to the U.S. Attorney, if appropriate.

(1) There is usually a deadline appointed by the bankruptcy court for filing of the Proof of Claim, so prompt action is necessary. This deadline cannot be extended by the court and a Proof of Claim will be rejected by the court if it is filed after the deadline.

(2) The Proof of Claim form may need to be filed with the bankruptcy court before due process of the overpayment has been completed.

d. The Bankruptcy Code requires a debtor to file a schedule (list) of all assets and liabilities, listing all creditors and amounts due when seeking bankruptcy protection. See 11 U.S.C. 521(1). A debt is not generally discharged if:

(1) It was not listed in a Chapter 13 case.

(2) It arose after the date of the bankruptcy filing, after the date the debt was discharged or if the bankruptcy case was dismissed by the bankruptcy court. See 11 U.S.C. §362(c). In the event the bankruptcy case is dismissed, the automatic stay no longer applies. See 11 U.S.C. §362(c).

(3) The debtor committed fraud to obtain the payment originally, and a timely objection to dischargeability on this basis is filed with the court. See 11 U.S.C. §523. There is a deadline appointed by the bankruptcy court for filing the objection to dischargeability, so prompt action is necessary by the Office. If such a case arises, e-mail communication should immediately ensue with the Regional Solicitor or SOL/FEEWC so that a lawsuit/objection to dischargeability can be commenced in a timely fashion. If the deadline to object to dischargeability has passed and no request for extension of time to file the objection is filed with the court, the objection will be rejected and the debt may nonetheless be subject to discharge.

e. A debt is nullified and cannot be recovered if the bankruptcy court has discharged the debt in a bankruptcy proceeding (Chapter 7 or Chapter 13).

(1) If a debtor's obligation to repay an overpayment is forgiven by the bankruptcy court having discharged the debt in a bankruptcy proceeding, the debt is authorized for termination (write-off) in accordance with PM 6-0500.14.

(2) The CE should ensure that the debt record is properly terminated.

18. Third Party Liability Debts. Effective July 1, 2013, all cases that are identified as having third party potential are to be referred to SOL/FEEWC, regardless of the employing agency or the amount of refundable disbursements. Thus, when a debt to the United States is established by SOL/FEEWC's approval of a Statement of Recovery (SOR), SOL/FEEWC has an obligation to collect the debt. *See In re Dixon*, 132 B.R. 16 (S.D. Ohio 1991) which held that for any payment made by a third party tortfeasor, the injured employee, after deducting the costs of suit and a reasonable attorney fee, is obligated to refund to the United States the amount it paid for compensation under the FECA.

a. Pursuant to 20 CFR 10.715, interest may be assessed on third party debts.

b. There are two types of third party debts:

(1) The first type occurs when a completed Form CA-1108 (Long Form Statement of Recovery) or CA-1122 (Short Form Statement of Recovery) is submitted but no payment is made, or only a partial payment is made, and a balance remains due the Government.

(2) The second type occurs when compensation is suspended or declared forfeit because the claimant has failed to comply with § 8131 of the FECA and its third party liability regulations.

b. The principal amount in third party debts may not be waived or compromised unless the debt arises from forfeiture of compensation under 5 U.S.C. 8131 for refusal to cooperate with the OWCP and the OWCP has sufficient information to determine the amount of the Government's statutory right of reimbursement. In such a case, the debt may be compromised down to (but not

below) the amount of the Government's statutory right of reimbursement. The OWCP may negotiate a compromise of accrued charges, and may accept installment payments, but must not issue any compromise order or other document which excuses any part of the statutory right of reimbursement.

c. SOL/FEEWC may collect third party debts from attorneys who have not repaid the Government's statutory right of reimbursement, after satisfying the necessary due process requirements, through referral of the debt to the Department of the Treasury or Department of Justice. SOL/FEEWC may also collect third party debts from the debtor/beneficiary through referral of the debt to the Department of the Treasury or Department of Justice; in the alternative, SOL/FEEWC may recommend that the OWCP collect the debt through deductions from the beneficiary's continuing compensation.

d. SOL/FEEWC must pursue collection efforts. FEEWC should advise the FECA beneficiary that a debt is owed to the United States, and make an initial demand for payment. If the beneficiary has an attorney FEEWC should advise the attorney that he or she is jointly and severally liable for the debt owed to the United States and make an initial demand for payment to the attorney and send a copy to the beneficiary. Demand letters must be mailed or hand-delivered on the same day of the date on the letter. The initial demand letter must notify the debtor:

- (1) Of the basis for the debt and the amount;
 - (2) Of the applicable standards for imposing interest, penalties, and administrative costs;
 - (3) Of the date by which payment should be made;
 - (4) The name, address, and telephone number of a contact person or office within the agency;
 - (5) That he or she may enter into a mutually agreeable written repayment agreement;
 - (6) That he or she may make a written request for a review of the determinations regarding the amount of the debt, its past-due status, and its legal enforceability; and
 - (7) That, unless payment is received within 30 days, interest shall accrue, at the U.S. Treasury rate (Current Value of Funds), as of the date of the initial demand letter, but if payment is made within 30 days, interest will be waived.
- e. If payment is not received within 30 days, a second demand letter should be released notifying the debtor that the debt remains unpaid, and that the attorney, firm, and client are subject to the provisions of 5 U.S.C. § 8132 which apply to any individual who disburses funds received from a third party recovery without satisfying, or assuring the satisfaction of, the interest of the United States.
- f. If payment is not received within 30 days of the second demand letter, FEEWC should make a determination whether they are able to collect the debt, plus applicable interest, through any of the following options:

(1) Installment Payment Plan. FEEWC may enter into an agreement with the debtor if a debt can be collected through installment payments within three years.

- (a) The agreement shall provide that payments be made directly to the OWCP.
 - (b) Once the agreement is signed, FEEWC will notify the OWCP of the terms of the agreement.
 - (c) The CE will then enter the debt into the debt management system and monitor incoming payments.
- (2) Deduction from continuing compensation. In appropriate cases, FEEWC will prepare a memorandum to the CE recommending collection of the debt from continuing compensation entitlement. On receipt of the memorandum, the CE will:

- (a) enter the debt into the debt management system;
- (b) request financial information from the debtor; and
- (c) make a determination as to the amount to be collected from each continuing compensation payment, if not determined already by FEEWC, and begin deductions.

(3) Suspension or forfeiture. Where FEEWC concludes that suspension or forfeiture is an appropriate response to nonpayment of the debt, FEEWC will prepare a memorandum to the CE recommending the action.

- (a) The CE will then issue a formal decision with appropriate appeal rights.
- (b) The CE will enter the appropriate information into the debt management system.

(4) Referral to the Department of the Treasury. Where payment is not received within 60 days of the date of the initial demand letter, and FEEWC concludes that referral to the Department of the Treasury is appropriate, FEEWC will send a third letter which notifies the debtor(s) of its intent to collect the debt by referral to Treasury. If previous letters have complied with due process requirements it is not necessary to restate them.

(a) FEEWC will also complete a Debt Information Sheet and the necessary background materials supporting the existence and amount of the debt, along with documentation of attempts to collect it to the OWCP's National Office requesting that the debt be referred to the Department of the Treasury for collection.

(b) The debt will remain on FEEWC's collection docket until SOL receives notice from the Department of the Treasury that the debt has been collected, or that they have ceased collection efforts. (d) Where the Department of the Treasury notifies FEEWC that it has ceased collection efforts, FEEWC should keep it on the collection docket until the statute of limitations has run or until it is otherwise uncollectible.

(f) Debts due from DOL employees will be collected or waived through internal procedures; thus, they should not be sent to Treasury for cross-servicing.

(5) Referral to the Department of Justice (DOJ). Where payment is not received within 60 days of the date of the initial demand letter, and FEEWC concludes that referral to the Department of Justice is appropriate, FEEWC will prepare a memorandum to the DOJ, and will submit a Claims Collection Litigation Report to the Department of Justice Nationwide Central Intake Facility (NCIF), P.O. Box 65720, Washington, D.C. 20035.

(a) 28 U.S.C. § 2415(a) provides that any suit to enforce collection of a debt must be filed within six years after the right of action accrues or within one year after a final administrative decision has been rendered on the matter, whichever is later;

(b) The debt will remain on the FEEWC collection docket until FEEWC receives notice from DOJ that the debt has been collected, or that DOJ has ceased litigation efforts.

(c) Where DOJ notifies FEEWC that it has ceased litigation efforts, FEEWC will make a determination whether to close the file and remove it from the collection docket.

(6) Salary offset. FEEWC may initiate salary offset proceedings, and must follow the Department of Labor Salary Offset regulations set forth in 29 CFR §§20.74 through 20.90.

g. If all collection efforts fail, including litigation where appropriate, the debt may be written off.

(1) Write-off is allowable when compromise is not, because write-off is an administrative action which may be reversed if circumstances change, whereas compromise is a formal agreement which is binding on the Office, provided that the debtor makes payments as promised.

(2) A memorandum should be placed in the case file noting the existence of the outstanding third party debt due the Government.

(3) The memo should warn that in the event further benefits are claimed, the debt record should be reopened and the debt satisfied before any additional payments are made.

19. Court Ordered Restitution in Fraud Cases. When a debtor has been convicted in court of filing a false claim which resulted in a debt due the Government, the court often orders the defendant to make restitution to the United States as a condition of probation. The amount of restitution may or may not be the full amount of the debt owed to the OWCP.

a. If the Court Order states that the restitution amount will be in full satisfaction of the debt owed the United States, i.e., a "Global Settlement," the Court Order takes precedence over the Office's administrative debt collection process.

(1) If the restitution amount is less than the outstanding debt principal balance, the principal balance must be reduced to the restitution amount set by the court. However, if the probation period ends and the debtor fails to make full restitution of the amount ordered by the court, the

OWCP may pursue collection of the full original debt amount. The OWCP may wish to request SOL assistance in contacting the Department of Justice to ascertain the status of the restitution.

(2) Interest may not be applied to the debt unless stipulated in the Court Order.

b. If the Court Order does not represent a "Global Settlement," the OWCP should continue to pursue collection of the full amount of the debt, taking credit for any restitution amounts received.

(1) Unless assessment of interest is stipulated in the Court Order, interest may not be applied to the restitution amount and any restitution payments received should be applied directly to the debt principal.

(2) In *Joseph Popp*, 48 ECAB 624, Docket No. 95-352 (August 14, 1997), ECAB held that the court order in question did not indicate that the recovery of \$15,293 from appellant was meant to be in full satisfaction of the debt owed to the United States, i.e., that it was meant to constitute a global settlement. The OWCP was therefore not precluded from continuing to pursue full collection of appellant's debt in the amount of \$25,628.75. See also, *J.D.*, Docket No. 13-86 (issued June 3, 2013) where ECAB stated: "it is well established that to constitute a global settlement a court order must clearly state that the restitution is meant to represent the full satisfaction of any debt owed to the United States.... The court order does not contain the explicit, essential language stating that the restitution ordered represented a 'global settlement' with respect to the debt owed to the United States."; *K.S.*, Docket No. 08-639 (issued April 22, 2009)(appellant's attorney argued that the court-ordered restitution of \$20,056.80 constituted a global settlement. ECAB held that the court order "did not indicate that the recovery from appellant in restitution was meant to be in full satisfaction of the debt owed to the United States such that it would constitute a global settlement. Thus, the Office was not precluded from pursuing collection of the overpayment in compensation, with credit to be given to the restitution amount received.")

c. Loss to the Government Calculations. In criminal FECA fraud cases, the OWCP is sometimes asked to assist the DOJ in calculating the loss to the Government and preparing a victim impact statement in accordance with Federal sentencing guidelines. This victim impact statement may result in return of funds to the FECA program. This may involve calculation using the *Shadrick* formula to determine how benefits would have been paid. All Loss to the Government cases should be referred to the National Office for review

FECA Part 7 - Nurse Intervention: Discusses DFEC's Nurse Intervention Program.

Chapter 7-0100, Introduction to Nurse Intervention

1. OWCP Objectives. The Office of Workers' Compensation Programs (OWCP) is committed to seeing that benefits for compensation and medical services are appropriately and timely provided. OWCP is also committed to assisting injured workers in obtaining a successful medical recovery and minimizing the period of disability from work. Management of disability claims begins as soon as a new claim is received indicating that the employee has lost time from work as a result of the injury or is disabled from his or her date of injury position.

2. Scope. This chapter defines the objectives and purpose of nurse intervention and the types of nurses involved in the OWCP nurse intervention program. Federal Employees' Compensation Act (FECA) Procedure Manual (PM) 2-0600 discusses disability management from a CE's perspective, and FECA PM 2-0811 discusses the role of nurse case management.

Services of field nurses are authorized by 5 U.S.C. 8103; 20 C.F.R. §10.310(a) specifically references that "OWCP may also utilize the services of a field nurse to facilitate and coordinate medical care for the employee."

Disclosure of information to contract nurses is authorized by routine use "e" of DOL/GOVT-1, which permits disclosure: To physicians, pharmacies, and other health care providers for their use in treating the claimant, in conducting an examination or preparing an evaluation on behalf of OWCP, and for other purposes relating to the medical management of the claim, including evaluation of and payment for charges for medical and related services and supplies.

3. Purpose. To further the objectives noted above, OWCP created the Nurse Intervention Program and incorporated it into the Quality Case Management (QCM) portion of the Disability Management process. QCM is a case management approach which has as its primary goal the medical recovery and reemployment of injured workers who are in the beginning stages of disability. The objectives of QCM are to take a series of purposeful actions to obtain medical care in a timely manner, to obtain timely work tolerance limitations, and to prevent cases from reaching the long-term disability roll. QCM is an initiative to intervene with injured workers, employing agencies (EA) and medical providers as early as possible in the recovery process to assist in the facilitation of medical treatment plans and arrange for appropriate reemployment.

Incorporating nurse intervention services into the QCM disability management process, and involving nurses in the early stages of disability cases, facilitates expedited medical care and recovery and can result in shortening the length of disability from work. Although the Claims Examiner (CE) ultimately remains responsible for the case management activities and overall direction of the case, QCM consists of more than just CE intervention. The best outcomes stem from an active team approach where the CE, the nurse, the EA, the claimant, and the medical providers use all available tools to facilitate medical recovery and a successful return to work. As a result, nurse intervention is an integral part of the overall disability management of a claim.

4. National Office Nurse Consultant. The National Office Nurse Consultant (NONC) serves as the National Coordinator for the OWCP nurse intervention program. The NONC is responsible for overseeing the appropriate application of medical standards to the OWCP nurse program; planning and developing methods for the assessment of the OWCP nurse programs; serving as a resource for the District Office Staff Nurses; and, as needed, implementing improvements based upon the analysis of internal OWCP data and examination of outside trends in the workers' compensation field.

5. District Office Staff Nurses. Each district office retains the services of a Staff Nurse (SN) to administer the policies and procedures of the OWCP nurse intervention program. The SN coordinates the assignment of contract nurses for specific cases; monitors contract nurses' performance in correlation to both the contract specifications and the quality of services provided; reviews nurse reports for completeness and timeliness prior to authorizing payment of bills; and communicates with the CE as needed with regard to issues that arise during the nurse intervention phase.

As mentioned above, the QCM disability management process is a collaborative effort. While the CE maintains authority over the case management actions, communication between the SN, CE, and contract nurse is essential to reaching the goals and objectives established for any given disability case. The SN is in a unique position to timely identify and bring to the CE's attention medical issues or obstacles that need prompt attention. In addition, active involvement of the SN facilitates the interactions and communications between the CE and contract nurse.

A CE or other district office staff member may consult with the SN in order to assess medical treatments and protocols; discuss whether a particular treatment or surgery is appropriate; or seek recommendations on alternative avenues for continued treatment. The SN is also able to provide clarification and explanation related to medical issues or treatment requests that may be unfamiliar to the CE.

The SN also serves as a liaison and resource for EA representatives. The EA may contact the SN directly regarding any concerns or questions it may have about a specific contract nurse, nurse assignment, or the OWCP nurse intervention program in general. The SN may also participate in agency training sessions offered by the district office.

6. Continuation of Pay (COP) Nurses. COP Nurses (CN) are contracted nurses assigned in traumatic injury cases where the injured worker has immediate disability and has not

returned to work within 7 days following the date of work stoppage (this information is taken from the data contained on the Form CA-1). The CN enables the district offices to identify cases in need of prompt adjudication and assists the CEs in prioritizing their adjudication efforts. The CNs have a role only during the COP period and are strictly triage nurses whose work is performed telephonically. (CNs are not assigned in occupational disease cases.)

Within 7 days of case assignment, the CN should contact the claimant, the EA and the treating physician. At a minimum, the CN should obtain a history of the injury from the claimant; confirm the work status with the EA and ascertain whether work accommodations are available; and contact the physician's office to obtain a history of the medical treatment provided and the expected treatment plan. This information is then used by the CE to make decisions about the best case management path for that particular case, which may include expedited adjudication of the case and referral for Field Nurse (FN) assignment.

7. Field Nurses. The FN is a contracted registered nurse who assists in the management of disability claims in a number of ways. FN services are a valuable tool for assisting in the claimant's recovery process by coordinating medical care, facilitating a safe and timely return to work, and aiding the CE in moving a disability case towards resolution. The FN's contact is generally in person; however, in some instances the activity may be only telephonic in nature.

Early referral for FN intervention services is critical to ensuring successful disability management. FN assignment should occur as soon as possible after the injury occurs and the claim has been approved for a work-related injury. FN assignment should occur if the claimant has not returned to work and may also occur if the claimant has returned to work but remains disabled from performing his or her date of injury position. An FN is usually initially assigned to a case for 120 days, but this assignment period may be extended.

Specific FN activities may include the following: making assessments of the initial extent of the injury; coordinating treatment necessary for recovery; communicating return-to-work expectations; attending the claimant's medical appointments to facilitate communication about return to work and ease any authorization difficulties the claimant may be encountering; identifying possible barriers to the claimant's return to work and then developing a plan of action with the CE to resolve the identified barriers; making recommendations for vocational rehabilitation; and acting as a liaison between the CE, claimant, EA, and medical providers.

Chapter 7-0300, Continuation of Pay (COP) Nurses

1. Background. The Office of Workers' Compensation Programs (OWCP) has been using Continuation of Pay (COP) Nurses for many years. Federal Employees' Compensation Act (FECA) Bulletin 00-15 (COP Nurse Intervention), issued September 18, 2000, introduced the implementation of the COP Nurse (CN) intervention program as an effort to provide early identification and triaging of certain traumatic injury cases involving disability from work during the 45-day COP period. By utilizing early intervention of the CN process, there has been a

favorable impact upon expedited adjudication of traumatic injury disability cases, thus allowing early disability management interventions to assist with medical recovery and return to work (RTW) efforts.

Since the release of FECA Bulletin 00-15, subsequent updates have been made to the CN intervention program to facilitate quicker assignments to the CN and more efficient follow-up actions by the OWCP claims staff. FECA Bulletin 01-09 (COP Nurse Intervention), issued February 5, 2001, incorporated changes to the CN intervention program which further enabled the district offices to identify traumatic injury cases in need of prompt adjudication and assisted Claims Examiners (CE) in prioritizing their adjudication efforts. Specific triage codes were created whereby the CN was able to identify the disability status of a claimant upon closure of his/her intervention activities. These CN disability triage closure codes, along with the automated updates and processes to both the CN's web-based "home page" and the district office's case management system, assisted the CEs in identifying and prioritizing the adjudication of these cases. In addition, case management reports were revised so that OWCP claims staff were better able to track and monitor traumatic injury cases that included the prioritized triaged closure coding.

FECA Bulletin 10-04 (COP (Continuation of Pay) Nurse Intervention Process Updates), issued September 10, 2010, was the latest update to the CN intervention process. This Bulletin provided guidance to OWCP claims staff, the district office Staff Nurse (SN), and employing agencies (EA) regarding significant updates and revisions to the CN intervention program. Those updates and revisions included earlier CN case eligibility, quicker CN assignments, specific expectations for CN intervention activities, shorter timeframes for CN activities and reporting, allowance of CN access to view certain applications within OWCP's case management system, and expansion of CN closure codes. The EAs' access to view case statuses through the Agency Query System (AQS) was updated to allow them to see which cases were assigned to a CN, and upon CN closure, they were able to see the CN closure status and date. EAs were also provided information regarding the preferred method of prompt reporting of an injured worker's RTW via electronic submission of Form CA-3. Finally, OWCP claims staff was advised of necessary case management actions in regard to CN assignments, CN closures, and notices of RTW. Additional reports were made available to assist the OWCP claims staff to more effectively manage cases during the CN intervention process.

2. Purpose and Scope. This chapter defines the objectives and purpose of the CN intervention program and the roles and responsibilities of the stakeholders involved.

FECA Procedure Manual (PM) 2-0600 (Disability Management) discusses disability management from a CE's perspective, and FECA PM 2-0811 (Nurse Case Management) discusses the role of nurse intervention in the Disability Management process.

3. Introduction. Involving nurses in the early stages of disability cases (even prior to case adjudication) facilitates expedited medical care and recovery and can result in shortening the length of disability from work.

The CN is a registered nurse who is assigned to traumatic injury cases where the injured worker has immediate time loss and has not returned to work within seven (7) days following the date of work stoppage. The CN assignment occurs prior to case adjudication. The CN is strictly a triage nurse who performs all work telephonically.

The information obtained by the CN is then used to make decisions about the best path for that particular case. In particular, the information provided by the CN should assist the CE by triaging the severity of the injury and/or disability. This most often leads to the CE being able to expedite adjudication of traumatic injury disability cases and subsequently determine whether a referral for Field Nurse intervention would be beneficial to assist with the medical recovery and RTW efforts integral to the success of early disability case management.

Note: COP is not payable in occupational disease cases, and occupational disease cases are ineligible for CN assignments.

4. Identification of Cases for Assignment of COP Nurse.

a. Based on the data entered when a traumatic injury case is created from Form CA-1 (specifically, the date the injured worker stopped working), a case becomes automatically eligible for CN assignment if all of the following conditions are met:

- (1) It is a traumatic injury case;
- (2) The injured worker stopped work at least 7 days ago;
- (3) The injured worker stopped work less than 31 days ago;
- (4) The injured worker has not returned to work;
- (5) The injured worker is in a COP status (based on the checkbox on the Form CA-1); and
- (6) The case is an administratively closed case or its current pay status is either Unreviewed (UN) or Under Development (UD).

b. COP cases are automatically referred to the SN for assignment through the office's case management system based on the criteria noted above. When the SN makes the assignment, it is recorded and tracked. The CN is usually assigned on a rotational basis if there is more than one CN per state/territory. The CN assignment occurs even though the case has not yet been formally accepted.

c. CN assignments are made electronically through the office's case management system, and necessary information is accessed by the CN via remote access to select applications of the office's case management system. The CN can view his/her open cases, cases requiring action, and new assignments.

d. If the EA reports a RTW after the Form CA-1 has been submitted but prior to the CN assignment, the RTW date should be immediately updated in OWCP's case management system so that a CN is not assigned. If a RTW is reported after the CN assignment but before the CN closure, the RTW date should be immediately updated in OWCP's case management system so that CN intervention can be closed (whether the CN has taken any actions or not).

5. COP Nurse Intervention Actions. Although CN intervention is not extensive during the COP period, the medical knowledge and experience of a CN assists with the identification of cases that require more extensive intervention due to the severity of the injuries, contemplated surgical intervention, or lost time from work.

a. In order to effectively triage the case, within 7 days of case assignment the CN should:

(1) Contact the injured worker to obtain a history of injury, history of treatment, and current work status, as well as physician contact information.

(2) Contact the EA to confirm the injured worker's current work status and ascertain whether light duty work accommodations are available, if needed.

(3) Contact the treating physician's office to obtain a verbal history of treatment, the expected treatment plan, and, if available, the date of the injured worker's next appointment. At that time, the CN can also provide general information regarding communication with the OWCP (such as the address for submission of treatment notes/reports), how to submit medical authorization requests, and how to submit bills should the case be approved. The CN should also advise the physician's office whether light duty job accommodations can be provided based on the prior contact with the EA and, if appropriate, provide a Form CA-20, Attending Physician's Report, requesting that it be completed and submitted to OWCP.

b. The CN should obtain the necessary information, as outlined above, and submit a closure report within 7 days. However, if the CN determines that the injured worker will be returning to work within the following week, and the specific contact information supporting a definitive RTW date has been entered into the case management system, the CN assignment can remain open beyond the 7-day time limit in order to verify and report the RTW date and status. However, in these specific situations, the CN closure should still occur no later than 14 days after assignment.

c. Once the CN has gathered the information, he/she enters it into the case management system. These entries are then automatically part of the COP Nurse Report. The CN should also include any other relevant information pertaining to possible issues or concerns regarding the recovery process or potential barriers to the RTW effort. The CN should make a specific recommendation pertaining to whether a Field Nurse assignment would be beneficial. The CN closure report should contain the RTW status and provide a recommendation regarding early intervention and assignment to a Field Nurse.

d. When the CN closes the case, he/she should also confirm appropriate handling/destruction of case file records.

6. COP Nurse Reimbursement. When the CN closes a case, the SN reviews the closure for appropriateness and accuracy. Once the SN has approved the closure, the COP Nurse Report is automatically generated for processing into the electronic case file, and the bill is processed electronically and submitted for payment to the central bill payment processing facility.

7. Claims Examiner Action Upon COP Nurse Closure. After the SN approves the CN closure, the CN report will be viewable in the case file.

- a. If the CN closes the case and the injured worker has not returned to work in a full-time capacity, the case should be reviewed for expedited adjudication action. The information provided in the CN closure report may also be used to determine whether a referral for Field Nurse intervention is needed.
- b. For an administratively closed case, any CN closure code that denotes less than a full-time RTW will "flip" the case to UN status so that it can be adjudicated. Since Field Nurses are not assigned to unadjudicated cases, the CE should attempt to expedite the adjudication process in these cases where the claimant has not achieved a RTW in a full-time capacity. If the case cannot be accepted upon first review, prompt development action should be undertaken. The claimant will be afforded 30 days to submit necessary evidence, but the claim should be monitored during that 30-day period so that it can be accepted as soon as the proper supporting documentation is received.
- c. If a traumatic injury case has been accepted, and the claimant has not returned to work in a full-time capacity, the case should be referred for Field Nurse assignment promptly after acceptance. This referral should occur even if the COP period has not elapsed. In addition, a Field Nurse referral should also be considered if the claimant has returned to work full time but in a light-duty status.

8. COP Nurse Closure Codes. Every case assigned to a CN is closed with a COP Nurse Closure Code in the case management system.

COP Nurse Closure codes are outlined below:

- 9A: COP Case Closed-Case Accepted
- 9B: COP Case Closed by CE with FT/LD RTW
- 9C: COP Case Closed by CE with FT/RD RTW
- 9D: COP Case Closed-Case Denied
- 9E: COP Case Closed by CE with PT RTW
- 9F: COP Case Closed Using CA-3 with FT/RD RTW
- 9G: COP Case Closed Using CA-3 with FT/LD RTW
- 9H: COP Case Closed-Emergency Hospitalization
- 9K: COP Case Closed Using CA-3 with PT RTW
- 9L: COP Case Closed by Nurse with FT/LD RTW
- 9N: COP Case Closed-No RTW
- 9O: COP Case Closed-Claimant Not Cooperating

- 9P: COP Case Closed by Nurse with PT RTW
- 9R: COP Case Closed by Nurse with FT/RD RTW
- 9S: COP Case Closed-Surgery Imminent
- 9T: COP Case Closed-Catastrophic Case
- 9U: COP Case Closed-RTW Unknown
- 9X: COP Case Closed-Stopped Work >45 days
- 9Y: COP Case Closed Using CA-3-RTW without status

FECA Part 8 - Rehabilitation: Discusses DFEC's Vocational Rehabilitation Program.

Chapter 8-0100, Introduction to Rehabilitation

1. OWCP Objectives. The Office of Workers' Compensation Programs (OWCP) is committed to seeing that benefits for compensation and medical services are appropriately and timely provided. OWCP is also committed to assisting injured workers in obtaining a successful medical recovery and minimizing the period of disability from work. Management of disability claims begins as soon as a new claim is received indicating that the employee has lost time from work as a result of the injury or is disabled from his or her date of injury position.

2. Purpose. The purpose of vocational rehabilitation within the Division of Federal Employees' Compensation (DFEC) is to assist disabled employees who are covered by the Federal Employees' Compensation Act (FECA). Vocational rehabilitation is part of DFEC's Disability Management process, and the goal is to minimize the injured worker's disability and assist with a return to gainful work. Rehabilitation helps injured workers to become self-supporting and productive, and saves money by eliminating or reducing workers' compensation payments.

DFEC Rehabilitation Specialists (RSs) and Claims Examiners (CEs) in the district offices carry out the program with the assistance of contracted Rehabilitation Counselors (RCs), private and public agency rehabilitation providers, physicians, and employers, so that eligible workers receive the rehabilitation services best designed to return them to suitable work, preferably with little or no loss of earnings. The emphasis of DFEC's program is on early referral and evaluation of all injured workers who need services; case management standards to ensure that plans are efficient and of good quality; flexibility to provide the widest range of services from private and public rehabilitation agencies; preference for reemployment with the previous employer; and placement of workers in jobs where disability does not prevent them from competing with non-disabled employees.

DFEC provides all benefits to the injured worker and makes all decisions on eligibility for benefits. Procedures have been designed to allow DFEC to accomplish early, beneficial intervention in disability cases while also making timely eligibility determinations. Two themes are basic to the rehabilitation portion of case management so that DFEC can meet these dual goals: (1) close coordination of CE and RS/RC actions, and (2) a clear, consistent message to the injured worker that return to some kind of work is expected as soon as the worker is medically ready.

When it appears that the claimant's work-related injury will prevent a return to the job held on the date of injury (DOI), vocational rehabilitation services may be provided to assist the claimant in returning to the workforce in suitable employment. These services may occur simultaneously with Nurse Intervention (see Part 7 of the FECA PM). OWCP will make every reasonable effort to arrange for employment of a partially disabled worker, taking into consideration not only the effects of the work-related condition and any condition(s) pre-existing the injury, but also any medical condition(s) arising after the compensable injury. Of critical programmatic importance is understanding that return to work placement efforts with the claimant's previous employer are an essential part of the vocational rehabilitation process, and that vocational rehabilitation does not consist only of testing, training and outside employment. Such rehabilitation efforts will be directed initially to the employing agency (EA), but if reemployment with the agency is not possible, OWCP will help the worker secure employment with a new employer. This may include DFEC-sponsored vocational training, if needed, to furnish the worker with the necessary skills to obtain other employment.

3. Scope. This chapter provides the legislative and regulatory authority under which vocational rehabilitation services are provided and governed, and discusses the claimant's entitlement to compensation benefits during vocational rehabilitation and the effects on services if the claimant elects benefits from the Office of Personnel Management (OPM) during the rehabilitation effort.

This chapter also addresses related topics such as restoration rights with the Federal government, and defines the different types of rehabilitative services available, as well as the roles of the rehabilitation professionals who participate in the vocational rehabilitation effort.

Further information about vocational rehabilitation can be found in the OWCP Procedure Manual (PM), Part 3, Rehabilitation; however, since Part 8 of the FECA PM contains the most current guidance and procedures specific to DFEC, Part 8 of the FECA PM should be consulted prior to the OWCP PM, and the FECA PM guidance followed if any difference exists.

While Part 8 of the FECA PM provides a programmatic view of vocational rehabilitation and discusses vocational rehabilitation from the RS's perspective, FECA PM 2-0600 discusses disability management from a CE's perspective, and FECA PM 2-0813 discusses the vocational rehabilitation process from a CE's perspective.

4. Statutory and Regulatory Requirements. The FECA 5 U.S.C. 8101 et seq. and Code of Federal Regulations (CFR) Title 20, parts 1-25, establish rehabilitation benefits and define a claimant's responsibility to undertake a program when so directed.

a. **Statutory Requirements.** The FECA allows the Office to direct a claimant to undergo vocational rehabilitation and to reduce, prospectively, the claimant's monetary compensation for refusal to do so.

1) Section 8103 (a) of the FECA provides for any medical care prescribed by a qualified physician which is considered likely by the Secretary to cure, give relief, reduce the degree or

period of disability; or aid in lessening the amount of monthly compensation. The section permits DFEC to authorize medical treatment.

2) Section 8104 of the FECA provides that a permanently disabled individual may be directed to undergo vocational rehabilitation. The injured worker receives compensation while cooperating and participating in the rehabilitation process.

3) Section 8111 of the FECA allows the Office to pay an individual undergoing vocational rehabilitation additional compensation necessary for maintenance, not to exceed \$200 per month.

4) Section 8113 (b) of the FECA allows the Office to prospectively reduce compensation in accordance with a claimant's wage-earning capacity if he or she refuses, without good cause, to undergo vocational rehabilitation.

5) Section 8115 (a) of the FECA provides for the reduction of compensation to reflect a worker's earning capacity.

6) Section 8151 of the FECA provides restoration rights for injured employees and is administered by OPM.

7) Appropriations language for the Department of Labor provides "That such sums as are necessary may be used for a demonstration project under Section 8104 of title 5, United States Code, in which the Secretary may reimburse an employer, who is not the employer at the time of injury, for portions of the salary of a reemployed, disabled beneficiary..." This language provides authority to use the FECA fund to pay a portion of the salary of a newly reemployed Federal worker (who is eligible for disability benefits under the FECA) via Assisted Re-employment.

b. Regulatory Requirements. The Code of Federal Regulations discusses the vocational rehabilitation services provided at 20 CFR §10.518, which may include vocational evaluation, testing, training and placement services. Additionally, the actions taken when the employee refuses to cooperate with vocational rehabilitation, which includes reducing the claimants compensation during the period of non-cooperation and a reduction to zero absent evidence to the contrary, are discussed at 20 CFR §10.519. Finally, the method used for determining compensation after services are provided, such as actual earnings if they fairly and reasonably represent the claimant's earning capacity, is discussed at 20 CFR §10.520.

5. Roles and Responsibilities. The Vocational Rehabilitation (VR) Program is comprised of a National Office Rehabilitation Consultant; Rehabilitation Specialists located in the district offices; and Rehabilitation Counselors, who are certified counselors in the field. The CE refers appropriate cases for rehabilitation services, and with recommendations from the RS, is responsible for the management and overall direction of the case, even during the rehabilitation period.

A brief outline of the various roles is provided here, but FECA PM 2-0813 can also be referenced for additional information regarding the roles of the RS, RC, and CE in the rehabilitation effort.

a. National Office Rehabilitation Consultant (NORC). The NORC serves as the National Coordinator for DFEC's Vocational Rehabilitation Program and is responsible for overseeing all aspects of the VR Program, which includes serving as a professional resource for the Rehabilitation Specialists located in the district offices. The NORC monitors and evaluates the quality and timeliness of rehabilitation services received by injured workers, and assures that services are provided in accordance with DFEC policies and procedures. The NORC also develops new initiatives and return-to-work options for the vocational rehabilitation of injured federal workers; fosters relationships with Federal agencies to promote selective placement job opportunities for FECA injured workers; develops training materials for RSs, RCs and claims staff as necessary; and certifies FECA claimants eligible for the Schedule A Appointing Authority.

b. Rehabilitation Specialist (RS). The RS's responsibilities include, but are not limited to, the following: coordinating the assignment of RCs for specific cases; monitoring the RC's performance in correlation to both the contract specifications and the quality of service provided; providing guidance to RCs regarding VR services and course of action; reviewing RC reports for completeness and timeliness prior to authorizing payment of bills; communicating with the CEs regarding the cases assigned for VR services; relaying important or time sensitive information to the CEs so that action can be taken if needed; providing guidance to CEs on how to recognize when vocational services are necessary to assist the claimant with returning to work; serving as a vocational resource to the CEs; and providing solutions for return-to-work barriers in cases.

c. Rehabilitation Counselor (RC). The RC's responsibilities include, but are not limited to, the following: coordinating any necessary medical rehabilitation services; evaluating the claimant's vocational abilities and transferable skills; recommending potential suitable and available occupational titles as the basis of potential earning capacity; facilitating employment placement including with the previous employer; arranging for vocational testing and training; developing and overseeing individual vocational re-employment plans; conducting labor market surveys; assisting the claimant with job-seeking skills such as resume building and interview techniques; identifying potential employers; arranging for specialized ergonomic job modification services; and making recommendations to the RS and CE if a particular barrier is hindering the return-to-work effort.

d. Claims Examiner (CE). The CE's responsibilities include, but are not limited to, the following: referring appropriate cases for rehabilitation services; evaluating medical determinations in cases; responding to requests from the RS or RC; reviewing rehabilitation plans for medical suitability; advising the RS and RC of any changes in the medical or factual evidence which might alter any current course of action; issuing warning letters if non-cooperation occurs; and issuing notices of proposed actions and formal decisions pertaining to a claimant's entitlement to compensation.

6. Compensation Entitlement during and after Vocational Rehabilitation.

a. Compensation for Wage Loss. Section 8104 (b) of the FECA provides that an individual undergoing an OWCP-approved rehabilitation program is entitled to receive compensation at the

rate for total disability, less any earnings received from employment which is not undertaken as a specific part of the rehabilitation program.

b. Retirement Benefits. OWCP is a return-to-work program and not a retirement program; however, if eligible, the claimant may have a right under law to choose retirement benefits from OPM in lieu of OWCP benefits (see FECA PM 2-1000). An election offer should be issued if the claimant states this is his or her choice.

A claimant may not receive vocational rehabilitation services simultaneously with retirement benefits from OPM. See FECA Program Memorandum No. 27. However, a claimant may not use the retirement process to avoid the obligation to undergo vocational rehabilitation when directed by OWCP. Despite issuing an election letter, the CE and RS should pursue case management and rehabilitation to its logical conclusion. Sending the election letter does not guarantee OPM election. Until the claimant actually submits a signed election form choosing OPM benefits, he or she is required to participate fully in rehabilitation or be subject to the sanction process.

When reviewing instances of non-cooperation in conjunction with an OPM election during the vocational rehabilitation process, it is important to focus on the behavior and level of non-cooperation. Sanctions may apply to the non-cooperative behavior but not to the choice to elect OPM. If the claimant does not cooperate during the election process, any behavior which is deemed to be non-cooperation will be subject to sanctions pursuant to 5 U.S.C. 8113. A non-cooperation sanction under 5 U.S.C. 8113 may not be initiated once a claimant has officially elected OPM benefits. It may only be finalized following an OPM election if the warning letter was issued while the claimant was in receipt of FECA benefits.

If the claimant elects OPM benefits during Placement, vocational rehabilitation efforts should be terminated and the CE provided with the factual information necessary to determine the claimant's Loss of Wage-Earning Capacity (LWEC).

c. Schedule Awards. If a claimant requests a schedule award while participating in vocational rehabilitation, development of the award should proceed. Payment of the award, however, should usually be deferred until the completion of rehabilitation, since payment of a schedule award is most beneficial after a return to employment, as it may not be made concurrently with compensation for wage loss, and a claimant will often opt to receive OPM benefits concurrently with a schedule award, and concurrent receipt of OPM and OWCP benefits is prohibited during a period in which vocational rehabilitation services are being provided.

If a claimant is already receiving compensation for a schedule award while in rehabilitation, he or she should continue receiving those benefits unless the claimant is also receiving an annuity from OPM, in which case the claimant should be advised that he or she cannot be provided with vocational rehabilitation services while receiving an OPM annuity. The claimant should be offered an election, and if he or she elects OWCP benefits, the schedule award payments should be converted to payments for temporary total disability until completion of the rehabilitation effort. If the claimant elects OPM benefits, the schedule award benefits should continue, and medical and factual development should be undertaken to determine the claimant's LWEC

entitlement at the end of the schedule award, but vocational rehabilitation efforts should be terminated.

d. Loss of Wage Earning Capacity (LWEC). The loss of wage-earning capacity determination performed pursuant to 5 U.S.C. 8115 provides that an injured worker will not be penalized for returning to a lower-paying job because of a disabling condition. It also permits the adjustment of compensation to reflect partial rather than total disability, if the requirements of the law are strictly met.

1) LWEC Based on Actual Earnings. The worker's salary, after placement in a lower-paying position, may be used as a basis for LWEC determination if it fairly reasonably represents the worker's earning capacity. The worker receives compensation based on the difference between the pre-injury and post-injury wages. 20 C.F.R. § 10.520.

2) LWEC Based on Potential Earnings (Constructed LWEC). If an injured worker does not return to work during the rehabilitation effort, OWCP may find that work suitable to the worker's physical condition, vocational abilities, and educational background was reasonably available in the worker's commuting area (or, in some cases, the area where the worker resided when injured). At the end of a rehabilitation program, if the claimant does not return to work, the RC is required, if possible, to provide relevant information for two available and appropriate jobs, including salary and an explanation of how any specific vocational preparation requirements are met. Based on this information, the CE determines whether these jobs are suitable to form the basis of an LWEC determination. The RC or RS should use available non-private sources, including the state employment services, to provide this information.

Compensation may also be reduced following successful completion of training, to reflect the worker's earning capacity as a result of training. If the worker drops out of or refuses training without a good reason, compensation may be reduced to reflect likely earnings had the training been completed. In both cases, the suitability and availability of the specific types of positions and the typical earnings must be documented.

7. Restoration Rights with the Federal Government. Section 8151 of the FECA provides civil service retention rights to Federal employees who have recovered either fully or partially from an employment-related injury or illness, and who can perform the duties of the original job or its equivalent. The EA must restore a permanent employee (i.e., one with career or career-conditional status) who recovers within one year after beginning compensation to that position or its equivalent. This provision does not apply to temporary or term employees. 20 CFR §10.505 explains that the employer should make all reasonable efforts to place the employee in his or her former or an equivalent position in accordance with 5 U.S.C. 8151 if the employee has fully recovered after one year.

a. OPM's regulations on retention rights are published at 5 CFR §§302, 330, and 353. They require agencies to grant leave without pay (LWOP) to disabled workers for at least the first year the injured worker is receiving compensation. 20 CFR §353.301 provides an overview of restoration rights for fully recovered and partially recovered employees. OPM has jurisdiction

and is responsible for enforcing these regulations. See Charles J. McCuistion, 37 ECAB 193 (1985) (DOL has no jurisdiction over restoration under 5 U.S.C. 8151).

b. An injured worker who has been terminated and who wishes to reclaim his or her job should be advised to contact the EA. If this effort fails, OWCP will contact the EA, citing 5 U.S.C. 8151 as the basis for the worker's attempt to regain employment. In addition, 5 U.S.C. 8151 (b) (2) and its implementing regulations provide for priority placement under certain circumstances. If this course is also unsuccessful, the injured worker may be advised to exercise his or her appeal rights as provided by OPM.

c. Issues pertaining to retention rights should be referred to the EA or OPM, and OWCP should not offer claimants advice on these rights. It should also be noted that not all individuals covered by FECA are entitled to restoration rights.

8. Available Services.

a. Medical Rehabilitation Services. Medical Rehabilitation refers to those medical and related services necessary to correct, minimize or modify the impairment caused by a disease or injury so that the injured worker can return to an adequate level of function and employment. Thus, it is distinguished from actual medical treatment to cure or relieve the effects of the injury.

Various medical rehabilitation services can be provided during this phase. These include coordination of care in cases of catastrophic injury; Functional Capacity Evaluations (FCE), work hardening, or any other physical therapy program aimed at producing work tolerance limitations; clarification of a work release and/or imposed work tolerance limitations; speech therapy, orthotics, prosthetics, or other assistive devices that would make the claimant employable; and/or psychiatric pain management counseling. Substance abuse treatment may be considered if substance abuse prevents an injured worker from participating in a rehabilitation plan or returning to work.

Housing and vehicle modifications can also be provided under the rehabilitation program.

Medical rehabilitation services such as home and van modifications are considered medically necessary services to which the claimant is entitled as part of his/her medical benefit. The concurrent payment of these benefits, in conjunction with retirement benefits, is permitted based on the 1960 amendments to the Compensation Act (Public Law 86-767). See FECA Program Memorandum 27.

b. Vocational Rehabilitation Services. Active vocational rehabilitation services are based on stable and well-defined work tolerance limitations which may or may not have been established during a period of medical rehabilitation (FCE, work hardening, or other physical therapy program aimed at producing work restrictions). Vocational rehabilitation services include counseling and guidance, selective placement assistance (i.e. with the previous employer), transferable skills analyses, vocational assessment, labor market surveys, Schedule A certification, pre-vocational and short-term training, job placement assistance, assisted reemployment and assistance following initial re-employment. Long term training is considered

only in exceptional circumstances, and self-employment assistance is provided only in very rare instances.

Medical rehabilitation may also be provided in conjunction with vocational rehabilitation, but, as indicated in paragraph 6.b. above, active vocational rehabilitation services aimed at identifying a suitable job cannot be provided to a claimant in receipt of OPM benefits.

c. Substantial Services. Injured workers are considered rehabilitated if they return to an appropriate occupation within their physical and vocational limits, after receiving substantial services which include professional counseling and guidance, placement assistance, training, medical rehabilitation, or any combination thereof. Injured workers returning to their pre-injury occupation are not considered rehabilitated unless medical rehabilitation, significant accommodation, or placement assistance was provided. Intermittent requests for return-to-work status updates either to the EA or the claimant are not considered substantial services.

The record, including RS and RC reports, must demonstrate and fully document the substantial services provided.

Chapter 8-0200, Referrals for Rehabilitation

1. Authority. Statutory and regulatory provisions pertaining to vocational rehabilitation under the Federal Employees' Compensation Act (FECA) can be found in FECA Procedure Manual 8-100. While this chapter focuses on referrals for vocational rehabilitation services, there is no requirement under the FECA to provide such services. Relevant case law from the Employees' Compensation Appeals Board (ECAB) pertaining to the provision of rehabilitation services is provided below.

a. 5 U.S.C. 8104 provides that an employee may be directed to undergo rehabilitation. However, when an employee is no longer disabled within the meaning of the FECA, there is no entitlement to vocational rehabilitation benefits under the Act. See Roniva Brown, 38 ECAB 338 (1986).

b. ECAB has stated "There is no requirement that vocational rehabilitation be afforded each and every claimant who is permanently disabled due to a compensable condition under the Act." See Billie Gentry, 38 ECAB 498,506 (1987).

c. ECAB has recognized that the vocational rehabilitation provisions of the FECA vest OWCP with discretionary powers and a decision granting or denying an application for training will not be set aside by ECAB unless it represents an abuse of discretion, that is, a manifestly unreasonable exercise of judgment. See Mabel R. Chapman, 30 ECAB 421 (1979); Raymond F. Porter 29 ECAB 15 (1977).

d. The fact that an employee sustains a physical impairment permanent in nature is not sufficient to warrant the provision of vocational rehabilitation, as there must be a showing of a loss of wage-earning capacity. The purpose of providing training under the Act is to upgrade the skills

and education of beneficiaries who cannot return to their former federal employment in order that they may qualify for other suitable employment to restore lost earning capacity. See Gary L. Loser, 38 ECAB 673 (1987).

2. Purpose and Scope. Referral screening is the process through which the Rehabilitation Specialist (RS) determines whether vocational rehabilitation services are needed to return an injured worker to employment and productivity. Referral screening may also be undertaken for other limited purposes. Referral screening has two related steps: the review of the compensation case file and the outcome determination.

This chapter explains and describes the procedures for evaluation of injured workers for rehabilitation services. This chapter also explains the sources of referrals, includes referral requirements depending on level of service, discusses referral statuses, and provides procedures for the closure of rehabilitation referrals.

3. Referral Sources and Mechanics. The probability of effective rehabilitation, resulting in the best return-to-work arrangement, is greatly increased when such efforts begin as early as possible in the recovery process. Generally, it is the policy of the Office of Workers' Compensation Programs (OWCP) to offer rehabilitation services to any claimant who is potentially permanently disabled for the job held at the time of injury, if needed, provided that the condition has stabilized sufficiently, work tolerances are well defined, and a realistic goal can be identified.

Federal injured workers have a right to return to their original jobs if they recover fully within one year. (Civil service retention and restoration rights are not within OWCP jurisdiction or control; the Office of Personnel Management has jurisdiction over matters arising under 5 U.S.C. 8151.) It is generally easier for agencies to offer jobs to injured workers if they have not been separated from Federal service, which may happen routinely after one year of disability. 20 C.F.R. §10.505 explains that the employer should make all reasonable efforts to place the employee in his or her former or an equivalent position in accordance with 5 U.S.C. 8151 if the employee has fully recovered after one year. For this reason, the Department of Federal Employees Compensation (DFEC) has instituted intensive early case management procedures for its disability cases. See FECA PM 2-0600 for a detailed discussion of disability management.

a. The responsibility for referring injured workers for rehabilitation services rests primarily with the Claims Examiner (CE), who oversees the disability management process and is in the best position to act promptly when services are needed. A sufficient number of referrals is necessary to reach program goals related to return to work. If cases are not being referred by the CEs in sufficient numbers or are being referred long after the medical condition stabilizes, the RS should use the supplemental sources described below to look for potential vocational rehabilitation candidates.

b. Potential rehabilitation referrals can also be identified or brought to the attention of the RS by sources other than CEs, such as representatives/attorneys, doctors, employers or vocational Rehabilitation Counselors (RCs), or by injured employees themselves. The RS should normally obtain the concurrence of the CE for referrals obtained from any of these sources, since the CE is

responsible for medical determinations in cases. Unless there is recent documentation from the CE regarding the weight of the medical evidence of record, e.g. a letter from the CE requesting a job offer from the employing agency (EA) based on identified work tolerance limitations, the RS should request a completed OWCP-14 from the CE and follow up as necessary until once is received.

The CE should promptly refer the case for rehabilitation services except where the medical evidence establishes that the case is not in posture for such referral.

(1) Computer-Generated Reports. To identify cases for early intervention, the RS may use computer generated reports from various sources and notify the CE of cases which appear appropriate for rehabilitation services, including Functional Capacity Evaluations (FCEs) or Occupational Rehabilitation Programs (ORPs). See paragraph 7 below.

(2) Field Nurses (FN). FNs who are monitoring the injured worker's medical care are also referral sources, as they are able to offer pertinent and timely information regarding the condition of the injured worker from their contact with claimant and physician. The FN may recommend a vocational rehabilitation referral at any time, or specifically at the end of nurse services or if the claimant has not collaborated with or fully benefited from nursing services. The nurses' referrals will be transmitted by the CE.

(3) Previous Employer. If the agency indicates its interest in the reemployment of the injured worker, via phone for example, the RS should document the agency's request with a CA-110 (or equivalent) and request that the CE determine whether the medical evidence warrants such referral.

(4) Physician and Other Health Professionals. If a physician notes that vocational rehabilitation services are warranted in a medical report to the CE, the CE should initiate the referral process. Rarely, a physician may contact the RS directly requesting rehabilitation services for a particular injured worker. The RS should ask the physician to submit a report which clearly establishes that the claimant has stable and well-defined residuals. While the restrictions do not have to be on Form OWCP-5, work limitations from the accepted employment conditions that prevent the claimant from returning to the job held at the time of injury should be set forth in sufficient detail in terms of limitations and capabilities for an assessment of rehabilitation/work readiness to be made. The RS may also request that the physician include an accompanying statement that the injured worker is ready to undertake a vocational rehabilitation program.

(5) The Injured Worker. Injured workers may contact the RS or other district office staff to inquire about the availability of rehabilitation services.

(6) Other Sources. Referrals or inquiries may also be initiated by attorneys, union representatives, or RCs.

4. Referral Requirements. If the current medical evidence indicates that the claimant has objective residuals of the work-related condition and has stable, well-defined work limitations which allow him or her to work 8 hours per day, the case should be referred for vocational

rehabilitation services. Cases must be referred promptly when the injured worker is receiving compensation and no light duty offer has been made by the agency. These cases are given immediate attention and ideally a plan should be in place within one year of the first day of compensable disability, though circumstances vary by case.

The CE refers cases for vocational rehabilitation services using Form OWCP-14 (or equivalent). The referral should include:

- a. The accepted conditions in the case, as well any accepted conditions in other FECA files that are pertinent with regard to medical restrictions. Other significant non-work related conditions should also be noted.
- b. The name of the attending physician.
- c. The physician's name and date of medical report which represents the weight of medical evidence.
- d. The date on which disability (or recurrent disability) began, to identify the one-year time frame for placement with the previous employer.
- e. The gross amount of compensation the claimant is awarded each week and the pay rate on which this amount is based.
- f. Any medical or adjudicatory action which is in process or imminent (e.g., second opinion examination or referral for investigation) should be identified.
- g. An indication as to whether or not Field Nurse (FN) services are active and, if applicable, the reasons for continued FN service (e.g., a remaining medical issue is still being resolved).
- h. The CE should indicate whether or not direct contact by the RS or RC with the attending physician is authorized. The CE may authorize such contact when it will not potentially disturb the weight of medical evidence concerning work limitations. However, the CE should not authorize such contact when work tolerance limitations have been established by a second opinion or referee examination.
- i. If the agency has specifically indicated that placement services with the previous employer are unavailable or inappropriate, the CE should provide notification of such.
- j. Any pertinent notes regarding a request for specific services; for example, the injured worker has returned to work part-time but medical reports indicate capacity for full-time work, and the CE wants an RC to work with the previous employer to obtain longer hours within the injured worker's work limitations.
- k. When the case is being referred on a limited basis, the CE should include the nature of the limited referral, the CE's assessment of the situation, and the desired action from the RC. See paragraph 7 below.

Once the referral has been completed and made a part of the case record, the CE should send a Vocational Rehabilitation referral to the RS via the case management system, which will automatically populate the appropriate code in the Disability Management (DM) record.

5. Active Field Nurse Cases and Dual Tracking. Active FN cases may be referred for dual tracking. The referral in these cases will be for "Medical Rehabilitation" and the period will usually be limited to 3 months for concurrent services. Refer to FECA PM 2-0600-8(c) and 2-0600-9(e) for further information on the dual tracking of cases.

a. In some dual tracking cases, the restrictions may not be completely defined. As a result, full plan development cannot begin immediately with these claimants, but in the interest of expediting the return to work, the RC may assist with work hardening and functional capacity evaluation scheduling and begin the groundwork for the development of a return-to-work plan by obtaining the claimant's work history, performing preliminary labor market surveys and conducting a transferable skills analysis.

The FN will focus on the medical aspects of the case, and the RC will focus on the vocational aspects of the case. Once the claimant has stable and well-defined restrictions, nurse intervention will cease and the RS will direct the RC to begin actual plan development.

b. The FN or CE may also recommend a task based rehabilitation referral in conjunction with FN services. For instance, if vocational testing, an ergonomic evaluation, or assistive technology would enable the employing agency to offer a job to the claimant or explore job opportunities for placement in another departmental position, a dual assignment would be appropriate for this purpose. A dual tracking assignment may be solicited by the CE, FN, RC, RS, or Staff Nurse (SN).

6. Screening. Screening a case provides the RS with basic information regarding the injured worker's medical condition, work capabilities, reemployment potential and other data which will determine whether or not the case is in posture for referral to an RC. The goal of screening is to confirm that the injured worker needs vocational rehabilitation services to return to employment and achieve a productive level of functioning.

a. Timeframes. Rehabilitation referrals should be reviewed and recorded in the case management system within five work days of receipt by the RS. Accurate and prompt recording of cases is key to maintaining the efficiency of the rehabilitation work flow in the district office.

b. Medical Information. The major sources of medical information in the case file are OWCP standard forms and narrative medical reports submitted by the treating physician and other medical professionals involved in the case.

(1) The CE's OWCP-14 will point to the physician's report which is accepted as defining the injured worker's work tolerance limitations. It may be from an attending physician, second opinion physician, or referee specialist. Other reports may give supplementary information, but work limitations which differ from those the CE has designated should not be used as the basis for the rehabilitation effort. The OWCP-14 will also indicate whether the physician may be

contacted for clarification which is normally granted only if the claimant's attending physician provided the work tolerance limitations.

(2) Narrative medical reports contain information about the nature, extent and duration of the injury or illness, course of treatment recommended, and expected outcome. Standard forms may also serve this purpose. Pertinent data may be on Form CA-1, Federal Employee's Notice of Injury and Claim for Continuation of Pay/Compensation, Form CA-2, Claim for Occupational Disease, and Form CA-20, Attending Physician's Report.

Form OWCP-5, Work Capacity Evaluation provides specific limitations recommended by the examining physician and an estimate of the number of hours per day the injured worker is able to perform certain activities.

c. Non-Medical Information. The RS also needs information about the employer or agency, education and history of employment. Forms which may contain this information are the CA-1 and CA-2, cited above. An application for employment, if available, provides the injured worker's work history and other pertinent data, while the position description gives the physical demands for the date of injury job.

d. Evaluation of Injured Worker Information. The RS assesses the information in the case file, with emphasis on the present accepted medical and vocational condition of the injured worker and the feasibility of rehabilitation and reemployment.

(1) The RS should defer to the CE on medical issues to avoid creating an appearance of conflicts concerning medical evidence.

(2) If the medical condition of the injured worker is not described or appears unstable, the RS uses Form OWCP-3 or equivalent to notify the CE of the issues that need to be clarified and asks that an updated report be obtained. The RS may also use a Rehabilitation Action Report (OWCP-44). At the same time, the RS proceeds to the next step in the referral.

(3) If non-medical evidence is incomplete, the RS should note this fact and advise the RC to obtain the missing information from the injured worker during the initial interview, if necessary.

e. The RS should continue with the referral process in cases with the exception of injured workers who have successfully returned to work. These cases should be closed and recorded appropriately in the case management system.

7. Referral Outcome. Once the RS has completed an initial assessment of the case, s/he should be able to determine whether or not the injured worker is a candidate for vocational rehabilitation services.

a. Closing a Case from Referral. A case can be closed from referral if the injured worker has successfully returned to work or will return to work shortly without benefit of rehabilitation intervention; or if the injured worker is not able to work four hours per day and there is no possibility of improvement. The RS should notify the CE of closure on Form OWCP-3 or

equivalent, explaining why rehabilitation services were not offered. The RS may recommend additional medical development and subsequent referral at a later date. If the case is closed for medical infeasibility, the CE should concur that this is what the medical reports indicate. The case should then be coded in the case management system.

b. Opening a Case. If the injured worker has not returned to work, is unable to perform his or her usual work because of the compensable injury, and will benefit from rehabilitation services, the case can be opened using form OWCP-3 or equivalent. The OWCP-3 will identify the status in which the case is being opened and provide initial instructions to the RC based on the information provided by the CE on Form OWCP-14 or equivalent.

(1) If the CE has specifically indicated that placement services with the previous employer are unavailable based upon the employer's notification of such, the case should be opened in Plan Development status.

Note - If this information (the EA's declination) is not clear and evident in the file, the RC should be instructed to contact the EA to determine if a return to work with the EA is possible.

(2) All other cases, should be opened in Placement Previous Employer status so that employment possibilities within the claimant's former agency may be explored for at least thirty days. However, the RC should also proceed with the preliminary Plan Development components during this period so that an appropriate plan is not delayed if the former agency is unable to reemploy the claimant.

(3) When opening a case, the RS decides whether to refer a case to an outside rehabilitation counselor (RC) for services, or to retain direct control.

(a) Usually, the RS refers the injured worker to an OWCP- certified RC. The RC will work directly with the injured worker, and develop and implement a rehabilitation program. The RS authorizes services as required, approves or disapproves the recommended program, and evaluates the quality and timeliness of services.

(b) As a rule, RC services should be provided in person as necessary. However, where this is not possible (e.g. remoteness of the area in which the claimant resides or lack of available RCs), an RC may be assigned to provide all services telephonically with the approval of the RS.

(c) In some cases, the RS may choose to retain control of the planning and coordination of the rehabilitation effort. This should happen only when services are not otherwise available or if the RS is able to accommodate any limited services requested. See paragraph 7 of this chapter for more information regarding limited referrals.

(4) The RS may decide to conduct a conference with the claimant, CE, and/or RC to obtain any missing information, introduce the claimant to the vocational rehabilitation process and establish rapport.

(5) All services must be authorized in advance by the RS in writing. Form OWCP-35 or equivalent is used to refer a case to an RC, authorize initial services, and give instructions. The form authorizes counseling, guidance, testing by an outside vendor arranged by the RC, and placement services by the RC or by a placement professional supervised by the RC. The RS may authorize services for any amount up to \$5,000 and any period up to two years on the OWCP-35.

(6) Forms OWCP-3 and OWCP-35 (or equivalent) must be documented for the file, signed by the RS and sent to the selected RC with copies distributed to the injured worker, employer, and authorized representative, if any. Form OWCP-35 may be sent to the treating physician for information purposes.

(7) The RC should additionally be provided with copies of the accepted work-tolerance limitation on Form OWCP-5 Work Capacity Evaluation or equivalent and any pertinent medical and Field Nurse reports.

The RC should defer to the CE on medical issues so to avoid creating conflicts of medical evidence.

8. Limited Referrals. If the claimant is only able to perform part-time or sub-sedentary work, or could otherwise engage in active vocational rehabilitation services but for a non-employment-related condition which post-dates the injury, limited vocational rehabilitation services may be appropriate.

a. An Occupational Rehabilitation Program (ORP) may be appropriate when the specific work limitations are unknown or sub-sedentary but there is an expectation that a short period of medical rehabilitation will result in restrictions which can be used for a return to work. The RS may refer the claimant for an ORP when the physician prescribes a functional capacity evaluation (FCE), work hardening, or any other therapy program aimed at exploring work capabilities and documenting work restrictions. Upon completion of the ORP, the case should then be reviewed for placement services if work tolerance limitations were obtained.

b. A task based rehabilitation referral may be appropriate if a functional capacity evaluation (FCE), vocational testing, ergonomic evaluation, job site analysis or assistive technology would enable the employing agency to offer a job to the claimant or explore job opportunities for placement in another departmental position.

c. For claimants who cannot work 8 hours per day, a referral to an RC may be made for placement services with the previous employer. Placement with a new employer may be considered in those labor markets with sufficient part-time work in the commuting area. If later medical evidence demonstrates an improvement in medical status, attempts to establish the claimant's ability to work a full day should be pursued.

d. For claimants who are limited to sub-sedentary exertion levels, the RS may initiate a referral if sufficient sub-sedentary work exists within the commuting area. The RS should instruct the RC to confirm that sufficient numbers of otherwise suitable sub-sedentary jobs are identified, in order for a rehabilitation plan to commence.

e. Where the weight of the medical evidence establishes that the claimant could work in at least a sedentary capacity due to the work injury, but is more severely restricted from work due to a non-employment-related condition which post-dates the injury, the CE may refer the case for limited vocational services solely for the purpose of determining the claimant's capacity to earn wages in the open labor market based on the restrictions attributable to the work injury and any pre-existing medical conditions. The completed OWCP-14 should identify the non-employment-related condition(s) which arose after the work injury. Upon referral the RS should advise the RC that any restrictions resulting from these post-existing condition(s) need not be taken into consideration when identifying positions which represent the claimant's wage-earning capacity.

f. When vehicle and/or housing modifications are necessary to accommodate the claimant's accepted medical conditions, a limited referral to an RC may be made as rehabilitation services are often necessary in developing such proposals. See FECA PM 2-1800.

Chapter 8-0800, Assisted Reemployment

1. Purpose and Scope. The objective of Assisted Reemployment (AR) is to increase the number of job offers made by private employers, thereby increasing the number of permanently disabled workers who make a successful transition from the Federal Employees' Compensation Act (FECA) compensation rolls to regular, productive employment. AR is a temporary subsidy designed to encourage employers to hire and retain qualified rehabilitated workers.

The Office of Workers' Compensation Programs (OWCP) Procedure Manual discusses AR in chapter 3-0401. That chapter may be referenced for a historical perspective, but since it has not been recently updated, this chapter (FECA PM 8-0800) should be consulted, since it contains the most current policies and procedures pertaining to AR for the Division of Federal Employees' Compensation (DFEC).

2. Background. Assisted Reemployment began as a four-year demonstration project in FY 1992. As conveyed in FECA Bulletin 92-08 (Return to Work/Reemployment: Assisted Reemployment), issued on December 17, 1991, the goal was to increase the number of permanently disabled employees who could successfully return to the labor force even though they could not be placed with their former employer. OWCP then issued follow-up bulletins on the subject and incorporated it into the Procedure Manual.

AR is now a staple of the FECA program and one of several options that DFEC uses to assist injured workers with a return to gainful employment.

3. Funding Authority. Appropriations language for the Department of Labor provides "That such sums as are necessary may be used for a demonstration project under Section 8104 of title 5, United States Code, in which the Secretary may reimburse an employer, who is not the

employer at the time of injury, for portions of the salary of a reemployed, disabled beneficiary...." This language provides authority to use the FECA fund to pay a portion of the salary of a newly reemployed Federal worker (who is eligible for disability benefits under the FECA) via AR.

4. Eligible Employers. AR salary reimbursement may be offered to employers in the private sector, or to State or local government agencies. It may not be offered to Federal agencies at this time.

A business owned or managed by the injured worker, the injured worker's relatives, an employee of OWCP (or his/her family), or an OWCP vocational rehabilitation counselor (or his/her family) is not eligible for an AR subsidy.

5. Reimbursement Parameters. The rate and duration of wage reimbursements offered should be negotiated separately with each employer, depending on the nature of the job market and the particular circumstances in the case. AR subsidies, however, are subject to these restrictions:

- a. The period of the subsidy for any injured worker may not exceed 36 consecutive months.
- b. The rate of reimbursement may not exceed 75% of gross wages paid to the injured worker.
- c. If a subsidy of longer than 1 year is approved, it should be phased out over the entire period, usually in no more than three rate changes, e.g., 75% in the first year, 50% in the second year and 25% in the last year.
- d. At no time may the wage subsidy paid to the employer, plus any compensation payment paid to the injured worker for his/her Loss of Wage-Earning Capacity (LWEC), exceed the amount of compensation for total disability which would be paid to the injured worker in the absence of employment.
- e. The subsidy is not transferrable from one employer to another.
- f. If the injured worker's entitlement to compensation is terminated for any reason, e.g. no continuing injury-related disability, the subsidy terminates at that time as well.
- g. If the injured worker's entitlement to compensation is suspended (e.g. for failure to attend an OWCP-directed examination or return Form CA-1032), any subsidy payment is suspended as well. If previously approved, reimbursement may be made retroactively if compensation benefits are restored for failure to return Form CA-1032. If compensation benefits are not payable during a period of obstruction of a medical examination under 5 U.S.C. 8123, no subsidy payment may be made for a period in which the claimant is not in receipt of compensation benefits.
- h. If the injured worker quits or is fired from the position for which the AR subsidy is being paid, the AR subsidy terminates as of that date.

i. If the new employer fails to respond in full to any inquiry made by OWCP pertaining to the injured worker or the subsidy arrangement, the AR subsidy can be terminated.

j. An Assisted Reemployment Memorandum of Agreement must be signed by the employer and included in the OWCP case file prior to any payment being made.

k. Wage reimbursements made to employers will be treated as taxable income, and a Form 1099 will be issued to each employer at the end of each calendar year.

6. Eligible Cases. A Claims Examiner (CE), a Rehabilitation Specialist (RS) or a Rehabilitation Counselor (RC) may propose AR for an injured worker during Plan Development, or at any time during Placement, especially if it seems that it may be difficult to place the injured worker.

For instance, AR may be appropriate if the injured worker has significant transferrable skills but placement will be difficult due to a tight job market in that specialty, or if an injured worker has completed training in a field which has become highly competitive due to area economic conditions.

Before proceeding with AR, the file should reflect that the Employing Agency (EA) has declined or failed to offer appropriate modified employment. Additionally, AR subsidies should not be considered in instances where the claimant is not putting forth a good-faith effort in the return-to-work process, or has demonstrated non-cooperative behavior or otherwise poor conduct.

AR should be considered for employees who currently qualify for the identified position, and the unsubsidized wages should fairly and reasonably represent the injured worker's earning capacity. AR should not to be substituted for necessary training or to employ the injured worker in an unsuitable position. If training is necessary, formal or on-the-job training should be implemented before AR is considered.

7. Assisted Reemployment Initiation. When the RS determines that AR would be beneficial in a particular case, the RS should document the file (via Form OWCP-3 or equivalent) and advise the RC. The RS and RC should discuss the particular case, and the RS should provide the RC with information pertaining to the amount of a possible AR wage subsidy based on the claimant's compensation. The CE should assist with obtaining this information for the RS by calculating the injured worker's projected wage-earning capacity (using form CA-816 or equivalent) based on the unsubsidized wages of the identified position.

The RC, in cooperation with the injured worker and under the guidance of the RS, should then incorporate AR into the vocational rehabilitation plan and placement efforts. Although the injured worker's concurrence (or co-signature) is not required to pursue AR, the injured worker should be copied on any revisions of the plan or placement information.

In general, the RC proceeds as with any other vocational rehabilitation case in plan development or placement. As with any placement with a new employer, a thorough vocational evaluation

should be performed before jobs under AR are pursued, with the goal of identifying jobs which can be obtained by the injured worker which can significantly reduce the loss of wage-earning capacity.

8. Placement Phase. Once the RS has concurred that AR should be pursued, the RC should initiate employer contacts, verify that available positions are within the physical and vocational abilities of the worker, and arrange interviews for the injured worker.

- a. If the injured worker is released to full-time work, the AR subsidy should only be considered for an employer who is offering the injured worker full-time work. A part-time AR subsidy should not be considered for an injured worker who has been released to full-time work.
- b. The RC should inform a potentially interested private employer of all pertinent aspects of the AR subsidy, including: details of the Assisted Reemployment Memorandum of Agreement, information needed by OWCP to assure prompt processing of wage reimbursement submissions, and the fact that reimbursement payments must be reported as taxable income.
- c. The RC should also advise any prospective employer of the assistance that can be provided by OWCP for any necessary job modifications in the workplace, and of available post-employment services.
- d. The RC should provide a summary of each prospective AR encounter to the RS in the monthly report. The summary should contain the date of the contact, the employer's name and address, the type of contact (phone, personal, etc.), details of the wage subsidy offered, and the result of the contact.
- e. If an employer expresses significant interest, the RS and RC may arrange for a conference call to discuss all relevant issues and answer any questions the employer may have. (The CE may also attend this conference.) If conducted, this call should be documented as an informal conference by the RS. See FECA PM 2-0500-3(b) and 2-0600-12(c) for a discussion of the level of documentation required for an informal conference.
- f. If the injured worker fails to cooperate with the rehabilitation effort, the RC/RS should proceed to document the file for CE review to determine if non-cooperation sanctions or a constructed LWEC decision is appropriate. If the claimant is uncooperative and later decides to cooperate, an AR subsidy should usually not be considered based on this pattern of behavior.

9. Assisted Reemployment Approval. Once an employer has agreed to an AR subsidy, the RS will draft a written Assisted Reemployment Memorandum of Agreement to record the terms of the wage subsidy.

- a. The Assisted Reemployment Memorandum of Agreement must include the following elements:

- (1) Injured worker's full name and claim number;

- (2) Employer's name, address and Employer Identification Number (EIN);
- (3) The agreed upon amount of payments, with schedule for any decrease over time;
- (4) All steps which an employer must take to ensure accurate and timely reimbursement;
- (5) A job description and specification of the injured worker's starting wage rate;
- (6) An agreement by the employer to comply with the procedures and all applicable Federal, State and local laws; and
- (7) Pertinent items outlined in Paragraph 5 of this chapter.

b. OWCP's share of the cost is subject to a \$15,000 limit for RS authorization. Any total subsidy greater than this amount must be approved by the Supervisory Rehabilitation Specialist.

c. Due to the length/amount of most wage subsidies, most AR placements will require authorization of the Supervisory Rehabilitation Specialist. Once arrangements have been finalized and the injured worker has accepted the job offer, the Assisted Reemployment Memorandum of Agreement should be provided to the Lead Vocational Rehabilitation Specialist for preliminary review. If no changes are needed, the Lead Vocational Rehabilitation Specialist will forward the Memorandum of Agreement to the Supervisory Rehabilitation Specialist for final review, approval and signature.

d. A copy of the signed agreement, with a cover letter, should be sent to the employer, the injured worker and the EA. A copy must also be placed in the case file.

e. When the injured worker accepts a position, the RS must notify the CE promptly so that compensation can be adjusted to reflect the injured worker's actual wages on return to work, and so that the CE can calculate the employee's wage-earning capacity. It is extremely important that the CE be notified promptly when reemployment begins so that compensation is paid at the correct rate.

10. Case Closure. A worker may be considered successfully rehabilitated when employed for more than 60 days without interruption (due to the disability). Normally, the RS will close a case at this time. The same basic principle applies to cases with AR subsidies, except that wage reimbursement payments will be made on the injured worker's behalf for up to three years after the return to work, and post-employment services may be provided throughout this entire period.

11. Post-Employment Services. For AR cases, the RS may authorize post-employment services throughout the period of wage reimbursement if the injured worker has adjustment difficulties and needs additional services to maintain the vocational goal. Services may include counseling, guidance, additional training, and medical rehabilitation, as well as contact with the new employer.

a. Initial post-employment services should extend for a period of 60 days, as with a usual return-to-work. Unless there is an indication that further services are needed at the end of 60 days, the case can be closed without any additional services at that time. The 60-day period of time is sufficient in most cases.

During the first two months of reemployment, the RC should counsel and guide the injured worker. At a minimum, the RC should contact the worker at the end of the first day, first week, first month, and second month of employment. The RC should also contact the employer at the end of the first week, first month, and second month of employment. These contacts should be detailed in the RC's monthly report.

b. If there are significant unresolved issues at the end of 60 days, and the RC believes that an additional period of post-employment services would be useful to achieve a successful rehabilitation, the RC should document these reasons and seek such authorization from the RS. The RS can then extend the post-employment service period until any pending issues are resolved. Extensions should usually be granted in only 30-60 intervals to address specific issues and not for indefinite periods of time or for undefined reasons.

c. When post-employment services would no longer be helpful, the case should be closed. However, post-employment services may extend for the life of wage subsidies to the employer (not to exceed three years), even if on an limited intermittent basis, if the file reflects a true need for such services.

12. Payment of Assisted Reemployment Subsidies. All steps which employers must take to obtain accurate and timely reimbursements should be specified in the Assisted Reemployment Memorandum of Agreement.

a. Employers should submit claims on a monthly or quarterly basis for reimbursement of wages paid to injured workers.

b. Requests for reimbursement should be submitted on Form CA-2231, Claim for Reimbursement Assisted Reemployment (available on the DFEC internet home page), and include the following:

- (1) Employer's name, phone number and full mailing address for remittance;
- (2) Employer's Federal tax identification number;
- (3) Injured worker's full name, FECA claim number and signature;
- (4) Hours worked, hourly rate, amount of gross wages paid, amount to be reimbursed, and the period covered; and
- (5) Name and signature of the authorized official certifying that information submitted is correct.

c. Upon receipt, the RS should verify the information submitted against the Assisted Reemployment Memorandum of Agreement. The RS should also review the case file to determine if there is any evidence indicating that the claimant may no longer be working for that employer, i.e. the most recent Form CA-1032.

(1) If all is in order, the RS should approve the reimbursement request for payment.

(2) If there is evidence indicating that the injured worker is no longer employed with the employer submitting the claim for AR reimbursement, the RS should consult with the CE and Claims Supervisor to determine the next course of action, which may include communication with the injured worker, and possibly a referral to the Office of Inspector General if there is any indication of a fraudulent claim on behalf of the employer or claimant. See FECA PM 2-402.

d. If the claimant did not sign the CA-2231, the reason for the missing signature provided by the employer in the applicable block of the CA-2231 should be scrutinized, and the file should be reviewed carefully to ascertain whether the claimant is still working with that employer.

Like (c) above, if there is any doubt, the RS should consult with the CE and Claims Supervisor to determine the next course of action, which may include communication with the injured worker, and possibly a referral to the Office of Inspector General if there is any indication of a fraudulent claim on behalf of the employer.

A CA-2231 without the claimant's signature should usually not be used as the basis for a reimbursement payment absent unique and documented circumstances. If such payment is made one time, the employer and claimant should be advised to make sure the form is signed for the next submission.

e. AR reimbursement requests are processed as Prompt Pay bills.

(1) Claims must be paid (check dated or electronic payment issued) within 30 days of receipt unless the employer was notified of a defect within seven days.

(2) Claims not paid must be returned with appropriate advice within seven days of receipt.

Exhibit 1: Assisted Reemployment Memorandum of Agreement

Assisted Reemployment Memorandum of Agreement

This memorandum constitutes the agreement between <<EMPLOYER NAME>> and the US Department of Labor, Office of Workers' Compensation Programs (OWCP), and defines the terms and parameters whereby OWCP will reimburse <<EMPLOYER NAME>> for wages paid to <<CLAIMANT NAME>>, whose OWCP file number is <<CLAIM NUMBER>>.

By entering into this agreement, OWCP does not in any way formally associate itself with, or endorse the activities of, <<EMPLOYER NAME>>.

<<CLAIMANT NAME>> will work for <<EMPLOYER NAME>> as a <<JOB TITLE>>. The duties of this job include the following: <<DESCRIPTION>>.

<<EMPLOYER NAME>> agrees to notify OWCP in writing within 48 hours of any substantial change in these job duties, or if <<CLAIMANT NAME>> is no longer an employee.

<<CLAIMANT NAME>> will work the following schedule <<DETAILS>>, and <<EMPLOYER NAME>> agrees to pay the following wage: <<DETAILS>>.

OWCP will reimburse <<EMPLOYER NAME>> for part of the wages paid to <<CLAIMANT NAME>> according to the following schedule: <<DETAILS>>. This Assisted Reemployment subsidy arrangement cannot be transferred to another employer.

OWCP will make these reimbursement payments to <<EMPLOYER NAME>> on a quarterly basis upon receipt of a fully completed Form CA-2231, available on-line at <http://www.dol.gov/owcp/dfec/index.htm>. Completion of this form requires:

- Employee's full name
- Employee's OWCP file number (as listed in the first paragraph above)
- Hours worked and rate of pay
- Gross wages paid
- Amount to be reimbursed
- Time period covered
- Complete remittance address for <<EMPLOYER NAME>>
- Tax identification number (EIN) for <<EMPLOYER NAME>>
- Name and signature of the authorized official for <<EMPLOYER NAME>> certifying that information submitted is correct
- Signature of <<CLAIMANT NAME>>

Assisted Reemployment subsidy payments will be treated as taxable income.

If <<CLAIMANT NAME>> is no longer employed by <<EMPLOYER NAME>>, this Assisted Reemployment subsidy ends as of the last date worked.

If compensation for <<CLAIMANT NAME>> is terminated or suspended by OWCP for any reason, payments under this Assisted Reemployment Agreement terminate as of the date of termination or suspension.

If <<EMPLOYER NAME>> fails to respond in full to any inquiry made by OWCP pertaining to <<CLAIMANT NAME>> or the subsidy arrangement, OWCP can terminate the Assisted Reemployment subsidy.

By signing this agreement, all parties agree with the conditions set forth in this Assisted Reemployment Memorandum of Agreement.

PERIOD OF AGREEMENT: Unless otherwise specified, this agreement expires <<# of months/years>> from the date of the last signature below. This agreement may be terminated by either party on thirty (30) days notice.

The contents of this agreement (and any other information provided to the employer by OWCP regarding this claim) are protected under the Privacy Act of 1974, as amended. Do not disclose without the prior written approval of OWCP.

(EMPLOYER DESIGNEE SIGNATURE)

Date: _____
<<EMPLOYER DESIGNEE NAME>>
<<EMPLOYER DESIGNEE TITLE>>
<<EMPLOYER NAME>>
<<EMPLOYER IDENTIFICATION NUMBER>>
<<EMPLOYER ADDRESS>>

(REHABILITATION SPECIALIST SIGNATURE)

Date: _____
<<REHABILITATION SPECIALIST NAME>>
REHABILITATION SPECIALIST

(DISTRICT DIRECTOR SIGNATURE)

Date: _____
<<OWCP DISTRICT DIRECTOR NAME>>
DISTRICT DIRECTOR