DEPARTMENT OF LABOR

OFFICE OF WORKERS COMPENSATION PROGRAMS

DIVISION OF LONGSHORE AND HARBOR WORKERS' COMPENSATION (DLHWC)

LONGSHORE AND HARBOR WORKERS' COMPENSATION ACT

PROCEDURE MANUAL

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Procedure Manual
Division of Longshore and Harbor Workers' Compensation (DLHWC)

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1. Purpose and Scope. The Introduction to the Longshore and Harbor Workers' Compensation Act (LHWCA) Procedure Manual (PM) outlines some of the basic things you need to know about the Procedure Manual, e.g., its structure, composition, and relationship to other written instructions. The Introduction also contains a description of the organization and structure of the Division of Longshore and Harbor Workers' Compensation (DLHWC), and discusses the benefits and services available under the LHWCA and the requirements which must be met to obtain these benefits and services.

1. **Chapter 0-100** provides information on the structure of the LHWCA PM and directions for its use and maintenance.
2. **Chapter 0-200** presents a brief summary of the statutory authority for the compensation programs administered by the Division of Longshore and Harbor Workers' Compensation (DLHWC) and briefly describes the LHWCA and its extensions.
3. **Chapter 0-300** describes the various benefits and services which injured workers are eligible to receive under the LHWCA as extended and the requirements which must be met to qualify for these benefits and services.
4. **Chapter 0-400** describes the background and structure of the DLHWC, its organization, delegations of authority, and relationships to the Employment Standards Administration (ESA) and other offices of the Department of Labor.

5. **Chapter 0-500** describes the communications and directives system authorized for DLHWC. It describes the various directives used and establishes responsibilities and procedures for the issuance of those directives.
6. **Chapter 0-600** contains a list of reference resource materials for use in researching claims-related or program-related issues.
7. **Chapter 0-601** contains a Glossary which defines frequently used terms.
8. **Chapter 0-602** contains a list of commonly used Abbreviations.

2. <u>Structure of the LHWCA PM</u>. The Procedure Manual (PM) consists of ten major divisions or Parts. The Parts, in turn, are further divided into chapters which are identified by triple-digit identifiers, e.g., 0-100, 0-200, etc. Chapters are further divided into paragraphs and other necessary subdivisions as follows:

1. **Divisions and Subdivisions**.
    a. Part: 0 (1, 2, etc.)
    b. Chapter: -100 (200, 300, etc.)
    c. Subchapter: -101 (102, 103, etc.)
    d. Paragraph: .1 (.2, .3, etc.)
    e. Subparagraph: a (b, c, etc.)
    f. Sub-Subparagraph: (1) ((2), (3), etc.)
    g. Sub-Sub-Subparagraph: (a) ((b), (c), etc.)
2. **Citations**. Citation to a portion of the LHWCA PM should be as specific as possible and should be made in the following manner:
    a. Citation to a Part: LHWCA PM 3
    b. Citation to a Chapter: LHWCA PM 3-200
    c. Citation to a Subchapter: LHWCA PM 3-205
    d. Citation to a Paragraph: LHWCA PM 3-205.3
    e. Citation to a Subparagraph: LHWCA PM 3-205.3b
    f. Citation to a Sub-Subparagraph: LHWCA PM 3-205.3b(7)
    g. Citation to a Sub-Sub-Subparagraph: LHWCA PM 3-205.3b(7)(g)

3. **DLHWC Directives**. Detailed instructions for the preparation, review, clearance, publication, and distribution of DLHWC directives are contained in the LHWCA PM 0-500.
4. **Checklist**. Located in front of the LHWCA PM is a "Checklist" of all pages issued and currently in effect within the LHWCA PM system. Checklists are issued periodically and supersede previous editions.

3. Maintenance and Revision.

1. **New Issuances**. New and revised chapters and pages of all PM material are distributed by numbered PM Transmittals. The Transmittals contain an explanation of the material transmitted, provide filing instructions for the new material, and directions on the disposition of any superseded or obsolete material.
2. **Filing Instructions**. Detailed filing instructions are contained in PM 0-500. With routine changes or additions, observe the following procedure:
    a. File new material in accordance with the instructions contained in the PM Transmittal which transmits them.
    b. Remove and destroy any material identified as superseded or obsolete.
    c. File the Transmittal behind the latest "Checklist" which is located in front of the PM.
    d. When a new Checklist is received, destroy the Transmittals which have accumulated behind the previous Checklist. Keep only the latest Checklist in the manual.)

Chapter 0-0200, Authority and Background of the LHWCA

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1. Purpose and Scope. This Chapter presents a brief summary of the statutory authority for the compensation programs administered by DLHWC and briefly describes the LHWCA and its extensions.

2. Authority. The basic authority for all DLHWC compensation programs and their administration by agencies and persons within the Department of Labor is derived from the Longshore and Harbor Workers' Compensation Act (LHWCA), 33 U.S.C. sections 901-950, its extensions and from the implementing rules and regulations issued by the Department, 20 C.F.R. Parts 701-704. Administration of the LHWCA was initially vested in an independent establishment known as the U.S. Employees' Compensation Commission. The Commission was abolished in 1946 and its functions transferred to the Federal Security Agency to be performed by a newly created Bureau of Employees' Compensation. In 1950, the Bureau was transferred to the Department of Labor (Reorganization Plan No. 19 of 1950). By Secretary's Order No. 13-71, the Assistant Secretary, Employment Standards Administration (ESA), established the Office of Workers' Compensation Programs (OWCP) within ESA and designated the Director thereof to administer the programs assigned to OWCP by the Assistant Secretary. See PM 0-400 for a discussion of the relationships and lines of authority within OWCP and between OWCP and ESA.

3. Basic Act. The Longshore and Harbor Workers' Compensation Act (LHWCA)(33 U.S.C. sections 901-950) was passed in 1927 to provide compensation payable by an employer to an employee, or the employee's dependents, for disability or death due to an injury occurring upon the navigable waters of the United States. The LHWCA provides payment for medical care required for the injury, disability compensation payments, and a maintenance allowance during rehabilitation training. In the event of death caused by injury, benefits include payment for reasonable funeral expenses and compensation payments to surviving dependents. The Act resolved a problem of worker coverage when the worker's activity was on the navigable waters of the United States. Before the enactment of the law, state workers' compensation programs applied to injuries occurring on land, and the Supreme Court had held that a state could not extend its workers' compensation remedy to cover longshoremen injured over the navigable waters of the United States (**Southern Pacific Co. v. Jensen**, 244 U.S. 205 (1917)).

4. Amendments of 1972. The LHWCA Amendments of 1972 (Pub. L. No. 86-1251), enacted in October 1972, extended coverage to maritime workers employed in shoreside areas such as piers, wharves, drydocks, terminals, building ways, marine railways, or other adjoining areas customarily used by employees in loading, unloading, repairing, or building a vessel. Other changes included in the Amendments pertained to maximum and minimum benefit rates, student benefits, time for commencement of compensation, medical services, disfigurements, special fund, injury following previous impairment, death benefits, annual increases in compensation, time for notice and claims, fees for services, hearing procedure, a Benefits Review Board, representation of the Secretary of Labor by the Solicitor, claimant assistance, third party liability, prohibition against discrimination against certain employees, annual adjustment of benefit levels, and other miscellaneous provisions. Under the LHWCA, the employer must notify the DOL of all lost-time injuries as well as any action taken regarding the employee's claims, i.e., payment, medical treatment provided, or denial of the claim.

5. Amendments of 1984. The most recent changes to the Act were the LHWCA Amendments of 1984 (Pub. L. No. 98-426, 98 Stat. 1639), enacted September 28, 1984. The changes made by some of the major provisions of the 1984 Amendments include:

1. **The Act's jurisdiction was clarified and limited** by exclusion of certain groups of employees and facilities from LHWCA coverage, to the extent workers are covered under a state workers' compensation law.
2. **Compensation for unrelated death was eliminated**; a five percent ceiling was placed on annual increases under section 10 in compensation payable for permanent total disability and death; death cases are now subject to the maximum weekly benefit; and, for the purpose of calculating benefit rates, wages are defined to exclude fringe benefits.
3. **To provide additional safeguards against fraudulent activities** by employees to obtain benefits, and by employers or insurance carriers to deny, reduce or terminate benefits, fines and penalties for such actions were increased. In addition, provisions were added authorizing the Secretary to debar health care providers and claimant representatives for fraud or abuse.
4. **A method for computing compensation** for victims of latent disabilities due to occupational disease which do not become manifest until after the employee retires was established. Also, time of injury was redefined as

occurring after the disease becomes manifest and the claimant is aware of the relationship between the disease, the resulting disability, and the employment. The time requirements for filing a notice of disease (injury) and a claim for compensation were extended.

5. **Uninsured employers and carriers not authorized to write insurance** under the Act are prohibited from receiving second injury (section 8(f)) relief; applications for second injury relief must now be filed by ECs with an OWCP DD prior to consideration of claims for permanent disability alleged to be more serious because of contribution from a manifest preexisting disability; and the formula for determining industry assessments was revised to include a factor for section 8(f) cases which are attributable to each employer and insurance carrier.
6. **To expedite case processing activities** under both the LHWCA and Black Lung Benefits Act, the permanent membership of the Benefits Review Board was increased from three to five members and the Secretary was authorized to appoint up to four administrative law judges as temporary members.

6. Extensions. Since 1927, provisions of the Act have been extended to include additional groups of employees:

1. **The District of Columbia Workmen's Compensation Act** (DCCA) (36 D.C. Code section 501)(1973)) enacted in 1928 extended the provisions of the Longshore Act to injuries and deaths which arose out of employment with District of Columbia employers. In 1979 the District of Columbia government repealed the 1928 Act and enacted its own workers' compensation law, which became effective on July 26, 1982. Injuries to employees in the District of Columbia occurring prior to July 26, 1982 are covered by the DCCA, an extension of the Longshore Act. However, as the repeal of the 1928 Act had the effect of severing the application of the Longshore Act to the District of Columbia, the 1984 Amendments to the Longshore Act have no effect on and are not to be applied to claims for injuries sustained prior to July 26, 1982. This position [i.e., that the 1984 LHWCA Amendments do not apply to DCCA cases generally] was adopted by the Secretary after the holding in Keener v.

WMATA, 800 F.2d 1173 (D.C. Cir. 1986). The provisions of the Longshore Act, **as they existed in 1982**, are preserved for the benefit of employees whose claims are derived from injuries occurring prior to July 26, 1982. In July of 1988, the administration of claims filed under the DCCA was delegated to the District of Columbia Government, to be handled by the Department of Employment Services.

2. **The Longshore Act, as extended by the Defense Base Act** (DBA), 42 U.S.C. section 1651 **et seq.**, enacted in 1941, provides workers' compensation coverage for workers engaged in employment on overseas defense bases, or under contracts with the United States, or an agency thereof, for public work to be performed outside of the continental United States. To be compensable under the Act, a claim must stem from employment either on a U.S. base overseas or under a "contract" for "public work" overseas, public work constituting government related construction projects, work connected with national defense, or employment under a service contract supporting either activity.

   (1) History. When enacted in 1941 its main purpose was to extend coverage for civilians engaged in employment overseas at American Military Bases. The statute was adopted at the request of the Secretary of War in order to enable the U.S. Government and its defense contractors to avoid enormous expenses when securing workers' compensation insurance for overseas employees who had suffered industrial accidents that had taken place outside the United States. Subsequently, after World War II, the Defense Base Act's coverage was expanded to include civilians working on overseas construction projects for the United States. Employees covered under the Federal Employees' Compensation Act are excluded from coverage.

   (2) Zone of Special Danger. The traditional concept of causal relationship does not normally apply to claims filed under the DBA. This is due to the advent of the "zone of special danger" doctrine. The zone of special danger doctrine (see **Self v. Hanson**, 305 F. 2d 699, 702 (9th Circuit 1962) is a judicially created legal concept. The U.S. Supreme

Court, in a 1951 decision, first enunciated and defined the scope of compensability under the Defense Base Act in the following terms:

The test of recovery is not a causal relation between the nature of employment of the injured person and the accident. Nor is it necessary that the employee be engaged at the time of the injury in activity of benefit to his/her employer. All that is required is that the "obligation or condition" of employment create the "zone of special danger" out of which the injury arose.

(3) Reasonable Recreation. Normally, a DBA claim arising out of an injury or death of an employee that takes place while the injured worker is on duty in most cases is found to be compensable. The difficult task under this Act is to determine compensability when the injury occurs while the employee was off duty and engaged in some form of recreational activity. In **O'Keefe v. Pan American World Airways, Inc.**, 338 F. 2d 319, 322 (5th Cir. 1964), cert. Denied, 380 U.S. 951 (1965), the court recognized that these types of claims may be compensable:

Employees working under the DBA far away from their families and friends, in remote places where there are severely limited recreational and social activities, are in different circumstances from employees working at home. Personal activities of a social or recreational nature must be considered as incident to the overseas employment relationship.

That being said, the CE should keep in mind that not every claim arising out of an off duty injury or death is compensable. The issue then arises as to what types of recreational activities fall within the zone of special danger such that claims for injuries or deaths arising out of those activities are compensable. What constitutes reasonable recreation in a given case is considered a fact question as opposed to a question of law. This question is normally answered by the trier of fact based on a review of the evidence. Due to the absence of any case law precedent,

defining the concept of reasonable recreation has compelled the courts to employ a case by case analysis of compensability.

3. **The Outer Continental Shelf Lands Act** (OCSLA) 43 U.S.C. section 1331 **et sec.**. This Act emerged out of Congressional recognition that the need to develop and explore the natural resources of the continental shelf would require governmental intervention and a new body of federal laws. Due to technological advances offshore, by 1937 offshore oil and gas exploration became more practical. This generated more interest at home and abroad in mineral resources. The OCSLA was enacted by Congress in 1953. The purpose was to "safeguard the U.S. interest in any international race for the vast wealth of the continental shelf," by providing an administrative and legal framework within which this wealth could be developed and exploited by the Federal Government.

   Continental shelves have been defined as those slightly submerged portions of the continents that surround all the continental areas of the earth. They are a part of the same continental mass that forms the lands above water. They are part of the continent temporarily overlapped by oceans. The outer boundary of each shelf is marked by a sharp increase in the slope of the sea floor. It is the point where the continental mass drops off steeply toward the ocean depths. Typically, this abrupt drop occurs where the water reaches depths of 600 feet or greater. This depth is used as a gauge in defining the outer limits of the shelf. For example, the Atlantic coastal region from the shore to the outer edge of the shelf is approximately 250 miles, and the average distance is about 70 miles.

   (1) Conditions of Coverage. The OCSLA provides workers' compensation coverage for the death or disability of an employee resulting from any injury occurring as a result of operations connected with the exploration, development, removal, and transportation of natural resources from the seabed and subsoil of the Outer Continental Shelf. The Act applies to all submerged lands (and artificial islands and fixed structures thereon) which lie beneath navigable waters seaward of state

jurisdictional boundaries, and which are subject to the jurisdiction and control of the United States.

(a) Coverage under the OCSLA is not based on the same requirements as coverage requirements under the LHWCA. One of the main differences is that work activities covered under the OCSLA is not considered maritime employment. See **Herb's Welding v. Gray**, 470 U.S. 414 (1985).

(b) Each State has a claim over the area off their shores. For most States, the claim occurs within the three-mile radius or limit. The area within three miles falls under State jurisdiction. The area beyond is called the Outer Continental Shelf and is subject to the Federal OCSLA.

(c) The OCSLA is unique because most offshore employees stay on the platform for their full tour of duty, which is normally a 7 or 14 day shift, 12 hours of "work duties" per day at which point they return to shore for 7 days "off". Since the employees are on the platform 24 hours per day at the convenience of the employer and they are housed and fed by the employer, OCSLA workers are considered to be "in the course and scope of their employment" for their entire shift, 24 hours per day.

4. **The Nonappropriated Funds Instrumentalities Act** (NFIA), was enacted in 1952 by Congress to define the status of civilian employees working under the Nonappropriated Fund at various U.S. military bases. Nonappropriated Funds are funds that are not appropriated by the Congressional Budget or the Defense Budget. The NAFIA includes the various military branch exchanges and other activities that provide entertainment, recreation and housing to military employees on military bases in the U.S. and overseas. NAF civilian employees are not classified as Federal Government employees and, therefore, are not covered under the Federal Employees compensation Act. Although their jobs are tailored more towards the private sector, their industrial work related claims do not fall under the state workers' compensation system. NAF employees are compensated from revenue earned by business

operations. All funds are maintained in a Federal Reserve Bank as required by federal statute.

5. **The War Hazards Compensation Act**, (WHA), 42 U.S.C., section 1701 et seq., enacted in 1942, applies the benefit structure of the LHWCA to certain employees of contractors engaged in work outside the continental United Sates and exposed to war risks. These cases are normally adjudicated under the Defense Base Act until a compensation order is issued at which point the employer/carrier applies to the Division of Federal Employees' Compensation, Branch of Special Claims, for reimbursement from the FECA Compensation Fund under the provisions of the War Hazards Compensation Act. The regulations at 20 C.F.R. 61.101(a) provide that applications for reimbursement are to be sent to the U.S. Department of Labor, Office of Workers' Compensation Programs, Branch of Special Claims, P.O. Box 37117, Washington, DC 20013-7117. Employers/carriers should not be instructed to send the applications to the Longshore district office servicing the Defense Base Act claim. If a Longshore district office should receive such an application, it should be forwarded directly to the Branch of Special Claims. If an employer/carrier inquires as to the documentation needed in support of an application for reimbursement, they should be made aware of the provisions of 20 C.F.R. 61.101(b) and (c).

   20 C.F.R. 61.101 provides as follows:

   Sec. 61.101 Filing a request for reimbursement.

   (a) A carrier or employer may file a request for reimbursement. The request shall be submitted to the U.S. Department of Labor, Office of Workers' Compensation Programs, Branch of Special Claims, P.O. Box 37117, Washington, DC 20013-7117;

   (b) Each request for reimbursement shall include documentation itemizing the payments for which reimbursement is claimed. The documentation shall be sufficient to establish the purpose of the payment, the name of the payee, the date(s) for which payment was

made, and the amount of the payment. Copies of any medical reports and bills related to medical examination or treatment for which reimbursement is claimed shall also be submitted. If the carrier cannot provide copies of the payment drafts or receipts, the Office may accept a certified listing of payments which includes payee name, description of services rendered, date of services rendered, amount paid, date paid check or draft number, and signature of certifier.

(c) When filing an initial request for reimbursement under the Act, the carrier shall submit copies of all available documents related to the workers' compensation case, including-- (1) Notice and claim forms; (2) Statements of the employee or employer; (3) Medical reports; (4) Compensation orders; and (5) Proof of liability (e.g., insurance policy or other documentation).

(1) History. As a result of the Pearl Harbor Attack during World War II, military demands required contractors to extend their operations into areas not covered under the Defense Base Act; in which case a number of interim arrangements were entered into by contractors to provide a standard of compensation for their employees. These arrangements mainly provided voluntary workers' compensation coverages of no set pattern and various guarantees of payments for disability or death. Due to danger that these employees were faced with, each successive group of employees leaving the country sought out their employer's guarantees. These informal arrangements provided neither consistency nor equality. As a result, the Act of December 2, 1942, commonly known as the War Compensation Act was passed.

(2) Definition. A "war risk hazard" is a hazard arising during a war in which the United States is engaged during an armed conflict whether or not war has been declared; or during a war or armed conflict between military forces of any origin, occurring within any country in which a covered individual is serving.

(3) The DBA provides a reimbursement system through the Federal Employees' Compensation Program to self-insured employer and insurers for losses that they may have paid under the Defense Base Act, once the claim has been declared a war risk hazard.

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1. Purpose and Scope. This Chapter presents a brief, overall summary of the statutory authority for the compensation programs administered by the DLHWC; describes the various types of coverage provided; and, outlines the benefits and services available to eligible workers or their survivors.

2. Basic Eligibility Requirements.

For more detailed information concerning potentially complex issues (e.g., coverage), the CE should also consult other reference materials such as the Longshore Desk Book and applicable Program Memoranda or contact the National Office. These requirements are also discussed further in paragraphs 4-8, below.

1. **Medical Benefits**. There are four basic requirements for a worker to be entitled to medical benefits under the Act. The condition requiring medical treatment, services, or appliances must be (1) causally related, at least in part, to (2) an accidental injury or exposure to injurious conditions (3) in the course of covered employment (4) at a covered location.

2. **Periodic benefits** for disability or death as well as medical expenses are payable if, in addition, the disability or death results at least in part from the condition.
3. **Funeral Benefits**. To be entitled to an award of contested periodic (or funeral) benefits, there must also have been a timely claim under the Act filed in the DD's office. Elements (3) and (4) as defined in the Act itself are replaced by other "coverage" determinants under its extensions (e.g., the DBA and OCSLA).

3. Presumptions. Section 20 of the Act provides that in any proceeding for the enforcement of a claim for compensation under the Act it is presumed, in the absence of substantial evidence to the contrary

Section 20 of the Act provides the claimant with a presumption in the areas covered which shifts the burden to the employer to rebut the presumption with substantial evidence. In order for the section 20(a) presumption to apply to causation, a claimant must establish a **prima facie** case by proving that he or she suffered some harm or pain, and that working conditions existed or an accident occurred which could have caused the harm or pain. Once the claimant establishes the two elements of the **prima facie** case, the section 20(a) presumption applies to link the harm or pain with the claimant's employment. The section 20(a) presumption also applies to the issue of whether an injury arose in the course of employment.

1. **That the claim comes within the provisions of the Act**. (Relevant principally to sections 2(2), 2(3), and 3(a) of the Act.)
2. **That sufficient notice of such claim has been given** (Relevant to sections 12, 13 and 30 of the Act.)
3. **That the injury was not occasioned solely by the intoxication of the injured employee** (Relevant to section 3(c) of the Act.)
4. **That the injury was not occasioned by the willful intention of the injured employee to injure or kill himself or another**. (Relevant to section 3(c) of the Act.)

4. Timely Claim. Under the provisions of section 13(a) of the Act and 20 C.F.R. section 702.221, a claim for compensation for disability or death must be in writing and filed with the DD in the compensation district in which the injury or

death occurred. The claim need not be filed on a particular form. Any written document will do as long as it discloses an intention to assert a right to compensation. It is not necessary that the written document explicitly state a claim as long as the fact that a claim is being made is inferable from the writing. It is also important to remember that the presumption contained in section 20(b) applies to the filing of a claim. The provisions concerning the timely filing of a claim are as follows:

1. **The right to compensation** for disability or death shall be barred unless the claim is filed within one year from the time the claimant becomes aware, or in the exercise of reasonable diligence should have been aware, of the relationship between the injury or death and the employment. Such awareness must include recognition of the full nature and character of the injury for the one year period to begin. If, however, the EC has made voluntary payments of compensation pursuant to section 14, a claim may be filed anytime before one year after the last payment.
2. **In the case of a hearing loss claim**, the time for filing a claim for compensation does not begin to run until the employee has received an audiogram with an accompanying report which indicates that he or she has suffered a loss of hearing related to employment.
3. **A claim for death or disability due to an occupational illness** which does not immediately result in death or disability will be timely if filed within two years after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability, or within one year from the date of the last payment of compensation, whichever is later. Thus, the filing period does not begin to run until the employee is disabled, or, in the case of a retired employee, until a permanent impairment exists.
4. **In death cases**, a separate claim must be filed for section 9 death benefits by the survivor even though a claim for disability benefits was filed by the decedent, and the death claim must be filed within the applicable time requirement.

5. **Where a person entitled to compensation** under the LHWCA is mentally incompetent or a minor, the time limitation does not begin to run until a guardian or other authorized representative has been appointed. The time limitation begins to run from the date of appointment of the guardian or representative. In the case of a minor who has no guardian appointed before he or she comes of age, time begins to run from the date he/she comes of age.
6. **Where a person brings a suit at law or in admiralty** to recover damages relative to an injury or death, and recovery is denied on the ground that such person is an employee, that the defendant was an employer within the meaning of the LHWCA, and that the employer has secured compensation to such employee under the LHWCA, the time limitation begins to run from the date of termination of such suit.
7. **Where an EC has been given notice** of or otherwise has knowledge of an injury or death and fails to file a report with the DD, the time limitations do not begin to run against a claim for benefits until the required report is filed with the DD. (See section 30(f) of the Act.)
8. **The failure to file a claim** within the appropriate time limitation shall not be a bar to the right to make claim unless objection to such failure is made at the first hearing of the claim in which all parties in interest are given reasonable notice and opportunity to be heard.

5. Coverage. The requirements for coverage under the LHWCA are defined in section 3(a). Besides the requirement for an injury which arises out of and in the course of employment, section 3(a) requires that the injured worker must be an "employee" (as defined by section 2(3)) and that the injury must have occurred "upon the navigable waters of the United States" (as defined by section 3(a)). These two requirements have come to be known as the "status" and "situs" tests, respectively. Prior to the enactment of the 1972 Amendments, the Act contained only a situs test; recovery was limited to those injured on the navigable waters, including any dry dock (construed by case law to include marine railways, building ways, graving docks and similar structures actually located on land). The term "employee" was not affirmatively defined, did not require maritime employment of the employee, and therefore, did not constitute a status test. Recognizing that modern cargo-handling techniques had moved much of the

longshoring duties off the vessel and onto land, the 1972 Amendments expanded the covered situs and added the status test, limiting coverage to "maritime employees."

1. **Status**. Section 2(3) contains a definition of the term "employee" which describes those workers who are covered by the Act and therefore have employment status. This definition includes: harbor workers, ship repairmen, shipbuilders, shipbreakers, longshoremen and others engaged in ship loading or unloading operations and traditional maritime employment (see LHWCA MEMO No. 58). Section 2(3) also contains a list of specified exclusions which are explained further in subparagraph 5.c, below.
2. **Situs**. Section 3 specifies which locations are covered by the Act. These covered locations are:
    a. The navigable waters of the United States.
    b. Adjoining areas which include any adjoining pier, wharf, drydock, terminal, building way, marine railway, or other adjoining area customarily used by an employer in loading, unloading, repairing, building or breaking a vessel. Section 3 also contains a list of exclusions which are explained further in subparagraph 5c, below.
3. **Exclusions**.
    a. As defined by the Act, section 2(3), the term employee does not include a master or member of a crew of any vessel, or a person engaged by the master to load or unload or repair any small vessel under 18 tons net. The 1984 Amendments expanded these exclusions to include:
        i. Individuals employed exclusively to perform office clerical, secretarial, security, or data processing work;
        ii. Individuals employed by a club, camp, recreational operation, restaurant, museum or retail outlet;
        iii. Individuals employed by a marina and who are not engaged in construction, replacement or expansion of such marina (except for routine maintenance);

iv. Individuals who (1) are employed by suppliers, transporters, or vendors, (2) are temporarily doing business on the premises of a covered employer, and (3) are not engaged in work normally performed by covered employees;

v. Aquaculture workers; and

vi. Individuals employed to build, repair, or dismantle any recreational vessel under sixty-five feet in length. These exclusions only apply if the workers otherwise excluded are covered by a state workers' compensation law.

b. Section 3 of the Act specifically excludes the following groups of employees:

i. An officer or employee of the United States, or any agency thereof, or of any State or foreign government, or subdivision thereof.

ii. An employee whose injury was occasioned solely by intoxication or by the willful intent to injury himself or another.

iii. The 1984 Amendments expanded the section 3 exclusions to include any employee of a facility certified by the Secretary to be engaged in work on exclusively small vessels. (See PM 4-400.13.)

4. **Extensions**. The Act (with its extensions) provides compensation to:

a. Workers employed by private employers carrying on employment within the District of Columbia. (District of Columbia Workmen's Compensation Act). This extension applies to injuries sustained prior to July 26, 1982. The administration of these claims was transferred to the Government of the District of Columbia in July 1988.

b. Workers engaged in employment on overseas defense bases and employment under contracts with the United States, or an agency thereof, for public work to be performed outside the continental United States. (The Defense Base Act).

c. Workers involved in the exploration, development, removal, and transportation of natural resources from the seabed and subsoil of the Outer Continental Shelf. (The Outer Continental Shelf Lands Act).
d. Civilian employees of nonappropriated fund instrumentalities of the Armed Forces. (The Nonappropriated Fund Instrumentalities Act).
e. Civilian employees of contractors engaged in work covered by the DBA and exposed to war risks. (The War Hazards Compensation Act). Please refer to PM 0-200.6 for more information on the extensions of the Act.

6. Employment-Relatedness of the "Injury".

1. **Arising Out Of and In The Course Of**. A medical condition qualifies for benefits under the Act if it results at least in part -- by way of direct causation, aggravation, precipitation of symptoms, or acceleration -- from an "injury." Under the LHWCA, injury is defined as an accidental injury or death arising out of and in the course of employment, and an occupational disease or infection that arises naturally out of such employment or naturally or unavoidably results from such accidental injury. The phrase "arising in the course of employment" relates to elements of time, place and work activity. To occur in the course of employment, an injury must occur at a time when the employee may reasonably be said to be engaged in the employer's business, at a place where the employee may reasonably be expected to be in connection with the employment, and while the employee was reasonably fulfilling the duties of his or her employment or engaged in doing something incidental thereto. This alone is not sufficient to establish entitlement to compensation. The concurrent requirement of an injury "arising out of the employment" must be shown. The phrase "arising out of employment" relates to the element of causal connection, the requirement being that a factor of employment caused the injury.
2. **Injury**. The term "injury" has been further defined as a physical or psychological harm or pain (i.e, something wrong with the human frame). A

prima facie claim for compensation is established where the claimant shows that he or she sustained such harm or pain and that an accident occurred in the course of employment, or conditions existed at work, which could have caused that harm or pain. The Act stipulates, however, that compensation shall not be payable for injuries caused solely by the intoxication of the employee or for injuries which are deliberately self-inflicted (section 3(b)).

7. Causal Relationship of the Disability or Death. A disability or death is compensable if it results, even in part, from an employment-related injury (medical condition). An exception arises when the injured worker's intentional post-injury conduct, rather than a natural consequence of the employment-related injury, is an "intervening cause" leading directly to the worsened disability. An example of an intervening cause would be a game of volleyball during which an injured worker breaks an arm which had only been strained by a employment-related injury.

8. Benefits. Employees and their authorized dependents or survivors are entitled to benefits under the LHWCA in case of injury, disability or death as set forth in sections 6, 7, 8, and 9 of the Act. Definitions contained in section 2 of the Act, this PM Chapter, referenced opinions and decisions of the BRB and Courts, and Part 3 of the Procedure Manual contain guidelines and procedures for determining eligibility for benefits and services.

1. **Medical Services**.
    a. Under the provisions of the LHWCA, the employer is responsible for providing medical, surgical, and other attendance or treatment, nursing and hospital services, medicine, crutches, and apparatus for the duration of the injury or as long as the process of recovery may require. Sections 702.401-.422 of the regulations and Part 5 of the Procedure Manual further describe the medical services available to an injured employee and the procedures governing them.
    b. The 1972 Amendments to the LHWCA provided that the injured employee shall have the right to choose an attending physician authorized by the Secretary to provide medical care under the Act.
    c. Fees paid to such physicians or to others furnishing approved medical services are limited by the Act to the charges prevailing in

the community for such treatment, and are subject to regulation by the Secretary under section 7(g) of the Act and 20 C.F.R. section 702.413.

d. While all medical services and supplies must be furnished by the EC from the moment the injury or illness occurs, the injured worker must be at least partly unable to earn his or her full usual pay for at least three days before being entitled to compensation. If the injured worker returns to full work at any time up to seventy-two hours from the time the injury was incurred, the coverage provided is for medical services and supplies only, unless a permanent, partial disability covered by the section 8(c) schedule results.

2. **Disability Benefits**. The LHWCA provides compensation for several types of disability which are described below:

    a. Temporary Total Disability (TTD). When the employee loses pay in excess of three days, compensation for TTD is paid until the employee is able to return to work or is found eligible for permanent total or permanent partial benefits. This disability is compensated at 66 2/3 percent of the employee's average weekly wage (AWW) prior to the injury, subject to a weekly maximum. No compensation is paid for the first three days unless the disability lasts more than fourteen days. In such cases compensation is paid from the first day of disability (sections 6(a) and 8(b)).

    b. Temporary Partial Disability (TPD). If an employee returns to less than full-time, regular employment prior to reaching maximum medical improvement, that employee is entitled to weekly compensation payments at the rate of 66 2/3 percent of the wage loss during the period of reduced wages, not to exceed five years (section 8(e)).

    c. Permanent Total Disability (PTD). Employees who sustain injuries (including occupational diseases) which totally disable them for an indefinite period of time are said to be permanently totally disabled. Certain anatomical losses, described in section 8(a) of the Act, also

qualify an employee to receive compensation for PTD, in the absence of conclusive proof to the contrary. Compensation for such PTD is paid at 66 2/3 percent of the employee's AWW (established at the time of the injury), subject to the statutory weekly maximums. These payments are adjusted annually, effective October 1 (section 10(f)), to reflect the increase in the National Average Weekly Wage (NAWW). (See PM 3-202.)

d. Permanent Partial Disability (PPD).
    i. Schedule Disabilities. The Act contains a schedule (section 8(c)(1)-(20)) which provides benefits for various types of permanent partial impairments based on a number of weeks of compensation payable at 66 2/3 percent of the injured worker's AWW. These benefits are called a schedule award. The schedule covers total or partial loss or loss of use of the extremities and the functions of hearing and vision. Partial loss or loss of use of a part of the body listed on the schedule is compensated for a period of weeks proportional to the partial loss. For example, a worker with 10 percent loss of use of an arm receives 31.2 weeks of compensation (10 percent of 312 weeks). Payment of a schedule award is not contingent on actual wage loss.
    ii. Partial Loss of Earning Capacity. Where the injury is not covered by a schedule award but permanently reduces the worker’s earning capacity on the open labor market, compensation is paid at the rate of 66 2/3 percent of the loss of wage earning capacity (section 8(c)(21)). The most common type of injury in this category is a back injury.
    iii. Retiree Impairments from Occupational Diseases (section 8(c)(23)). The 1984 Amendments created a third category of permanent partial disability benefits. These benefits are for employees who have an occupational disease which did

not immediately result in disability and which became manifest after the employee had voluntarily retired. Benefits are based upon the claimant's AWW (or the NAWW) and are based upon the percent of whole person impairment found in the American Medical Association's **Guides to the Evaluation of Permanent Impairment**. (See 20 C.F.R. sections 702.601-603 and PM 3-400.)

3. **Death Benefits**.

    a. Death benefits are payable to certain dependents of those covered under the LHWCA if the injury causes death. Compensation includes reasonable funeral expenses up to $3,000. In addition, a widow or widower receives 50 percent of the decedent's average weekly wages subject to a maximum of 200% of the National Average Weekly Wage. Upon remarriage, the widow/widower receives a lump sum payment of two years' compensation, and children's benefits are increased as of the date of remarriage. (See PM 3-302.)
    If there is one or more children, an additional 16 2/3 percent is provided up to the maximum 66 2/3 percent of the employee's average weekly wage. If there is no widow or widower, the rate is 50 percent of the decedent's wages, for one child, increased by 16 2/3 percent for any additional children. The maximum benefit is limited to 66 2/3 percent of the decedent's average weekly wage. All children share the benefits equally (section 9(a) and (b)). The right to death benefit compensation is not affected by the subsequent adoption of the child or children of a deceased employee who had a statutory compensable death. There is no provision in Section 2(14) of the Act which could terminate a child's right to continued payments in this instance.

    b. Other eligible survivors include dependent brothers, sisters, grandchildren, parents, and grandparents. The first three types of beneficiaries are entitled to receive 20 percent, and the latter two, 25 percent. However, those beneficiaries are subordinate to the

widow/widower and children, and can only receive an amount not more than the maximum percentage allowable. Thus, a widow and child would preclude any other beneficiaries. A widow/widower only would decrease a dependent brother's share from 20 percent to 16 2/3 percent (section 9(d)).

c. Compensation to a surviving spouse terminates upon death or remarriage. Awards to children, brothers, sisters, and grandchildren terminate when they reach eighteen years of age or cease to be a full-time students under age 23, whichever is later (PM 3-202.5). Such compensation may be extended, however, if the child is incapable of self-support by reason of physical or mental handicap.

4. **Attendant Allowance**. Certain money may be paid for an attendant when the employee is seriously injured and unable to care for personal body needs or functions. Such allowance may be paid directly to the person providing the service.
5. **Rehabilitation Services**. The rehabilitation program provides permanently disabled employees with early referral to and the benefit of needed medical or vocational rehabilitation programs for their early return to work. (See Part 5 Chapter 12, and OWCP Rehabilitation Procedure Manual.)

Chapter 0-0400, Organization and Function

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1. Purpose and Scope. This Chapter describes the organization, function, and objectives of the Division of Longshore and Harbor Workers' Compensation (DLHWC); lists established delegations of authority; and describes the relationships of the Longshore Division within the Employment Standards Division (ESA).

2. Organization.

1. **National Office**. The OWCP is an office within ESA responsible for the administration of LHWCA as well as two other Federal workers' compensation laws (Federal Employees' Compensation Act (FECA) and Black Lung Benefits Act (BLBA)). The OWCP organization structure is depicted in Exhibit 1, PM 10-300 and its overall mission consists of planning and directing the LHWCA program, as well as the activities of the two other compensation programs. The main role of the Division of Longshore and Harbor Workers' Compensation (DLHWC) NO is to establish policies, regulations, and procedures for the administration and operation of the program. The Division's responsibilities also include: administration of the Special Fund; providing technical guidance and direction for the evaluation/adjudication of claims and benefits; conducting Accountability Reviews of DOs; and providing ADP technical support for the Longshore Case Management System (LCMS). Both OWCP and DLHWC interface with the Office of Management, Administration and Planning (OMAP) on matters of ESA objectives and program evaluations, and with the Solicitor's Office on such matters as legal advice, assistance, and opinions.
2. **Field Organization**. In the field, there are 12 District Offices (DOs) headed by District Directors and 1 Sub-District Office. The District Director (DD) reports to the Regional Director (RD), OWCP, for the Region in which the office is located. The RD is responsible for the administration of the LHWCA and DO operations in their Regions. The role of the DOs is to ensure that the provisions of LHWCA are carried out, to monitor and mediate claims made under the Act's provisions, and to provide outreach and educational services

to program participants. A list of addresses and telephone numbers of DLHWC DOs along with their territorial jurisdiction appears in Exhibit 2, PM 10-300.

3. Delegations of Authority .

1. The Assistant Secretary, ESA, has the delegation of authority for the LHWCA program as set forth in Secretary's Order (S.O.) 16-75. Employment Standards Administrative Order 78-1 redelegated authority for the execution of the program and activities of the LHWCA, as amended and extended, to the Director, OWCP.
2. **The Regional Directors** are assigned responsibility for all OWCP programs within their geographic jurisdictions.
3. **The Assistant Secretary, ESA**, retains authority for administrative management (ESA Order 1-75).
4. **The Claims Examiner's (CE)** activities involve the processing, monitoring, and adjudication of claims, and educational services. More specifically, they perform the following tasks:
    a. Review and respond to lost-time and no-lost-time injury reports, jacketed cases, and associated correspondence;
    b. Provide medical supervision and advise the DD concerning appropriate resolution of contested issues with respect to medical-benefits liability;
    c. Refer claimants for impartial medical examinations;
    d. Conduct informal conferences for controverted claims; make recommendations for solutions of unresolved issues;
    e. Prepare compensation orders for signature of the DD;
    f. Prepare unresolved controverted claims for referral to the OALJ;
    g. Inform carriers/employers of LHWCA requirements; and
    h. Provide education for participants through seminars and presentations.

    The DD has the ultimate and final responsibility for efficient operation

of the LHWCA DO, including the day-to-day case flow and quality of the adjudicative process by the CE.

4. Objectives.

1. **The overall objectives of the DLHWC** are to administer the LHWCA, to insure that the provisions of the Act regarding benefits for injured employees are properly applied, to promptly and impartially assist in the resolution of any disputes which may arise, and to refer cases for a formal hearing in a timely manner when a dispute subject to hearing cannot be informally resolved. In this regard, output goals and performance standards are established by the DLHWC to permit the evaluation of individual and DO performance toward the achievement of objectives (PM Part 9).
2. **The Office of Management, Administration and Planning** (OMAP) has primary staff responsibility for evaluation of ESA program operations and conducts regular reviews of such programs to assure quality control. On the other hand, the DLHWC conducts Accountability Reviews of DLHWC activities in DOs to ensure that uniform standards are being applied in the determination of entitlement and the provision of benefits and services.
3. **Performance Standards**. A full account of the DLHWC program of performance evaluation, periodic report requirements, and a detail listing of performance standards appears in Part 9 of the LHWCA PM.

5. Functional Statements.

1. **National Office**. In connection with job-related injuries and deaths sustained by employees eligible for benefits of the LHWCA and its extensions, the NO establishes program policies, regulations and procedures; and provides professional and technical guidance for claims and benefit payments, administration of the Special Fund, and technical assistance programs.
2. **District Offices** administer the LHWCA and its extensions, within the geographic boundaries as shown in Exhibit 2, PM 10-300. Specific functions and procedures are set forth in the PM pages that follow this Introduction.

6. <u>Administrative Management</u>. The Functions of budget, accounting, personnel, management systems, etc., are centralized within ESA and exercised in the DLHWC district offices through the DOL regional offices, the NO and OMAP. The functions encompass all operations of the DLHWC that are not directly concerned with the administration of the LHWCA, and include, among others, the following:

1. **Correspondence Management. The DOL Correspondence Guide (DLMS Handbook 1-2)** is to be used as a guide throughout the Department. For more detailed information concerning style and grammar, refer to the **U.S. Government Printing Office (GPO) Style Manual**. See the **Word Division Supplement** to the **GPO Style Manual** for quick reference regarding spelling and word division.
    a. Stationery for use by all DOL offices has been designed to provide a uniform style and format consistent with the **Graphic Communications Standards Manual**.
    b. A DLHWC correspondence guide covering written communications and frequently used forms is contained in Part 10 of the LHWCA Procedure Manual.
    c. A standard filing pattern has been developed and is to be used by all elements of the OWCP. Copies of the pattern are available from the Office of the Director, OWCP.
2. **Forms Management**. The DOL forms management program is described in Chapter 200 of the Departmental Directives System (DLMS 1). It requires the proper design and accurate use and the elimination of unnecessary or duplicate forms. It also prohibits the use of unauthorized forms or form letters. Forms, form letters and other formats approved for use within the DLHWC are described and illustrated in appropriate sections of the LHWCA PM.
3. **Records Disposition**. A records disposal schedule for the program records of the OWCP has been prepared by ESA. The DLHWC portion of this schedule is discussed in PM 1-502 and an extract from the schedule has been included as Exhibit 7, PM 10-300 to be used as a guide by Mail and Records personnel in the DOs in the disposition of records of DLHWC field installations.

a. Program Records are to be disposed of only in accordance with the schedule described above.
b. Administrative Records are to be disposed of only in accordance with the GSA General Schedules with other instructions provided by ESA.

Chapter 0-0500, LHWCA Communications and Directives

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6. Method of Issue	09/00	00-01
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9. Responsibilities	09/00	00-01
10. Clearance and Review	09/00	00-01

1. Purpose and Scope. This Chapter describes the communications and directives system authorized for the DLHWC. It establishes responsibilities and procedures for the issuance of policies, procedures, guidelines, and staff instructions applicable to the preparation, clearance, approval, and publication of those directives.

2. Authority.

1. **Federal Property Management Regulation** (FPMR) 101-11.209-3 requires, among other things, the establishment of agency directives programs that will:
    a. Establish and maintain a system for the classification, codification, and supplementation of agency directives.
    b. Document policies, standards, procedures, and standing instructions.
    c. Preserve directives as an integral part of agency documentation deserving permanent preservation.

d. Describe in writing the standards, guides, and instructions developed for the preparation, clearance, and issuance of directives.

2. **Departmental Regulations** (DLMS 1-100 and OWCP AM 1-100 and 1-101) require the DLHWC to maintain a directives management program in compliance with statutory, regulatory, USDOL, and other requirements.

3. Authorized Directives.

1. **External directives** which may consist of either formal or informal releases or other documents.
    a. Formal releases include Federal Register rules or notices pertaining thereto, and other written instructions which initiate or govern the actions, conduct, or procedures of the DLHWC and the public when involved with programs administered under the Authority of the Longshore Act as extended (20 C.F.R. Parts 701-704).
    b. Informal releases include Notices to Insurance Carriers and Self-Insured Employers. "One time" report requirements, notices of annual assessments and similar communications are also included.
2. **Internal directives** fall into three categories: permanent (or indefinite-until-superseded), temporary/one-time, and informational.
    a. Permanent directives include all standing instructions, policies, forms, form letters, guidelines, and procedures. They require specific performance or continuing activity and remain in force until rescinded or superseded and replaced. Included in this body of material are the following:
        i. LHWCA Procedure Manual (LHWCA PM), its component volumes, Parts, and supplements which are distributed by PM Transmittals.
        ii. LHWCA Program Memorandums (LHWCA MEMOS) which provide case histories, background, judicial rationale, and other details inappropriate for inclusion in a manual of procedural directives. LHWCA MEMOS clearly cite the PM

chapter provisions to which they refer. As new LHWCA MEMOs are issued, they are simultaneously accompanied by the issue of revised or new PM pages briefly stating the new decisions, criteria, or implementing procedures.

iii. Other guides include the **DOL Correspondence Guide, DLMS Handbook 1-2, the GPO Style Manual**, and other such guides as may be described in and authorized for use by the LHWCA PM.

b. Temporary/one-time directives are issued as LHWCA Bulletins. They require or invite action from two or more district offices, may concern Longshore and other ESA personnel, and are effective only until the required action is completed. Bulletins may involve one-time or special reports, pilot procedures, arrangements for training classes or rotating assignments over a specified period of time, or specific instructions affecting an EC whose business extends into more than one district. Bulletins must always bear an expiration date upon issue and a reference to any PM chapters affected. They may be discarded when expired or when required action is completed. Bulletins are published on blue letterhead.

c. Informational directives are issued as LHWCA Circulars. Circulars require no specific action and are used to transmit copies of preliminary legal decisions, announcements of personnel changes, interesting events or activities, or other items of informational value; to call attention to standing instructions or performance standards which may require compliance or improvement; to announce proposed plans or anticipated program changes; or to keep field offices informed of the activities and interests of the NO. Circulars are reproduced on white letterhead.

4. <u>Records Required</u>. The record copy of each directive issued by the DLHWC shall be retained in the Office of the Director, OWCP. The record copy shall be accompanied by essential supporting documents such as clearance forms and comments, and a copy of the document used to transmit the issuance,

appropriately coded and cross-referenced in accordance with the standard subject matter correspondence classification codes established for the OWCP.

5. Style and Format. The style and format of the LHWCA PM shall follow that illustrated in this Chapter. (Also see PM 10-300, Exhibit 3 for the format of the Bulletin, Exhibit 4 for the LHWCA Circular, Exhibit 5 for the format of an LHWCA Transmittal, and Exhibit 6 for the LHWCA Notice.)

1. **Margins**. Margins are as illustrated on this page.
2. **Page Headings**. The name of the Manual, the Part number and title, and the chapter number and title appear at the top of each page.
3. **Paragraphs**. The primary breakdown of the Chapter is the paragraph. Within each Chapter, each paragraph is designated by an Arabic numeral followed by a period. Each paragraph should be identified by a title typed two spaces after the number, in upper and lower case, and underlined. Paragraphs are subdivided as follows:
   1. Paragraph
   a. First Subdivision
   (1) Second Subdivision
   (a) Third Subdivision
   (ii) Forth Subdivision
4. **Exhibits**. Forms will be arranged numerically in PM Chapter 10-200 of LHWCA PM. They are numbered at the lower right corner and are paginated only when an Exhibit consists of more than one page, see PM 10-300. Illustrations, graphics, reprints, charts, and other exhibits will be contained in PM 10-300.
5. **Notices**. The style and format of LHWCA Notices to Insurance Carrier and Self-Insured Employers Under the Longshore and Harbor Workers' Compensation Act as Extended shall be as illustrated in Exhibit 6, PM 10-300.

6. Method of Issue. New and revised Chapters and pages of all Procedure Manuals are distributed by numbered PM Transmittals (Exhibit 5, PM 10-300) containing an explanation of the material transmitted, and filing instructions for the removal of any superseded pages and the insertion of new or revised pages. When the indicated actions have been completed, file the Transmittal sheet

behind the checklist which is located at the end of the List of Chapters in the front of the LHWCA PM.

1. **Changes**. Avoid the use of pen-and-ink changes. Use them only to change reference or form numbers or to correct typographical errors. For language changes, either minor or substantive, re-issue the entire page or chapter.
2. **Page Identification**. Each page will include the Part of the Manual and the Chapter title and number.

7. Reproduction and Distribution. This is provided by the Office of the Director, OWCP. hat office prepares the necessary printing requisitions and arranges for distribution to all manual holders. Distribution codes are structured to the number, level, and category of manual holders on a need-to-know basis.

8. Maintenance of Procedure Manuals. In each office or work place at which a Manual is maintained, one employee shall be given the responsibility of filing new material and maintaining it on an up-to-date basis.

1. **Filing Instructions** Procedure Manuals are subdivided into and maintained in separate volumes or binders by Part, chapter, and paragraph. Pages are numbered beginning with "1" within each chapter. Exhibits are filed numerically in Part 10. Specific filing instructions for each new group of pages is included in the PM Transmittal.
2. **Checklists** These are issued periodically identifying the chapters and pages currently in effect. Each checklist is cumulative and supersedes its previous editions. When a new checklist is received, the employee responsible for maintaining the PM shall:
    a. Remove and destroy PM pages not listed.
    b. Identify and obtain listed material which is not included in the Procedure Manual.
    c. Destroy the Transmittals which have accumulated behind the previous checklist. Keep only the latest checklist in the Manual.

9. Responsibilities.

1. **Development, Preparation, and Updating** The Branch of Policies, Regulations, and Procedures is responsible for:
    a. Preparing and updating standing instructions, policies, and procedures within their respective areas of program or administrative jurisdiction.
    b. Preparing and submitting to the Director, DLHWC, periodically:
        i. Updated checklists identifying the directives currently in effect.
        ii. A statement certifying that the directives for which they are responsible are accurate, complete, and current.
    c. Reviewing their various directives on a continuing and systematic basis to ensure that they are complete and up-to-date, identifying subject voids and recommending corrective action.
    d. Maintaining accurate and up-to-date statements of their assigned functions, polices, and procedures in the OWCP PM and the LHWCA PM.
    e. Preparing standing instructions that are easily understood, complete, up-to-date, and readily accessible on both a need-to-know and a need-to-act basis.
    f. Cooperating with the office of the Director, OWCP, in applying standards and achieving program objectives; soliciting comments and suggestions from field installations; consulting with SOL/EB when indicated; and coordinating with officials in other elements of the OWCP during the development or revision of material affecting their operations or instructions.
2. **District Directors** are responsible for ensuring that adequate copies of each appropriate Part of the LHWCA PM are available at work places where they are needed and that the designated employees keep the material up to date. They are also responsible for securing compliance with the provisions of the LHWCA PM within their respective areas of jurisdiction.
3. **Individual employees of the DLHWC** are responsible for following the procedures set forth in the LHWCA PM, and for recommending additions,

corrections, or other changes that will improve content or coverage, or make these directives easier to understand and more useful. Suggested improvements should be forwarded through appropriate channels to the Director, DLHWC.

10. Clearance and Review.

1. **Within DLHWC**. Certain personnel at both the NO and the DOs will be given the opportunity to review and comment on proposed changes or additions to the LHWCA directives.
2. **Outside the DLHWC**. Officials who originate DLHWC directives are responsible for clearing and coordinating them with other elements of the OWCP regarding procedures that might affect their operations; with the office of the Director, OWCP in applying standards for uniformity and consistency (OWCP PM 1-100.6b)); and with other offices (Office of the Solicitor, Office of the Secretary, ESA, OALJ) and other agencies (OMB, HHS, etc.)
3. **Federal Register**. DLMS 1-113c states that "The Solicitor is responsible for reviewing and clearing proposed directives concerning matters which require publication in the Federal Register and proposed issuances of legal significance or implications."

Chapter 0-0600, References

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3. Subject-Word Index	09/00	00-01
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1. Purpose and Scope. This Chapter provides a list of reference or resource materials which may prove useful in researching claims-related or program-related issues. These documents, which should be available to DLHWC claims examining staff, supplement the standard reference documents, i.e., the LHWCA, the regulations pertaining to the LHWCA, and this Procedure Manual.

2. Reference/Resource Materials.

1. **Longshore Desk Book**. This book was created by the BRB as a book of first reference to assist the BRB and its staff in deciding cases under the LHWCA, as amended, and its extensions. It takes a section-by-section approach to the Act and contains numerous BRB and court citations. (Note, however, that the decisions therein do not necessarily comport with the Director's administrative construction).
2. **Benefits Review Board Service - Longshore Reporter**. The multi-volume **BRBS - Longshore Reporter**, published by Matthew Bender & Company, provides comprehensive coverage of published BRB and court opinions and decisions, and some ALJ decisions, in LHWCA cases.
3. **The Law of Workmen's Compensation**. This treatise by Arthur Larson presents and discusses the primary principles and rules of workers' compensation. Generally, these principles and rules are common to the vast majority of workers' compensation laws. While this treatise focuses primarily on state workers' compensation laws (which generate the greatest amount of case law), significant federal court decisions concerning the LHWCA are included.
4. **The Merck Manual of Diagnosis and Therapy**. This manual discusses numerous medical conditions, disorders and diseases, generally in terms of their etiology, symptoms, diagnosis and treatment.
5. **Guides to the Evaluation of Permanent Impairment**. This reference guide is published, and revised from time to time, by the American Medical Association. It is used by physicians for rating the physical impairment of various organ systems. These ratings are used as the basis of PPD awards under the Act in hearing loss and retiree cases, and are also relevant (though not conclusive) in determining the extent of "loss of use" under the schedule provisions of section 8(c)(19).

3. Subject-Word Index. The Preface contains a subject-word index with appropriate eference to the PM, the LHWCA, and the regulations.

4. Definitions and Abbreviations. Chapter 0-601 contains the definition of terms frequently used in the processing of Longshore cases; however, it does not include terms which are specifically defined in the Act or the regulations, or which are defined or extensively discussed elsewhere in the PM. Chapter 0-602 contains a list of abbreviations frequently used in the LHWCA PM.

Chapter 0-0601, Glossary

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2. Exclusions	09/00	00-01
3. Terms	09/00	00-01

1. Purpose and Scope. This Chapter provides definitions of certain terms used in the LHWCA PM. In some cases, these definitions may differ slightly from legal definitions in current use.

2. Exclusions. Generally, this chapter does not contain terms that are defined in section 2 of the Act or in the regulations, or which are defined or extensively discussed in the LHWCA PM. The word index (located in the Preface) may be useful in locating definitions or discussions of such terms.

3. Terms.

- **Abnormality**. Describes a function which is no longer within the normal range in either of two dimensions. Abnormality can result from a quantitative loss of function or from a qualitative change in functional capacity. Reduced range of motion is a quantitative abnormality. Tremor, spasm, rigidity, hallucinations, etc., represent qualitative changes.
- **Act**. The Longshore and Harbor Workers' Compensation Act, as amended and extended by the DCCA, DBA, OCSLA, and NFIA.
- **Acupuncture**. The Oriental practice in which needles are inserted into specific peripheral nerves to relieve the discomfort associated with painful disorders, to induce surgical anesthesia, and for therapeutic purposes. Acupuncturists are not considered physicians under the LHWCA, but the treatment may be approved if authorized by a duly qualified physician.

- **Anatomical Abnormality**. A visible abnormality in tissue formation or growth. Scars, disfigurement, and joint disease are all examples of an anatomical abnormality. Visibility can be attained through x-ray, CAT scan, and other tests.
- **Appeal**. The process of seeking review by the Benefits Review Board of a decision and order issued by an Administrative Law Judge or, under certain circumstances, of a compensation order issued by a District Director. The term is also used to refer to the process of seeking review of a final order of the Benefits Review Board in the U.S. Court of Appeals for the circuit in which the injury occurred. In DBA cases where the injury did not occur within any "circuit," the appellate jurisdiction is in the circuit that includes the OWCP district where the claim was filed.
- **Claims Examiner**. An employee of the OWCP having special training and experience in the field of claims adjudication under the specific act to which the Claims Examiner is assigned.
- **Compensation Order**. A legal document in connection with a compensation case. Issued over the signature of an Administrative Law Judge or, under certain situations, over the signature of the District Director, acting as a Deputy Commissioner, the order describes the findings of fact and either makes the award or denies the claim. A compensation order may be the subject of a direct appeal to the Benefits Review Board.
- **Compliance**. Conformity of an employer or insurance carrier with the provisions of the Act. On the part of the employer this may include obtaining required insurance coverage, posting a notice of insurance coverage, and reporting injuries specified by the law. On the part of the insurance carriers, the term includes payment of benefits, providing for medical care, issuing a coverage card to the DO, or reporting and making payment of the company's assessment under section 44.
- **Controversion**. A formal denial of responsibility under the Act by an employer or insurance carrier. The denial may be based on the belief that the injury did not occur in the course of employment or did not fall within the coverage of the LHWCA, or for other reasons. In essence the employer or carrier is refusing

on the basis of legal merit to accept liability or the asserted extent of liability voluntarily. The denial also relieves the employer or insurance carrier of a 10 percent penalty, provided the controversion is made within the time specified by section 14(d) of the Act. In brief, controversion is a denial by the EC of a claimant's right to compensation (or compensation beyond an admitted amount).

- **Determinative Audiogram**. The “determinative audiogram” is that test which is determinative of the disability for which the Claimant is being compensated.
- **Disability**. The term is defined in section 2(10) of the LHWCA. It is important to note that, with certain exceptions, disability is an economic concept, and not solely a medical concept. (Also see "Impairment.")
- **Dispute**. A contested issue with respect to an essential element of a compensation claim; or, as used informally, any question or difference with regard to the entitlement or amount of compensation due a claimant, medical treatment, etc.
- **Eligibility/Entitlement**. As used throughout the LHWCA PM, "eligibility" refers to the benefits and services which may be made available to an injured worker or his/her dependents. Through the evaluation/adjudication process, a determination is made regarding specific benefits to which an injured worker is entitled. "Entitlement" is one of the end products of the evaluation/adjudication process.
- **Evaluation/Adjudication**. The process by which the CE, DD, or the ALJ may determine the rate, duration, or type of specific benefit or service to which a beneficiary is entitled and must receive.
- **Filing**. The submission of forms or records to the OWCP within a time period required by the various sections of the Act.
- **Functional Abnormality**. Describes a condition in which the physiological function is abnormal. Pain, tremors, and difficulties in speech secondary to brain lesions are examples of functional abnormality.
- **Functional Loss**. Describes a situation in which a physiological function can no longer be performed by the individual. It should be measured in quantifiable

terms. A loss need not be absolute; it can be partial. Loss of joint movement is an example of functional loss.

- **Impairment**. The loss, loss of use, or derangement of any body part, system or function. Impairment does not necessarily equate to disability since an individual could have an impairment but not be disabled from work. Statutorily, however, disability means impairment in the case of retiree occupational disease cases and hearing loss cases.
- **Impartial Specialist**. A physician, usually a medical doctor of outstanding capability and often certified in a specialty by a national board, selected to perform a medical evaluation or provide treatment of an injured employee when a medical question has arisen.
- **Informal Conference**. A meeting or telephone conference scheduled by the OWCP at which the employer and/or insurance carrier or their representatives are in attendance with the injured party or the claimant and/or his/her representative for the purpose of resolving any outstanding claim-related issue. The meeting is conducted by the CE or DD.
- **Loss of Wage-Earning Capacity**. A computation of economic loss which takes into consideration a claimant's age, degree of disability, education, work history, training, and the availability of work in the area in which the claimant lives. Payment of compensation based on such computation may continue for the life of the claimant. However, if the employment-related condition causing such a loss remains temporary, benefits are restricted to five years.
- **Lost-Time Injury Report**. Form LS-202 entitled "Employer's First Report of Accident or Occupational Illness" concerning a job-related injury or illness which causes the loss of one or more shifts of work.
- **Permanent**. A descriptive term for a medical condition indicating that it has become static or well stabilized and that it is not expected to remit within a normal, predictable period despite medical treatment.
- **Permanent Partial Disability**. A job-related physical or mental disability which is permanent in nature but it is established that the employee is capable of earning wages (i.e., it is established that the employee is working or that there are realistically available job opportunities within the geographical area where

the employee resides which he or she is capable of performing, considering the employee's age, education, work experience, and physical restrictions, and which the employee could secure if he or she diligently tried). In cases of “scheduled” permanent partial disability, the actual loss of earning capacity is irrelevant as long as it is less than total.

- **Permanent Total Disability**. A job-related physical or mental disability which is permanent in nature and renders the employee incapable of earning pre-injury wages at the same work as at the time of injury or in any other employment. A prima facie case of total disability is established where the employee shows that he or she cannot return to his or her regular or usual employment due to the work-related injury.
- **Schedule Award**. A payment of compensation for job-related injury resulting in permanent impairment of a scheduled member of the body defined by section 8(c)(1)-(20) of the LHWCA.
- **Secretary**. The Secretary of Labor, or his or her designee, or the person who has been delegated the authority to act for and on behalf of the Secretary.
- **Subrogation**. The right of one who has paid an obligation for which another has primary liability to be indemnified by the other (e.g., where a case results in an employee's receipt of compensation under an award which includes disability due to malpractice, an insurance carrier may have subrogation rights to the recovery of the employee against the physician, but limited to the amount actually paid by the carrier or for which it has become liable because of the malpractice).
- **Temporary Disability**. This term refers to a situation in which the individual is incapacitated to perform his or her regular work because of an anatomical or functional abnormality or loss, but where it is expected that recovery merely awaits a normal healing period.
- **Temporary Partial Disability**. A job-related physical or mental disability which is temporary in nature and renders the injured employee unable to perform the full duties of his or her regular job, but can perform some of the duties of his or her job or can perform the duties on a less than full-time basis, or can perform other suitable work during the recovery period and such limited, part-time, or

alternative work is actually reasonably available to him or her. Compensation payments are limited to a maximum of five years.

- **Temporary Total Disability**. Differs from temporary partial disability in that the employee is totally disabled and cannot perform the duties of his or her job.
- **Third Party**. A party or individual who is neither the claimant nor the employer, who causes the injury or disability to the employee, entitling the employee or his or her survivors to pursue a suit, claim or action to recover damages.
- **Third Party Suit**. A legal action usually instituted by the injured party against a party, other than the employer, whose tort against the employee caused the compensable injury or death. The employee may pursue a third party suit concurrently while receiving compensation from the employer or insurance carrier.

Chapter 0-0602, Abbreviations

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2. Abbreviations	09/00	00-01

1. Purpose and Scope. This Chapter provides a list of abbreviations frequently used in the LHWCA PM.

2. Abbreviations.

- **ADP** Automated Data Processing
- **ALJ** Administrative Law Judge
- **APA** Administrative Procedures Act
- **AWW** Average Weekly Wage
- **BLBA** Black Lung Benefits Act
- **BRB** Benefits Review Board
- **CA** Compensation Act (Generally used in form designation, e.g., CA-58)

- **CE** Claims Examiner
- **CEC** Claims Examiner Clerk
- **CFR** Code of Federal Regulations (Generally used when citing a specific regulation, e.g., 20 C.F.R. section 702.100)
- **CR** Claims Representative
- **DBA** Defense Base Act
- **DCCA** District of Columbia Workmen's Compensation Act (Also DCWCA)
- **DD** District Director
- **DI** Disability Insurance
- **DLHWC** Division of Longshore and Harbor Workers' Compensation
- **DMMI** Date of Maximum Medical Improvement
- **DO** District Office
- **DOL** U.S. Department of Labor
- **EC** Employer/Carrier
- **ESA** Employment Standards Administration
- **FECA** Federal Employees' Compensation Act
- **FLSA** Fair Labor Standards Act
- **FOIA** Freedom of Information Act
- **FR** Federal Register (Generally used in citing a specific page within a Federal Register volume, e.g., 46 FR 135)
- **LCMS** Longshore Case Management System
- **LHWCA** Longshore and Harbor Workers' Compensation Act
- **LS** Longshore (Generally used in form designation, e.g., LS-202)
- **LT** Lost Time
- **MEMO** LHWCA Program Memorandum
- **MMI** Maximum Medical Improvement
- **MWD** Minimum Wage Determination
- **NAWW** National Average Weekly Wage
- **NFI** Non-appropriated Fund Instrumentalities

- **NFIA** Non-appropriated Fund Instrumentalities Act
- **NIOSH** National Institute for Occupational Safety and Health
- **NLT** No Lost Time
- **NO** National Office
- **OALJ** Office of Administrative Law Judges
- **OCSLA** Outer Continental Shelf Lands Act
- **OD** Occupational Disease
- **OMAP** Office of Management, Administration and Planning
- **OMB** Office of Management and Budget
- **OSHA** Occupational Safety and Health Act/Administration
- **OWCP** Office of Workers' Compensation Programs
- **PM** Procedure Manual (e.g., LHWCA PM)
- **PPD** Permanent Partial Disability
- **PPI** Permanent Partial Impairment
- **PTD** Permanent Total Disability
- **RD** Regional Director, OWCP
- **RS** Rehabilitation Specialist
- **SSA** Social Security Administration
- **SSN** Social Security Number
- **TPD** Temporary Partial Disability
- **TTD** Temporary Total Disability
- **USC** United States Code (Generally used in citing a section with the Code, e.g., 33 U.S.C. section 921)
- **WHA** War Hazards Compensation Act

Chapter 1-0100, (Reserved)

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Chapter 1-0200, Mail

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8. Delivering Case Files	09/00	00-01
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10. Processing Outgoing Mail	09/00	00-01

1. Purpose and Scope. This Chapter of the PM describes the approved procedures for handling and processing mail in the DO, including receipt, sorting, and routing of mail. Offices with a small case load may be able to combine and simplify processing. However, any such changes require the approval of the DD or higher authority.

2. Mail Classifications. This paragraph describes the sources and primary classifications of incoming mail. Mail may be delivered to a central mail room from several different sources (e.g., the U.S. Postal Service, the Department's mail room, the regional mail office). The mail must be processed as expeditiously as possible, consistent with control practices and procedures. If indicated, a DO may obtain and use a post office box for the receipt of Longshore Program mail. If a post office box is used, mail should be picked up twice a day but no less frequently than once per day. Except for mail that has been opened by mistake, or wrongly delivered to another recipient, the mail room receives unopened mail. The following are the primary classifications of mail received in the DO:

1. **Priority Mail**. The term "priority mail" denotes incoming documents and correspondence requiring prompt action. This type of mail is identified with an "Expedite" tag or other appropriate notation and delivered to the specified recipient ahead of the regular mail. Mail from the following sources is considered priority mail:
    - The President and the White House Staff
    - The Vice President and members of his staff
    - Members of the Cabinet

- Members of Congress
- Governors of States
- Heads of employee organizations
- Heads of national and international labor organizations
- National Office correspondence
- Regional Director correspondence
- ALJ/BRB correspondence

Based on their content, documents and mail of the following types are also designated as priority mail:

- Hardship reports
- Requests for medical treatment
- Appeals
- Freedom of Information Act requests and correspondence
- Privacy Act requests
- Other mail for which there is a time requirement on action, such as subpoena actions and controverted cases

Priority mail, if it can be identified without opening the envelope, is delivered unopened to the DD. In other cases, the mail will not be recognized as priority until it is opened. Priority mail will, therefore, be found both in the sort of unopened mail and the opened mail. The Supervisor of the Mail and File Section will decide, in questionable cases, whether to classify the mail as priority.

2. **Injury and Claim Forms** (See also CH.1-300.5 and 1-400.3). A case file is created, or an action is taken, following receipt of one or more of the following:
   LS-201 - Employee's Notice of Injury and Claim.
   LS-202 - Employer's First Report of Injury.
   LS-203 - Employee's Claim for Compensation.
   LS-206 - Payment of Compensation Without Award.
   LS-207 - Notice of Controversion of Right to Compensation
   LS-208 - Final Payment or Suspension of Compensation.

LS-262 - Claim for Death Benefits.
Other - A combination power-of-attorney and claim executed by the attorney or representative and signed by the claimant or a medical report.
A case may be created based on receipt of an LS-207 or a medical report where there is information indicating that the case will present serious disputes or that lost time is likely.
The more frequently used LS forms received in the DO, including those referenced above and in the following subparagraph, are shown as exhibits in PM 10-200 and discussed elsewhere in this PM.

3. **Other Case-Related Forms**. The Mail and Files Section also receives other documents on which action must be taken. Some examples include:
   LS-207 - Notice of Controversion of Right to Compensation
   LS-570 - Card Report of Insurance.
   CA-58 - Request for Case File Transfer.
   Other - Medical and rehabilitation reports.
4. **Correspondence**. In addition to the above, correspondence of various types will be received in the DO. Generally, it will be addressed to a CE or the DD, or will carry a case number. In most instances, this mail is routed to the CE handling the block of cases in which the case number or alphabetical breakdown falls.

3. Initial Sort. The Mail Clerk or designated office clerk should first screen the unopened mail for the following types of correspondence:

1. **Priority Mail**. The priority classification of mail is dependent on its source and on the action that it calls for within the office. It is defined in subparagraph 2.a., above. Such mail is usually directed to the DD and is, therefore, forwarded unopened. All mail that can be identified as priority is date-stamped on the envelope, marked as "Expedite" by the mail room, and forwarded unopened to the DD for action.
2. **Personal Mail**. Correspondence addressed to a particular Claims Examiner or Claims Clerk should be handled with other mail unless it is marked "personal,"

"confidential," "do not open in mail room," or similar notation. Personal mail is delivered unopened to the addressee. Some mail so addressed can be identified as priority mail and should be so handled; it should be marked "Expedite" and delivered to the addressee.

3. **Misdirected Mail**. Mail which has been misdirected should be forwarded internally to other DOL offices or returned to the Postal Service.
4. **Other Mail**. This constitutes the bulk of the mail on the initial sort, and is opened and processed by the Mail and Files Section as described in the following paragraphs.

4. Opening/Date-Stamping Mail.

1. **Opening Mail**. All mail remaining after priority, personal, and misdirected mail has been appropriately routed is to be opened.
   (1) In opening the mail, care should be taken not to damage the contents or to leave part of the contents in the envelope.
   (2) While opening the mail, you may occasionally notice that some of the pieces do not bear a current date. This is very important in the case of report Forms LS-202 and LS-208. Therefore, before either destroying the envelopes or date-stamping the mail, look through these forms and check the reporting dates.
   (a) Form LS-202 or other report of injury must be filed by an employer within ten days of the date of the injury. The DOL considers the report timely if the envelope is postmarked within 10 days of the date of injury. The date of the report should be noted when the envelope is opened. If the reported injury occurred less than ten days prior to the date received, no further action is required. If there is any question, attach the envelope to the LS-202 or, if this cannot be done, annotate the LS-202 to show the date of the postmark.
   (b) Form LS-208, Final Payment, should also have the envelope attached (or bear an annotation as to the date of postmark) if sixteen days or more have elapsed since the date of final payment shown on the LS-208 form. In some cases, mail containing this form will be addressed to the DD and the envelope will be delivered without opening; in this case (if the sixteen day period allotted

has passed), the office of the DD is responsible for ensuring that the envelope is attached to the form or that appropriate annotation is made.

2. **Date Stamping Mail**. After opening, all mail is to be date stamped to show the date of receipt in the office. Carefully check the setting of the date-stamping machine. If a manual machine is used, date stamp any mail remaining from the previous day before changing the setting to the current date and stamping the current mail. In stamping, do not make any writing illegible. Stamp all Longshore Program mail on the front. The date may be stamped on the back of a form if it cannot be placed on the front so as to be legible.

5. Sorting Opened Mail. After date-stamping, sort the mail according to the following classifications:

1. Priority mail.
2. Unnumbered mail.
3. Numbered mail.
4. Insurance mail.
5. Rehabilitation mail.
6. Misdirected mail.
7. Mail containing checks, drafts or cash.

6. Processing Mail.

1. **Priority Mail**. Check priority mail against the LCMS for the proper identifying case number on a priority basis. For a description of priority mail, see subparagraph 2.a., above. Check the case file number even if it is shown on the correspondence to make certain that the number is correct. It is suggested that the LCMS Case Search Find function be used where there is no case number and that the Claims Tab be used where a case number is provided. When the case number is determined or confirmed, obtain the case file and deliver the mail to the DD.
2. **Unnumbered Mail**. Unnumbered mail should be routed to appropriate personnel for identification of the case number through the Case Search

function of LCMS. It is recommended that this mail be further separated into two subgroups -- injury report/claim forms and all other correspondence.

3. **Numbered Mail**. Arrange the numbered mail in numerical order. Numbered mail will include mail originally received as unnumbered to which the case number has been added after a search of the LCMS, and internal mail such as CE requests for specific cases because of, for example, expired case call-ups. Forward numbered mail to appropriate personnel for attachment to case files (see paragraph 7, below).
4. **Insurance Mail**. All mail relating to carriers, self-insured employers, new employers' records, and other mail identified as relating to identification and/or assignment of carriers is routed to the individual designated by the DD to handle insurance-related matters.
5. **Rehabilitation Mail**. Rehabilitation mail from claimants or from state or private rehabilitation workers or organizations is delivered to the Rehabilitation Specialist or other specified designee.
6. **Misdirected Mail**. Misdirected mail not identified in the sort of unopened or unnumbered mail should be forwarded to the correct DOL office or returned to the Postal Service, as appropriate.
7. **Mail Containing Cash**. Mail containing checks, cash, or any form of monetary remittance must be processed in accordance with the Department of Labor's accounting and control procedures. Before delivering mail containing cash, checks, money orders, etc., follow the procedures for cash receipts described in paragraph 9, below.

7. Attaching Numbered Mail. Based on the batch of numbered mail, the necessary files should be pulled and the mail attached (see also PM 1-500.3). Mail may be attached to the case jacket or drop filed inside the jacket, but not secured on the spindle. The cases are now ready to be forwarded to the appropriate Claims Examiner. Except for cases with priority mail going to the DD, a case file should go to the Claims Examiner assigned to that case. The Claims Examiner will determine the next disposition of the case file. There should be no access of unauthorized personnel to the case files so that files removed from the file room are generally at the appropriate Claims Examiner station.

8. Delivering Case Files. Following the sorting operation and the delivery of priority mail, routine mail is to be delivered as follows:

1. **Cases With Mail Attached/New Cases**. Deliver case files with mail attached and newly created cases to the CE handling that range of case numbers.
2. **Interoffice Mail**. Pick up interoffice mail from stations as delivery is made. Such mail should be processed (e.g., CE requests for case files with expired call-ups) or delivered to the appropriate station within the office.
3. **Remaining Mail**. Each day's mail should be processed the day it is received. Therefore, at the close of each day all mail received during the day should have been cleared from the mail room. If this is not possible, the remaining mail should be processed first on the following business day. However, it should bear the date stamp showing the date of actual receipt in the office.

9. Cash Receipts. All cash received in a district office shall be processed in accordance with the Department of Labor's accounting and control procedures. This includes recording all cash upon receipt, maintaining prescribed records, physically safeguarding cash while in their possession and obtaining receipts when transferring the cash to appropriate individuals or organizations for further processing. Therefore, the DD, the Mail and Files Supervisor and any other employees responsible for processing cash receipts shall be familiar with the Department's cash control procedures (see Department of Labor Manual Series (DLMS) 6, sections 910-918, Cash Control).

1. **Cash**. The term "cash" as used in these procedures refers to currency, coins, money orders, and any type of negotiable instrument.
2. **Priority Handling**. All cash received by a DO shall be given priority handling and shall be processed immediately. Where cash cannot be transferred immediately and must be kept in the office, it should be kept in a secure location.
3. **Sources of Cash**. Cash is received by a district office primarily in relation to the following matters:
   (1) Charges for reproduction and services under the Freedom of Information Act and Privacy Act.
   (2) Payment of penalties for late reporting, sections 14(g) or 30(e), and for

discrimination, section 48(a) of the Act.

(3) Death benefit payments under section 44(c)(1) when there is no survivor entitled to benefits.

4. **No Enclosure**. Occasionally, letters are received which make reference to cash enclosures, but do not contain the cash. When such letters are received, the mail clerk should write the following notation on the letter:

   CASH NOT ENCLOSED AT TIME OF RECEIPT
   IN THE MAILROOM _____
   (Clerk's Initials)

   The letter will then be referred to the Claims Examiner for appropriate response.

5. **Recording on the Cash Receipts Register (CRR)**. When the letters containing cash receipts have been separated from all others, each cash item is recorded on DL Form 1-301, Cash Receipts Register (Exhibit 56, PM 10-200). (Refer to DLMS 6, sections 915-916, Cash Processing, for detailed instruction on recording and maintenance of the CRR.) The pages of the CRR shall be maintained by the DO for a period of two years from the date of the last entry on each page, after which they may be destroyed. In addition, if the cash received is a penalty payment, appropriate entries shall also be made on the Penalty Log. (See PM 8-302.9.)

6. **Transferring Cash**. After cash receipts have been recorded on DL Form 1-301, they are grouped by routing destination and recorded on DL Form 1-303, Cash Transfer Receipt (Exhibit 57, PM 10-200). A separate Cash Transfer Receipt (CTR) is prepared for each receiving agency. (Refer to DLMS 6, sections 915-917, Cash Processing, for detailed instructions on the use of Form DL 1-303.)

   (1) Penalty payments under sections 14(g), 30(e) and 48(a) of the Act, as well as death payments under section 44(c)(1), shall be transferred, by means of the DL Form 1-303, to the Director, DLHWC, for deposit in the Special Fund. Cash receipts for reproduction and services under the Freedom of Information Act and the Privacy Act shall be transferred, also by means of DL Form 1-303, to the appropriate regional office for processing and deposit. Any questions

concerning the proper office to which a particular cash receipt is to be transferred shall be referred to the DD, or an individual designated by the DD, to make this determination.

(2) The DO shall maintain the original (white) copy of the DL Form 1-303 in a chronologically arranged file. When the signed receipt (pink) copy of the DL Form 1-303 is returned to the DO from the office to which the cash was transferred, it will be attached to the original (white) copy in the file. Each month the Mail and Files Supervisor, or other individual designated by the DD, shall review this file to determine if there are any receipt copies which are outstanding. If so, inquiry shall be made with the office to which the DL Form 1-303 was sent to determine if the cash was received.

(3) The original and receipt copies of the DL Form 1-303 shall be maintained on file for a period of two years after the date the form was prepared, after which they may be destroyed. This file, in conjunction with the Cash Receipt Register, will enable auditors to trace cash receipts from the time of initial receipt in the district office to receipt by the depositing organization.

10. Processing Outgoing Mail. Outgoing mail and packages should be delivered to the Mail Room preferably twice per day, but no less than once a day, for mailing. The mail is processed as follows:

1. **Registered and Certified Mail**. This mail is processed in accordance with the USPS regulations and procedures established in each OWCP office location.
2. **Regular Mail**. All envelopes must show the addressee's ZIP code. Some city post offices require a further separation of local mail from out-of-town mail.
3. **Window Envelopes**. Depending on staff and office practice, window envelopes may be used. As mentioned above, the addressee's zip code must be clearly readable.
4. **Packages and Heavy Envelopes**. All such mail must be securely wrapped and or taped.
5. **Mail Metering**. Mail meter machines have replaced franked postage which was previously used on outgoing mail. Some district offices share the use of a meter machine with a FECA district office. Longshore Mail and File personnel

are to follow their local regional office's procedures for accounting for program mail costs.

Chapter 1-0300, Index and Control

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5. Pending Correspondence File	09/00	00-01
6. LS-570 Insurance Cards	09/00	00-01

1. Purpose and Scope. This Chapter of the PM describes the methods by which communications are identified with related cases, how cases are located, and how various special situations are treated. The Longshore Case Management System (LCMS) provides various automated features, such as case search and case create, which are either essential to or particularly useful in accomplishing certain tasks in the mail and file section. Mail and file personnel must have a working knowledge of the LCMS.

2. Searching For A Case File Number.

1. **Case File Number**. The primary control on mail and case files is by the case file number assigned at the time the case is jacketed. The number distinguishes between similar accidents to the same employee or ones that have happened to individuals with similar names. It is important that unnumbered mail receive the correct file number, and that a new case be created only where a case for that employee and for that accident does not already exist.
2. **LCMS**. To determine whether a case file already exists for a particular injury to a particular individual, and if so, the correct case number assigned, click on the "Find" button on the "Claim" screen of the LCMS. The "Select Case" screen will be displayed. You can search by case number, name, date of injury, etc. Since an unnumbered injury report form (LS-202, LS-201, LS-203,

LS-208, and LS-262) may be a duplicate of or related to an already existing case file, it is recommended that these injury report forms be searched through the LCMS. This will avoid the effort expended in keying these reports into the LCMS Case Create function only to find that a case for that injury already exists. However, depending on staff, volume and workflow, all unnumbered injury report forms may be sent directly for processing through the LCMS Case Create function since this function will identify an already existing case. In using the LCMS Find function, in addition to the name on the document, check where possible for:

- Possible variations in the spelling of the claimant's name.
- The claimant's SSN and/or date of birth.
- The date of injury.
- The company involved (using the Employer Identification Number from the LCMS).

A careful check before a number is assigned will avoid later problems for the claimant, the carrier and the DO.

3. <u>Unnumbered Correspondence</u>. Unnumbered letter mail related to injuries or deaths should be searched against the LCMS. Unnumbered injury report forms are discussed in paragraph 5, below.

1. **Case Number Found**. Mail for which a LCMS case search shows there is a case file number will be so marked by placing the number in the upper right corner of the mail. The numbered mail is then forwarded to the File Clerk to be combined with other numbered mail for attachment to the appropriate case files.
2. **Case Number Not Found**. Mail for which no case number has been found will be so marked by placing the notation NR (for No Record) in the upper right corner of the mail. The mail will be forwarded to a Claims Examiner for a determination as to the disposition of the correspondence. A possible disposition is for the CE to return the correspondence to the Mail and Files

Section for placement in a Pending Correspondence File (see paragraph 6, below).

4. <u>Unnumbered Injury Report Forms</u>. Most cases start with the receipt of the LS-202 form; LS-201, LS-203, and LS-262 forms from employees or dependents and the LS-208 are generally matched with the LS-202 report when the case file is assembled. Separate the injury reports submitted on these forms into the categories discussed below. All new lost time or death reports, and Forms LS-201, LS-203, LS-208 and LS-262 (whether reported as no lost time injuries or not so reported at this time), will be processed as indicated in this paragraph, and docketed as described in PM 1-400.
Also note that a case may be created based on receipt of an LS-207 or a medical report where there is information indicating that the case will present serious disputes or that lost time is likely.

1. **Lost Time (LT) Injury (Disabling Injury)**. A LT injury (reported on Forms LS-201, LS-202, LS-203, LS-208 and LS-262) is an injury which results in death or loss of time from work beyond the day or shift of injury. Unnumbered injury report forms should be checked through the LCMS Find function to see if the injury was previously reported.
    a. If a case file number is found, place the file number in the upper right corner of the form and send to the file unit to be attached to the case file.
    b. If the injury has not been previously reported, so indicate on the form by making the notation NR in the upper right corner and forward the form for docketing and jacketing.
2. **No Lost Time (NLT) Injury**. These reports are considered not to qualify as claims or cases. Note, however, that where an injury results in no loss of time from work but leaves an employee with a permanent impairment compensable under the schedule (i.e., section 908(c)(1)-(20)), a case should be created (The rationale for this policy is explained in Industry Notice No. 63, May 8, 1987. Please call the National Office if you need a copy of Industry Notice No. 63). Where there is no time lost and no evidence of either disfigurement, PPD, or occupational disease, such injury reports should be destroyed. However, if it is the experience of the district office that a significant number of initial NLT

reports received from a particular employer or carrier are subsequently reported as lost time injuries, the district office may file such NLT reports in a Pending Correspondence File (see paragraph 6, below). NLT injury reports filed in the Pending Correspondence File differ from the questionable reports described below in that for the NLT injury report there is no evidence indicating possible lost time, permanent partial disability, disfigurement, or occupational disease. Placement of these reports in the Pending Correspondence File should be based primarily on the DO's experience with particular employers and/or carriers subsequently submitting lost time reports.

3. **Questionable No Lost Time Injury**. A questionable no lost time injury is one where the injury report shows no lost time, but other information or evidence gives reason to believe there may be justification for a lost time, permanent partial disability, and/or disfigurement case. Injury report forms for such injuries should be searched through the LCMS.
    a. If a case file number is found, place the file number in the upper right corner of the form and send to the file unit to be attached to the case file.
    b. If the injury has not been previously reported, so indicate on the form by making the notation NR in the upper right corner and forward the form for docketing and jacketing. In making the decision to forward the report for docketing and jacketing, it should be remembered that there should be evidence indicating a lost time, permanent partial disability and/or disfigurement case. If there is any question as to whether the report should be docketed and jacketed, the matter should be referred to the Mail and Files Supervisor or other designated individual for resolution.

5. <u>Pending Correspondence File</u>. Depending on each DO's experience and need, correspondence for which there is no number, but where a case file is likely to be created, may be placed in a Pending Correspondence File. Correspondence should be filed alphabetically by the name of the potential claimant wherever possible, otherwise by the author of the correspondence. This file should be reviewed periodically to determine whether a case has been established for any of the correspondence; if so, the correspondence should be

numbered and associated with the correct case file. The file should also be purged periodically (e.g., every six months) and correspondence older than six months, for which no case file exists, should be removed and destroyed. The types of correspondence which may be placed in this file include:

1. **No Lost Time Cases**. Those NLT cases which the office believes will subsequently be reported as lost time (as discussed in subparagraph 5b, above) may be placed in this file.
2. **Unidentified Mail**. There will be occasions when mail is received without the full name of the employee and the mail cannot be returned. This mail may be placed in the Pending Correspondence File. Usually, other correspondence will follow which will identify it and allow for the matter to be resolved. When searching for mail which may be needed and there is reason to believe that it has already been received by the office, refer to the Pending Correspondence File.

6. LS-570 Insurance Cards. Insurance coverage by employers is recorded on LS-570 cards (Exhibit 52, PM 10-200). The file of LS-570 cards is kept by the individual designated by the DD to process or handle insurance-related matters. Authorization for issuance of the cards, their verification, and maintenance of the files is covered in Part 7 of the Procedure Manual. Where there is an individual designated to handle insurance-related matters, annotation of the carrier identification is the responsibility of that individual. All insurance correspondence is delivered to the individual designated by the DD to discharge this responsibility.

Paragraph and Subject	Date	Trans. No.
Table of Contents	09/00	00-01
1. Purpose and Scope	09/00	00-01
2. Establishing A Case File	09/00	00-01
3. Duplicate Cases	09/00	00-01
4. Multiple Claims for One Injury	09/00	00-01
5. Additional Hearing Loss Claim	09/00	00-01

1. Purpose and Scope. This Chapter of the PM is concerned with the procedures and requirements for creating, assembling, and maintaining the files for individual claims by the Mail and Files Section. The CE makes decisions concerning the claim and actions to be taken; these are discussed in Part 2 of this Manual.

2. Establishing A Case File. Reports of injury are docketed and jacketed if they contain a Form LS-202 reporting a lost time injury or a death. They may also be docketed and jacketed if they contain a Form LS-201, LS-203, LS-206, LS-208, or LS-262, regardless of whether the injury was reported as a no lost time injury (see PM 1-300.4), or if the injury is reported as NLT but there is evidence indicating lost time, permanent partial disability, occupational disease, and/or disfigurement (see PM 1-300.4c). Also, A case may be created based on receipt of an LS-207 or a medical report where there is information indicating that the case will present serious disputes or that lost time is likely. The creation of a case file signals the beginning of claims processing activity. Opening a case file does not establish eligibility for compensation, but signals that there is a possibility of eligibility. The docketing and jacketing process requires judgment. The Mail and Files Supervisor, or other experienced person designated by the DD, shall have the responsibility of determining which injury reports need not be docketed and jacketed, and which need verification of insurance coverage. All questionable cases shall be referred to the designated individual.

1. **Docketing**. Docketing a case means assigning a case file number through the LCMS Case Create Function. Case file numbers include one or two digits indicating the district office number and up to six digits for the sequential number assigned to the case by the Case Create function (e.g., 01-234567).
2. **LCMS Data Entry**. Most of the data to be entered during the case creation process is taken directly from the injury report form. However, the Employer ID and Carrier ID sequence numbers are not provided on the injury report forms. To facilitate identification and data entry of these numbers, a current LCMS printout of the district office's employer and carrier listings should be readily available to case create personnel. So as to avoid potential future problems, it is important that care be taken to enter case creation information accurately and correctly into the LCMS.
3. **Jacketing**. Jacketing a case means placing the injury reports and related documents in a folder bearing the case number assigned during the docketing process.

4. **Mailing Labels, LS-504 and Case Call-Up**. Docketing injury reports through the LCMS Case Create function will result in the automated production of a LS-504 which advises the claimant of his or her rights, and a letter addressed to the employer/carrier advising them of the case number. The LCMS will also automatically establish a thirty day call-up for subsequent CE review of the case.
5. **Timeliness of Case Creation**. It is imperative that all cases be docketed and jacketed as soon as possible after reports are received. In all instances they must be docketed and jacketed within 7 days of the date of receipt.
6. **Routing**. After the new cases have been docketed and jacketed, they should be sent to the CE as designated by local office procedure. Usually the last two digits of the case number determine the CE who will receive the case, but there are other acceptable methods of assigning cases to CEs.

3. <u>Duplicate Cases</u>. There are occasions when, through error, two cases are made for the same injury. After confirmation by the Mail and Files Supervisor or other designated individual that duplicate files have in fact been created, the following actions should be taken:

1. **Merge the File Material**. All correspondence, forms, etc., in the case with the higher file number should be renumbered and attached to the inside front cover of the case with the lower file number.
2. **Delete the Case From LCMS**. Delete the higher number case from the LCMS using the LCMS Case Delete function. It should be noted that use of the Case Delete function is limited to the DD.
3. **Notification of Deletion**. Since the claimant and EC were notified of the assignment of the case number, correspondence should be sent to both advising that the higher number case was found to be a duplicate of a previously created case, that all correspondence and forms already on record have been placed in the earlier case file, and that all future correspondence should refer only to the lower number.
4. **Reissue the Folder**. The higher number case folder should be reissued to a new case as soon as possible Creating a new case using the previously used

case folder must be done through the LCMS Supplemental Screen, Case Create.

4. Multiple Claims for One Injury. Occasionally, multiple claims by one employee for a single injury may be filed against several employers. Only one case should be created for the injury. Specifically, when an injury to a claimant (e.g., asbestosis or hearing loss) results in claims against several employers, a determination should be made as to which is the last responsible employer and only one case should be created, using that employer. If other employers are joined, enter their names on the Notes Tab on the Claims Screen in the LCMS. If later it is determined that another employer is the responsible employer, simply update the case record using the Basic Data Screen. Where it cannot initially be determined which employer is the responsible employer, leave this field blank when creating the case, since it is not a required field. This information may be added later as appropriate.

5. Additional Hearing Loss Claim. Whenever there is a new claim for additional hearing loss, a case file should be created (cross reference should be noted in each case file). Keep in mind that this is different from the situation where an employee files a number of claims against multiple employers for the same injury (hearing loss or other type of injury). In that situation only one case should be created (See Chapter 1-400.4., above).

Chapter 1-0500, File Maintenance

Paragraph and Subject	Date	Trans. No.
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1. Purpose and Scope	09/00	00-01
2. Case Classification	09/00	00-01
3. Filing Cases	09/00	00-01
4. Searching	09/00	00-01
5. Recall Mail	09/00	00-01
6. Old Mail	09/00	00-01
7. Requirements For Filing Cases	09/00	00-01
8. Filing Materials In The Case Folder	09/00	00-01
9. Repair of Files	09/00	00-01

1. Purpose and Scope. This Chapter describes the case files in the DO, the manner in which they are maintained, searched, and repaired; and the procedure for changing from open to closed status.

2. Case Classification. Case records in the district office fall into one of the two following basic classifications:

1. **Open Case**. This case is one in which some action is expected or a time period for closing has not run. This is the basic active file. Cases remain in this status until they are closed by the CE.
2. **Closed Case**. Cases in this classification are those that have been closed by the CE, but have not been sent to the Federal Records Center for storage. At the time the case is closed, the CE should update the Case Status and Case Type in the LCMS. This should be done on the LCMS Claim Screen. The LCMS Case Type codes are as follows:
    a. No Lost Time
    b. 3 or Fewer Days Lost
    c. More Than 3 Days Lost
    d. Death
    e. Other

3. Filing Cases. Prior to the introduction of the LCMS, open and closed cases were filed separately in the file room. This was necessary for the compiling of data for management reports and it facilitated the shipment of cases to the Federal Records Center according to the established retirement schedule. The LCMS now provides an automated capability of identifying open and closed cases, and district offices are no longer required to maintain separate open and closed files. Attaching mail is also facilitated since there is only one file room location for cases. With few exceptions case records shall be maintained in the file room. Exceptions include active cases which are being reviewed in another part of the office by district office personnel, and case records removed from the office (e.g., transferred to another DO or to the NO).

4. Searching.

1. **Numbered Mail**. Numbered mail will be checked against the cases in the file room, placing the incoming mail connected with each case inside the appropriate folder. The folder will be removed from the file and routed for action.

2. **Routing and Delivery**. The case files with attached incoming mail will be delivered to the appropriate claims examiner assigned to each group of claim numbers as determined by the individual office.
3. **Search List**. A search list of remaining mail will be prepared at least weekly, listing the file numbers in numerical order. All cases in the office not in the file room will next be searched from this list.
4. **Conducting the Search**. All locations in the office should be searched for cases with outstanding unattached mail. When a case is located for which mail has been received, the mail should be placed in the case folder and given directly to the responsible individual or placed in a location where the responsible individual will be aware of incoming mail which requires his or her attention.

5. Recall Mail. Mail for which no jacket has been located after a complete search of the files and desks of the office is designated as recall mail. It is interfiled with the next day's mail to be searched again.

6. Old Mail. At the end of each week, all unattached mail should be screened prior to interfiling with the next new mail group. Any expedite mail which has been in OWCP five or more working days should be given to the Mail and File Supervisor for special searching for the related cases.

7. Requirements For Filing Cases. A case is not to be filed if it contains loose mail. If there is loose mail in the case, the case should be returned to the responsible examiner for appropriate action.

8. Filing Materials In The Case Folder.

1. **Initialing and Dating Documents**. Claims Examiners and all other personnel with the responsibility for filing forms, reports, correspondence, etc., in the case file are responsible for initialing and dating all pieces of mail which they add to the case file. The notation will be made in the upper right hand corner of the first page of the document.
2. **Filing Order**. Generally, no reports or correspondence should be placed on the fastener until appropriate action has been completed. Mail and other material should be filed in chronological order based on date of receipt, except

that the LS-202 is always filed at the bottom. The file copy of a response should be placed on top of the reports or correspondence to which it pertains.

3. **Duplicate Material**. Copies or duplicates of forms, letters, medical reports, or other correspondence already on file should not be added to the case file. It is important to ensure that they are identical copies and not updated or revised versions of the earlier material. An exception to the rule of not adding duplicate records to the case file would be copies submitted by different parties. Such copies should be retained since they would be a part of the other party's evidence.

9. <u>Repair of Files</u>. With use, material in the case files and the case file folders can become damaged and could be made illegible. It is the responsibility of the Mail and Files Section to maintain the integrity of the case files.

1. **Loosened Pages**. In any instance where material has torn loose, partially or totally, from the fastener, repair or strengthen the page with a gummed or self-adhesive reinforcement or transparent tape, or by other appropriate and effective method.
2. **Torn or Damaged Pages**. Mend torn or damaged documents if possible. If mending is not sufficient, and there is a possibility of further damage, it may be necessary to photocopy the damaged document in order to have a serviceable copy in the file.
3. **Spilled/Disassembled Cases**. In the event that cases are dropped and spilled, or are disassembled (e.g., for photocopying purposes), make sure the contents are replaced in the proper folders and in the proper chronological order, with the LS-202 on the bottom.
4. **Damaged Case File Folders**. In all instances of damaged folders, the entire case file is to be referred to the Mail and Files Section for repair or replacement. Such repair or replacement is not to be performed other than by the Mail and Files Section.

Paragraph and Subject	Date	Trans. No.
Table of Contents	12/15	16-02
1. Purpose and Scope	12/15	16-02
2. Statutory and Regulatory Authority	12/15	16-02
3. Request for Transfer	12/15	16-02
4. Transfer Actions	12/15	16-02

1. Purpose and Scope. Newly filed claims are created within the jurisdiction of the compensation district in which the injury or death occurred (with some exceptions for Defense Base Act claims). This chapter describes the guidelines and procedures used in transferring files from one District Office to another after the case has been created.

2. Statutory and Regulatory Authority.

1. **Statutory Authority**.
    a. 33 U.S.C. §§ 12(a) and 13(a) state in pertinent part:
    b. Notice of an injury or death in respect of which compensation is payable under this Act shall be given … (1) to the deputy commissioner in the compensation district in which the injury or death occurred…
    c. … [T]he right to compensation for disability or death under this Act shall be barred unless a claim therefor is filed … with the deputy commissioner in the compensation district in which such injury or death occurred.
    d. 33 U.S.C. § 914(h) provides in part:
    The deputy commissioner (1) may upon his own initiative at any time in a case in which payments are being made without an award, and (2) shall in any case where right to compensation is controverted, or where payments of compensation have been stopped or suspended, upon receipt of notice from any person entitled to compensation, or from the employer, that the right to compensation is controverted, or that payments of compensation have been stopped or suspended, … take such further action as he considers will properly protect the rights of all parties.

e. 33 U.S.C. § 939(b) provides in part:
The Secretary shall establish compensation districts … and shall assign to each such district one or more deputy commissioners.

2. **Regulatory Authority**. 20 C.F.R. § 702.104 states,
    a. (a) At any time after a claim is filed, the district director having jurisdiction thereof may, with the prior or subsequent approval of the Director, transfer such case to the district director in another compensation district for the purpose of making an investigation, ordering medical examinations, or taking such other action as may be necessary or appropriate to further develop the claim. If, after filing a claim, the claimant moves to another compensation district, the district director may, upon request by the claimant or the employer and with the approval of the Director, transfer the case to such other compensation district.
    b. (b) The district director making the transfer may by letter or memorandum to the district director to whom the case is transferred give advice, comments, suggestions, or directions if appropriate to the particular case. All interested parties will be advised of the transfer.

3. <u>Request for Transfer</u>. While the District Director has the authority to transfer a case at his/her discretion as outlined in 20 C.F.R. 702.104(a), a case will not routinely be transferred based solely on a claimant's change of address. A written request for transfer from the claimant or the authorized representative should normally be received prior to the transfer.

1. Transfer requests should be based on a claimant's change of physical address so that the case is moved within the jurisdiction where the claimant currently lives. This allows for ease of administration with regard to services provided such as vocational rehabilitation.
2. A written request should be received from the claimant or his/her representative requesting the transfer. If the claimant moves to another compensation district and requests that the file be transferred to the district in which he/she currently lives, the request for transfer will usually be honored.

3. If an employer requests that a case be transferred, but the claimant does not, the claimant should be consulted prior to the transfer. The District Director (or designee) will then evaluate the request and response from the claimant prior to deciding whether to transfer the case.
4. Requests to transfer a case to a district other than the district in which the claimant resides will typically not be honored except in exceptional circumstances. For instance, a request to transfer the case solely for the convenience of an authorized representative will generally not be honored.

4. Transfer Actions. Upon receipt of a request to transfer the case to another district, the District Office administering the case will evaluate the request. If the District Director (or designee) finds the request to be appropriate, the case will be prepared for transfer. The transfer of files is to be initiated by the District Office having jurisdiction of the case.

1. Pending Actions. Prior to transfer, the District Office should insure that all required actions have been completed. A file is not to be transferred when outstanding adjudication actions have not been completed that can be completed by the District Office initiating the transfer.
   The District Director (or designee) making the transfer may give advice, comments, suggestions, or directions, as deemed appropriate, to the District Director to whom the case file is being transferred.
2. Case File Transfer Form. If there is a paper component to the file, a Case File Transfer Form, CA-58 (or equivalent) should be completed to show that the case file is being permanently transferred. After completion, the form should be placed into the imaged file and a copy should be attached to the outside of the paper case file. If the case is fully imaged this documentation is not needed.
3. Notification to Parties. The District Office should notify the claimant, attorneys and parties of interest that the case is being transferred and provide the contact information for the new District Office. The letter should be added to the case file before the transfer action is completed.
4. Longshore Case Management System (LCMS). When a case is transferred to another office, the originating office must change the LCMS case status to

"Transferred" and the case location to reflect the receiving office. Once this occurs, the imaged portion of the file will be available to the new district office. The new district office must then update the case status in LCMS as appropriate.

5. Mailing. Paper cases must be sent via certified mail or some other method that allows for tracking receipt. The tracking documentation should be placed into the imaged portion of the file prior to transferring the file.

Chapter 1-0502, Records Disposal

Paragraph and Subject	Date	Trans. No.
Table of Contents	09/00	00-01
1. Purpose and Scope	09/00	00-01
2. Procedures	09/00	00-01
3. NLT Cases and Index Cards	09/00	00-01

1. Purpose and Scope. This Chapter describes the requirements for transfer of inactive files and records, the time periods for which they must be held, and the responsibility for their disposition. The authority for storage and disposal is given in the OWCP Records Disposal Schedule for program records and in the GSA General Schedules for administrative records.

2. Procedures. A records disposal schedule for the program records of the OWCP has been prepared by ESA. A summary of that schedule is shown as Exhibit 7, PM 10-300.

1. **Program Records**. These records are to be disposed of in accordance with the schedule which is summarized as Exhibit 7, PM 10-300.
2. **Administrative Records**. These records are to be disposed of in accordance with the GSA General Schedules and with other instructions provided by ESA.

3. NLT Cases and Index Cards. The following clarifications concern the OWCP Records Disposal Schedule as it pertains to no lost time cases and to index cards.

1. **No Lost Time (NLT) Cases**. It is current policy that reports of no lost time injuries are not to be jacketed or retained (see PM 1-300.5). The guidance on

disposal of such reports is applicable only to those NLT cases which may have been jacketed or otherwise retained in the past.

2. **Index Cards**. With the implementation of the automated Longshore Case Management System (LCMS), index cards are no longer created for new cases. The guidance on the disposal of index cards is applicable to those cards retained for older cases not entered in the LCMS.

Chapter 1-0600, FOIA and Privacy Act Requests

Paragraph and Subject	Date	Trans. No.
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1. Purpose and Scope	09/00	00-01
2. Authority	09/00	00-01
3. Policy	09/00	00-01
4. Definitions	09/00	00-01
5. Responsibilities	09/00	00-01
6. Coverage	09/00	00-01
7. Processing Requests	09/00	00-01
8. Records and Reports	09/00	00-01
9. Routine Uses	09/00	00-01
10. Subpoenas	09/00	00-01

1. Purpose and Scope. This Chapter implements the regulations of the Department of Labor regarding 5 U.S.C. section 552, the Freedom of Information Act (FOIA) and the Privacy Act, 5 U.S.C. section 552a, as amended. It establishes the responsibilities and provides guidance for compliance with these Acts in accordance with provisions of Employment Standards Administration (ESA) Manual 4-100. The Office of the Solicitor or Regional Solicitor should be consulted for further guidance required on these matters.

2. Authority. DLMS 5-200/300, ESA Manual 4-100, and 29 C.F.R. Parts 70/71 establish the policies and procedures for the implementation of the FOIA and Privacy Act within the DOL and ESA. The responsible officials within the LHWCA to whom authority for release of information has been delegated are indicated in paragraph 5, below.

3. Policy.

1. **Organization of Records**. All records shall be placed in such order as to facilitate the identification of records of concern to the public under the Freedom of Information Act (FOIA) and Privacy Act.
2. **Aid to Those Seeking Information**. ESA will not only comply with the terms of proper requests under the FOIA and Privacy Act but will seek to assist members of the public who have misdirected their requests out of a lack of knowledge of pertinent information systems. Pursuant to the FOIA Amendments of 1996, “Reading Room Records” (i.e., final adjudicatory opinions, specific policy statements, staff manuals) created on or after November 1, 1996, are being made available on DLHWC’s internet Home Page.
3. **Press Releases**. In instances when information disclosed under the FOIA is of general interest, ESA will cooperate with the Office of Information, Publications and Reports and the Regional Information Officers in the preparation and release of an announcement when appropriate.
4. **Statistical Data**. Permission may also be granted by OWCP National Office for release of documents or information in district office files in connection with a study being conducted for a legitimate purpose by another agency of the U.S. Government or a contractor of the U.S. Government provided the information is to be used as statistical data about a particular aspect of the agency's work and safeguards are maintained to prevent the identification of any individuals whose files are included in the study, or the disclosure of personal information in the individual records.
5. **Personal Information**. LHWCA case records are non-public since they contain personal information which may be released only to parties in interest in specific cases of injury or death. All documents contained in LHWCA claim files are covered by the Privacy Act system of records entitled “DOL/ESA-15 Office of Workers’ Compensation Programs, Longshore and Harbor Workers; Compensation Act Case Files.” As a general matter, therefore, disclosure of any documents contained in a LHWCA claim file may be made only in accordance with that Act. Disclosure may be made to the subject of the file (the claimant) and to those persons or entities specified in the routine uses

applicable to DOL/ESA-15. See 58 Federal Register (FR) 49,599-600 (September 23, 1993), and the universal routine uses applicable to all DOL systems of records set forth at 63 FR 2,417-18 (January 15, 1998).

6. **Internal Communications**. Internal memoranda between DOs and the National Office are not to be released to parties outside the Department. This is particularly important in cases involving section 8(f) relief. Such memoranda between the DO and the National Office or the DO and the Regional Solicitor's Office contain information on the Department's handling of a particular section 8(f) application. Since this application may be the subject of a formal hearing, it is not appropriate to reveal the Department's views on the evidence submitted in support of the application or any possible litigation strategy. Therefore, these documents are to be considered privileged correspondence and are not to be released to any party

   It should be noted that internal memoranda should not be released in response to a request submitted under either the FOIA or the Privacy Act. The FOIA provides that requests that reasonably describe records in the custody of the agency are to be disclosed unless they fall within one of the nine exemptions to the FOIA. Exemption five (5) provides that staff opinion material found in internal memos, letters, recommendations and any nonfinal pre-decisional material up until the final action taken by the person with the legally delegated authority to take final action is exempt from disclosure. The findings of the responsible federal employee are factual material, not opinion and may be released.

7. **Copying of Records**. The Privacy Act provides the individual who is the subject of the records with the right to inspect or copy those records. If the individual requests a copy of a record under the Privacy Act, the first copy is made available to the requester or an individual designated by the requester at no charge. In addition, no charges will be assessed for the time spent searching for the record pursuant to a Privacy Act request. Copies of the record may be made by the requester in the DO on the DO copying machine or the record may be copied by DO personnel. However, the record should not be sent out to be copied by a private copying service, nor should employees of

such a private copying service be permitted to copy records on district office copying equipment. Employees of private copying services are not permitted access to records collected and maintained in Privacy Act systems. Access to such records is limited to the individual who is the subject of the record, such person's parent or guardian if the person is a minor or has been declared incompetent, or to the representative designated by such individual. Requirements for identification are contained in 29 C.F.R. section 71.5.

4. Definitions.

1. **Request**. To come under the FOIA or the Privacy Act, a request must be for an existing record. It is not necessary to create a record in response to a request. The request should be in writing.
2. **Public Record**. The FOIA covers records that are considered public. Nine specific exemptions are provided to cover records and parts of records that are considered non-public.
3. **Disclosure Officer**. The Disclosure Officer is a person designated as being responsible for answering requests under either Act.
4. **Disclosure**. Records may be disclosed by providing the requester with copies of the records which were requested or by providing that person with access to the records.
5. **Personal Information**. Personal information is information in governmental files about the aspects of a person's life.

5. Responsibilities.

1. **Disclosure Officer**. The following officials are designated as Disclosure Officers for the LHWCA for purposes of both the FOIA and the Privacy Act:
    a. **National Office (NO)**.
        i. Director, OWCP
        ii. Director, DLHWC
    b. **District Office (DO)**.
        i. Regional Directors (RD)

ii. District Director (DD)

2. **Duties of Disclosure Officers**. Disclosure Officers are responsible for the proper maintenance of all information systems under their jurisdiction as well as for final decisions concerning requests under the Acts. To avoid confusion of responsibilities under these Acts with other administrative responsibilities concerning records, they are made records custodians for the purposes of complying with the subpoenas and for the orderly retirement/destruction of records in keeping with National Archives and Records Service approved records schedules. Disclosure Officers are:
    a. Liable for their actions. If a suit contesting a refusal to disclose information under the FOIA is held against the Government and the Court finds the refusal to be "arbitrary and capricious," the Disclosure Officer or the alternate acting in that person's stead is subject to OPM investigation and any disciplinary action which may be recommended to DOL as a result.
    b. Subject to a $5,000 fine under the Privacy Act if a court finds them to have unlawfully disclosed material covered under the Act or to have failed to publish notice of a system of records covered under the Act.
    c. Authorized, where necessary, to delegate responsibility for carrying out the tasks of the Disclosure Officer with respect to the maintenance of records systems and the preparation of responses to requests. However, the authority and liability cannot be delegated short of designating additional Disclosure Officers.
    d. Responsible for ensuring that persons maintaining records or likely to receive requests under each Act are familiar with the relevant procedures and responsibilities. Training (formal or in-house) should be arranged for all such personnel.
    e. Responsible for ensuring that a contractor and the contractor's employees understand that the disclosure of any record (covered or not) is accomplished by the Disclosure Officer and not the contractor. (Section 3m of the Privacy Act makes contractors and their

employees working on records covered by the Privacy Act liable under the Act.)

f. Responsible for ensuring that information in case records is disclosed only in accordance with the Privacy Act. Only parties in interest are permitted access to the case record, and only these parties may receive copies of documents from the case file. Medical records and information may also be disclosed. However, if medical reports contain information of a nature that could be extremely injurious or shocking to the employee or claimant wishing to see his or her records (e.g., terminal conditions, social diseases, psychiatric illness, etc.), that person should be informed that the medical records or information will be released to his or her representative or treating physician.

6. Coverage. Requests from the public for information in documents in the custody of ESA should be treated either under the FOIA or the Privacy Act. Requests for copies of publications or for information (rather than documents) are not covered by either Act. Requests for records not covered by the Privacy Act or by individuals other than the covered individual (or his or her attorney, parent, or legal guardian) are requests under the FOIA. The chart in Attachment 1, ESA Manual 4-104, should assist Disclosure Officers in responding to requests for records. Where a request is made by a law enforcement agency, material can be released provided the above requirements of the Privacy Act are fully met. (For further coverage regarding the implementation of the FOIA and Privacy Act, see ESA Manual 4-104a/b.)

1. **Privacy Act of 1974 (5 U.S.C. section 552a)**. The provisions of the Privacy Act are meant to assure the private citizen's rights to confidentiality and secrecy of personal information, including financial and medical history. That statute, in addition to guaranteeing the claimant's access to the information contained in the file, prohibits disclosure to any person unless the subject of the file consents to such disclosure or the request meets one of the exceptions listed in section 552a(b). In as much as the gathering of any information by any source involves some distribution of that information, no matter how slight, the Privacy Act demands extra measure, through classification, secure custody, and restricted release of any information about an individual which is

maintained by an agency, and which can be called up or retrieved by name or other personally identifying number or symbol. The effect of the Privacy Act as it relates to compensation matters is to require offices of the OWCP to advise claimants why any information requested of them is necessary, to permit such claimants to have access to any materials which they may have submitted over their own signatures, and to have access to medical reports (subject to certain limitations) and other documents which may have been submitted by other persons in connection with the claim.

2. **Freedom of Information Act of 1967 (Pub. L. No. 90-23), as Amended**.
    a. The Freedom of Information Act (FOIA) was designed to provide members of the public a defined procedure for obtaining records from the Federal government. The Act was amended by Pub. L. No. 93-502, effective February 19, 1975, to clarify and liberalize the requirements for, and to expedite the disclosure of information to the public. The FOIA requires the publication of indexes of specified agency documents and record materials, provides time limitations for responding to requests, and establishes a system of penalties for non-compliance with the time limitations; requires identification of persons responsible for granting or denying requests; provides for court review of denials, including classified materials; and provides for the levying of charges for searching and copying requested materials.
    b. In each office (National and DOs), the Disclosure Officer is responsible for acknowledging FOIA requests; making a determination as to whether or not the request shall be granted; and either providing the material, or else advising the requester why the request cannot be allowed, in which case the Officer must also advise the requester of the avenues of appeal. The Disclosure Officer must maintain an accurate log of all FOIA requests and their disposition. A record must be kept of the number of denials and the reason therefor.

c. Time is a critical factor in processing FOIA requests for information. The Disclosure Officer has twenty working days from the date of receipt of an FOIA request to respond. If circumstances prevent the disclosure officer from providing the requested documents within the 20 working days, he/she should advise the requester in writing within the 20 working days of a specific latest date (generally within about 2 weeks) when the first response will be sent.

7. Processing Requests. Procedures for processing requests are detailed in ESA Manual 4-105, including the evaluation of requests, charges for services, denials, identification requirements, and handling of personal records.

8. Records and Reports. The records and reports required in the implementation of the FOIA and Privacy Act are described in ESA Manual 4-106. They include the instructions for:

1. **FOIA Indexes**. Periodic updating and publication of FOIA indexes.
2. **Routine Uses**. Informing the public of routine uses under the Privacy Act.
3. **Workload**. Maintaining records of FOIA workload, Form DL 1-520 (Request Under the Freedom of Information Act).
4. **Disclosure**. Recording the disclosure of material covered by the Privacy Act, Forms ESA 67a (Privacy Act Record System Log of Disclosures) and ESA 67b (OWCP Case File Privacy Act Disclosure Log).
5. **Contractors**. Monitoring contractors who generate, manipulate, or maintain records covered by the Privacy Act to prevent unauthorized disclosure.

9. Routine Uses. The routine uses applicable to all Department of Labor systems of records is set forth in the Federal Register at 63 FR 2,417 (January 15, 1998), a copy of which is available from the National Office.

10. Subpoenas. District Directors and National Office personnel should immediately contact their appropriate Solicitor's office whenever they receive an ALJ or court subpoena, or other request made in connection with ongoing litigation, calling for the production of documents.

Chapter 2-0100, (Reserved)

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Chapter 2-0200, Primary Case Review

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1. Purpose and Scope	09/00	00-01
2. Definition	09/00	00-01
3. Timely Review of Primary Cases	09/00	00-01
4. Routine Cases	09/00	00-01

1. Purpose and Scope. This Chapter provides an overview of the procedures for the initial review of a case file by the Claims Examiner (CE) or Claims Examiner Clerk (CEC).

2. Definition. A primary case is a recently created case that has not been reviewed by a CE or CEC. It usually contains only the initial report of injury and an indication of the employee's absence from work. However, often it will also contain other reports or information germane to the case. At a minimum such cases will normally contain at least one of the following reports or forms:

1. **LS-202**, Employee's First Report of Injury (Exhibit 16, PM 10-200)
    a. . . . reporting lost-time beyond the date of injury,
    b. . . . reporting a case of occupational disease, or
    c. . . . reporting a case of permanent impairment which is covered by the schedule in section 8(c)(1)-(20) of the Act.
2. **LS-206**, Payment of Compensation Without Award or LS-208, Notice of Final Payment (Exhibits 19 and 20, PM 10-200).
3. **LS-203**, Employee's Claim for Compensation, or LS-262, Claim for Death Benefits (Exhibits 17, and 32, PM 10-200).
4. **Settlement Application**. Application for approval of section 8(i) settlement.

3. Timely Review of Primary Cases. Proper claims management dictates that primary cases be reviewed promptly to insure that compensation payments are provided on a timely basis, appropriate medical care is being provided and that the injured worker is promptly informed when entitlement to compensation is controverted by the EC. For this reason one of the Longshore Program's performance standards requires that primary cases be reviewed within thirty days

of the date the case was jacketed. Generally, this will allow sufficient time for receipt by the DO of the initial evidence in a claim, i.e., the employer's report of injury, the attending physician's report, the employer's report of first payment of compensation or the notice of controversion.

4. Routine Cases. On receipt of primary cases the CE/CEC quickly analyzes the cases to segregate those which require full, systematic and thorough review from those which can be routinely closed or called up. In the routine type cases, frequently only one review of a case by a CE may be necessary. Such cases include those where lost-time did not exceed three days and no permanent partial disability is indicated, or those in which the appropriate payment for a short period of temporary disability has been paid and reported at the time of review. The initial review of routine cases by the CE/CEC should include monitoring for timeliness of required reports, completeness of the information thereon and review of the initial medical report for any treatment provided. More specific guidelines concerning this review are contained in PM 2-201 and 2-202.

Chapter 2-0201, Disability

Paragraph and Subject	Date	Trans. No.
Table of Contents	09/00	00-01
1. Purpose and Scope	09/00	00-01
2. Routine Cases	09/00	00-01
3. In-Depth Case Review	09/00	00-01
4. Formal Claims	09/00	00-01
5. Call-Up	09/00	00-01
6. Case Closing	09/00	00-01

1. Purpose and Scope. This Chapter contains the procedures for the initial review of a disability case file by the Claims Examiner (CE) or Claims Examiner Clerk (CEC).

2. Routine Cases. On receipt of a primary case with Form LS-202, Employer's First Report of Accident or Occupational Illness (Exhibit 16, PM 10-200), the CE or CEC checks the items listed in subparagraphs a to h, below, and recommends penalties or other action where necessary. Routine cases are closed or called-up. In some instances, only one review of a case, by an experienced CE, may be required. Such cases include those where lost time did not exceed three days and no permanent partial disability is indicated, or those in which the appropriate payment for a short period of temporary disability has been paid and reported at

the time of review. (See also PM 2-300.) The initial review of routine cases includes all of the following:

1. **Timeliness**. The CE/CEC checks the LS-202 for completeness of information and timely submission of the report by the EC. The LS-202 should be received in the district office within ten days after the injury or the date the employer had knowledge of the injury/illness. If the injury/illness did not immediately result in disability the ten day period is measured from when disability commences. Action to be taken when a late report is received is described in subparagraph 3f, below.
2. **Compensable Lost Time**. The timely submission of Form LS-206, Payment of Compensation Without Award (Exhibit 19, PM 10-200) by the EC indicates that compensation is being paid for time lost from work. For the procedures pertaining to the imposition of penalties and interest please refer to Part 8 of the Procedure Manual.
3. **Medical Report**. There should be the timely submission of the first report of treatment by the attending physician, Form LS-1, Request for Examination and/or Treatment (Exhibit 1, PM 10-200). (See also PM 5-300.) The CE/CEC reviews the medical evidence and assesses the severity of the injury, to determine whether or not the injured employee needs the care of a specialist and how long the anticipated disability may continue.
4. **Payment of Compensation Without Award**. When the EC makes voluntary compensation payments in accordance with the entitlements set forth in PM 0-300, the EC notifies the DD by submitting Form LS-206, Payment of Compensation Without An Award (Exhibit 19, PM 10-200). If Form LS-206 is among the initial reports received, the CE checks the compensation rate for accuracy as prescribed below in paragraph 3b. The LS-206 should be submitted to the DO by the EC immediately after the first payment of compensation is made, and should reflect first payment within twenty-eight days of the injury or the date disability began (for late payment penalties, see PM Chapter 8-202).
5. **Identification of Cases in Compensation Status**. If Form LS-206 has been received, indicating that compensation payments are continuing, the CE

should record this information in the LCMS (See Chapter 4, LCMS User's Manual.)

6. **Review of Cases for Right to File Claim**. Many routine cases require only one review. Such cases include those where time lost did not exceed three days and no permanent partial disability is reflected in the medical data, or those in which the appropriate payment for a short period of temporary disability has been paid and reported at the time of review. In the event no claim is received and the case is to be closed, but the CE considers the injury to be of a serious nature, a Form Ltr. LS-403, Letter to Employee on Right to File claim for Disability Compensation (Exhibit 38, PM 10-200) is sent to the employee apprising him or her of the right to file a claim. A call-up for thirty days is to be placed on the case after releasing Form LS-403. If no reply is received at the end of the thirty day period, the file is marked "closed", dated, initialed, and placed in the central files.
7. **Separate the More Complicated Cases**. The cases which require full, systematic, and thorough review should be separated from those which can be routinely closed or called up. For those cases (including claims) which require full review, consider each of the factors identified in paragraph 3, below.
8. **Check for Return to Duty Date**. Form LS-202 may not include the date that the claimant returned to duty. In such situations, the EC may file Form LS-210, Employer's Supplementary Report of Accident or Occupational Disease (Exhibit 23, PM 10-200). This Form may also be used where the injured employee has returned to duty and later becomes disabled again.

3. <u>In-Depth Case Review</u>. Cases involving serious injuries, occupational diseases, or other complications or other disputed issues, will require in-depth review. The CE must examine and resolve each issue which is or could become controversial. If these issues can be recognized and addressed at the time of the first review, it will simplify the later processing of the case. The file cannot be handled in a cursory manner.

1. **Determine Eligibility**. There are five basic requirements which must be met for an injured worker (or survivor in case of death) to be eligible for LHWCA coverage: timely filing of a claim, jurisdiction, fact of injury, course of

employment and causal relationship. These issues are discussed in detail in PM Chapter 0-300.

a. Timeliness. Claims regarding compensation for disability or death must be in writing and filed by or for the individual claiming benefits with the District Director (DD) of the compensation district in which the injury or death occurred. Eligibility requirements, time limitations, and exceptions are set forth in PM 0-300.4.

b. Employee (Jurisdiction Situs and Status). The situs/status factors influencing the coverage accorded maritime workers under the Act are explained in PM 0-300.5 and Program Memorandum No. 58, August 10, 1977. Please also refer to the Longshore Desk Book (Note, however, that the decisions therein do not necessarily comport with the Director's administrative construction).

c. Fact of Injury. There must be evidence of injury to an employee in a "covered" situation in order to establish eligibility for compensation. See PM 0-300.6.

d. Course of Employment. To be eligible for benefits, the covered employee must have sustained an injury which occurred in the course and scope of his/her employment, section 2(2) of the Act. Also, please refer to the Longshore Desk Book for a discussion of this issue (Note, however, that the decisions therein do not necessarily comport with the Director's administrative construction).

e. Causal Relationship. In addition to occurring in the course and scope of employment, to be compensable, an injury must arise out of the employment, section 2(2) of the Act. The section 20 presumption aids the claimant in establishing that the injury arose out of and in the course of the employment. See PM 0-300.3 and the Longshore Desk Book for a further discussion of this issue (Note, however, that the decisions therein do not necessarily comport with the Director's administrative construction).

f. The phrase "arising in the course of employment" relates to elements of time, place and work activity. To occur in the course of

employment, an injury must occur at a time when the employee may reasonably be said to be engaged in the employer's business, at a place where the employee may reasonably be expected to be in connection with the employment, and while the employee was reasonably fulfilling the duties of his or her employment or engaged in doing something incidental thereto. This alone is not sufficient to establish entitlement to compensation. The concurrent requirement of an injury "arising out of the employment" must be shown. The phrase "arising out of employment" relates to the element of causal connection, the requirement being that a factor of employment caused the injury.

2. **Verify Compensation Rate (Wage Rates, AWW)**. If Form LS-206 is among the initial reports received, the CE checks the compensation rate for accuracy.
    a. Partial Earnings Rate. If the compensation rate appears low or otherwise indicates that all income may not have been considered, the CE should send Form Ltr. LS-557 (Notice of Compensation Rate, Exhibit 51, PM 10-200) for the period in which the injury occurred if this Form has not previously been sent.
    b. Tentative Rate. The CE should send Form LS-426 (Request to Employee for Earnings Information Data on Employee's Earnings, Exhibit 39, PM 10-200) to the employee, requesting wage data.
    c. Minimum/Maximum Rates. The CE should check for the applicability of minimum/maximum rates payable pursuant to section 6(b) (Exhibit 26, PM 10-300).
    d. Accurate Rate. If the compensation rate appears to be accurate, the CE may place a call-up on the case file, (see Chapter 3, LCMS User's Manual), and await supplemental medical reports and Form LS-208 (Notice of Final Payment, Exhibit 21, PM 10-200).
3. **Consider Third Party Involvement**. Under section 33, a claimant may receive compensation or a death benefit under the Act while pursuing a civil action against a third party (not the employer) who, the claimant feels, caused

the injury or death through negligence. For further information please refer to PM 3-600.

4. **Consider Controversion of Entitlement**. If the EC controverts the employee's or survivor's right to compensation, there must be filed with the DD a Form LS-207, Notice of Controversion of Right to Compensation (Exhibit 20, PM 10-200) on or before the fourteenth day after the EC had knowledge of the alleged injury or death. This form is a notice that the right to compensation is controverted, listing the name of the claimant, the name of the employer, the date of the alleged injury or death, and the basis upon which the right to compensation is controverted. The form is submitted in duplicate to the DO and the CE sends a copy of the form to the claimant within ten days of receipt of the form in the DO. The Form LS-209, Request for Employee's Reply (Exhibit 22, PM 10-200) is used to transmit the LS-207. However, the LS-207 may be replaced with a cover letter prepared by a district office and tailored to accommodate local conditions and needs. For further guidance on the development of the case (e.g., arranging for informal conference, assessing penalties, etc.), see PM 3-301, 4-200 and Part 8.
5. **Consider Medical Evidence**. The LS-1, Request for Examination or Treatment and Attending Physician's Report of Injury and Treatment (Exhibit 1, PM 10-200) should be received in the DO within ten days of the examination or treatment. However, the initial medical report need not be on the LS-1, and frequently consists of a narrative report or a LS-204, Attending Physician's Supplementary Report, (Exhibit 18, PM 10-200). After reviewing the initial medical report the CE/CEC should be able to determine the severity of the injury, whether the injured employee needs the care of a specialist, and estimate how long the disability may last. The CE/CEC should also consider the availability and sufficiency of medical care based upon the medical reports in the primary case. For further information regarding medical issues please review Part 5 of the Procedure Manual.
6. **Consider Late Reports (Employer)**.
    a. Form LS-202. If the envelope, in which the Form LS-202 is submitted has a postmark date in excess of ten days beyond the injury date,

Form Ltr. LS-548, Request to Employer for Explanation of Late Filing of Form LS-202 (Exhibit 48, PM 10-200) should be released within ten working days to the employer after determining that the report is late. See PM 3-301.3f and 8-302.

b. Forms/Documents Other Than LS-202. If the primary case is received with a form or document other than Form LS-202 (e.g., Form LS-201 or LS-203), the CE releases Form LS-512, Request to Employer for LS-202 and Explanation for Failure to File (Exhibit 41, PM 10-200). The original form LS-201 or LS-203 (or other document) is kept in the file because it constitutes a notice of the injury or a claim. A copy is sent to the employer/carrier with a request for Forms LS-202 and LS-1. Unless a Form LS-203 is received, which would require a response from the EC, requests for other forms may be deferred at the initial handling of the file. The CE may place a thirty day call-up on the file to allow time for the submission of subsequent reports. If the EC's report has not been received at the time the file is reviewed on the call-up, Form Ltr. LS-512 should be released, advising the EC of the penalty provisions for late filing or failure or refusal to file a report of injury. See PM 8-302.

   Patterns of such late reporting by an individual or self-insured and any refusal to file a report, should be reported to the DD and in turn, to the National Office.

7. **Consider Rehabilitation Potential**. Upon receipt of a claim where the probability of return to work exceeds two months, the LCMS institutes a call-up for ten weeks to ensure the receipt of Form LS-222, Carrier's or Self-Insurer's Report on Rehabilitation (Exhibit 26, PM 10-200). For further details regarding the handling of potential rehabilitation cases, see PM 3-301.3g and OWCP Rehabilitation PM 3-300.
8. **Consider Adequacy of Report Forms**.
   a. Requirements for Additional Reports. During the initial review of the case, the CE should send to the carrier/employer Form LS-216, Request for Additional Reports (Exhibit 25, PM 10-200), requesting

an adequate medical report, if not included, and the submission of Form LS-206, if not included, showing that appropriate compensation has been voluntarily instituted. At this stage of the case development, Form LS-203 should be sent to the claimant only upon request or in cases where (in the opinion of the CE) they are necessary (e.g., to process a claim for occupational disease)

b. Call-Up. A thirty day call-up should be placed in the file, awaiting a reply to Form LS-216 and receipt of Forms LS-206, LS-208, and LS-1. This completes action on the case as a primary one and such case will thereafter be regarded as a secondary case. (See paragraph 5, below).

4. <u>Formal Claims</u>. Not all primary cases originate with the receipt of routine injury reports but on rare occasions the DD may process the claim without the pertinent data.

1. **Preparation and Submission of Claim**. Form LS-203, Employee's Claim for Compensation (Exhibit 17, PM 10-200), has been provided to serve as a formal written claim. However, no particular form is required to meet the time limitation provisions of the Act, and the completion and submission of Form LS-201 Notice of Employee's Injury (Exhibit 15, PM 10-200) will serve as a written claim to toll the statute. Any letter or other document containing words of claim will suffice as a claim. A written memorandum, prepared by a CE based on an oral communication with the claimant expressing an intention or desire to file a claim, has been held to be sufficient to toll the statute. (See PM 3-301.)
2. **Notification to Employer of Filing by Employee**. Within ten days after the filing of a claim for compensation for injury or death under the Act, the CE sends a copy of the claim to the EC. The claim is served personally or by mail. Form Ltr. LS-215a, Notice to Employer and Insurance Carrier That Claim Has Been Filed (Exhibit 24, PM 10-200) is used to transmit three copies of Form LS-207 for the response to the claim, if the claim is not to be approved. The LS-207 should be returned to the DO in triplicate. While awaiting the response, the CE shall proceed to develop and evaluate the claim.

5. Call-Up. As soon as a case is created, it is assigned a case status of "Primary" and a call-up date thirty days in the future. However, after the CE/CEC has completed the primary case review, the length of future call-ups is left to the discretion of the claims examiner depending on the circumstances of the case, and awaiting a reply to receipt of any forms or information which have been specifically requested. This completes action on the case as a primary one and such case will thereafter be regarded as a secondary case.

6. Case Closing. When the CE/CEC determines, after careful review that no further action is needed and the case is in posture to be closed, the following steps will be undertaken by the CE/CEC: Top document will be marked closed, dated and initialed by the CE.
Once the three steps listed above have been completed, the appropriate case closing date is also entered into the LCMS and the case is forwarded to the file room.

Chapter 2-0202, Death

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3. Contents of Death Case	09/00	00-01
4. Processing of Death Cases	09/00	00-01

1. Purpose and Scope. This Chapter contains the procedures for the initial review of a death case file by the Claims Examiner (CE) or Claims Examiner Clerk (CEC). This Chapter also augments the information contained in PM-201. Information on the processing of secondary death cases may be found in PM 3-302.

2. Policy. The Claims Examiner (CE), assisted by the Claims Examiner Clerk (CEC), is responsible for processing death claims and insuring that the survivor(s) of the deceased employee receives all benefits to which they may be entitled to under the Act, while protecting the rights of all parties. Claims must be in writing and filed by or for the individual claiming benefits with the DD of the compensation district in which the injury or death occurred.

3. Contents of Death Case. At a minimum, a death case should contain the following:

1. **Report of Injury/Death**. For example, Form LS-201 or LS-202 (Exhibits 15, and 16, PM 10-200).
2. **Death Certificate**. The case should also include a death certificate, and evidence concerning the factors of employment or injury suspected to be the cause of, to have contributed to, or to have hastened death.
3. **Certificates for Dependents**. These should include a marriage certificate, birth certificates for the eligible dependents, as well as evidence to establish student status and dependency where appropriate.
4. **SSN of each beneficiary**.
5. **Claim for Benefits**. One or all of the following claim forms should be included:
    a. Claim for Death Benefits, Form LS-262, Exhibit 32, PM 10-200;
    b. Application for Continuation of Death Benefit for Student, Form LS-266, Exhibit 34, PM 10-200;
    c. Certificate of Funeral Expenses, Form LS-265, Exhibit 33, PM 10-200.

4. Processing of Death Cases. If the names and/or addresses of beneficiaries are unknown, the CE should write to the EC requesting the information along with wage information and evidence of voluntary payment of compensation (if the case has not been controverted). Upon receipt of this information the CE should write to the widow/widower and/or beneficiaries enclosing blank Forms LS-262, Claim for Death Benefits (See Exhibit 32, PM 10-200) and LS-265, Certification of Burial Expenses (See Exhibit 33, PM 10-200). The CE should also request copies of the death certificate, marriage certificate and any other pertinent information which may be missing SSN. A copy of this letter should be sent to the EC.

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3. Definitions	09/00	00-01

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5. Primary Case Review	09/00	00-01
6. Secondary Case Review	09/00	00-01

1. Purpose and Scope. This Chapter provides an introduction to the handling of cases involving occupational diseases. Topics covered include: the changes brought about by the 1984 Amendments; and what evidence is necessary to make determinations on the level of disability, the average weekly wage and the timeliness of the claim for compensation.

2. References.

1. **The sections of the Act** pertaining to occupational diseases are: sections 2(10), 8(c)(23), 9(e)(2), 10(d)(2), 10(i), 12(a), and 13(b)(2).
2. **The sections of the regulations** pertaining to these diseases are: sections 702.212(b), 702.222(c), 702.601 to 702.604.
3. **The Law of Workmen's Compensation**, by Arthur Larson, section 41.00.
4. **Guides to the Evaluation of Permanent Impairment**, published and revised from time to time by the American Medical Association.
5. **Longshore (LHWCA) Procedure Manual**, PM 3-400, 3-401, and 3-402.

3. Definitions.

1. **Average Weekly Wage**.
    a. Use the average weekly wage at the time of injury if this date is prior to retirement.
    b. When the time of injury is after retirement and
        i. Within the first year after retirement, use 1/52 part of average annual earnings in the fifty-two week period prior to retirement,
        ii. More than one year after retirement, use the National Average Weekly Wage at the time of injury.
2. **Date of Last Injurious Exposure** The last date the claimant was exposed to the pernicious substance while working in employment covered by the Act.
3. **Disability**.

a. Where the disease becomes disabling prior to retirement, disability is based upon a loss of earnings or earning capacity.
b. Where the disease becomes disabling after retirement, disability is based upon the amount of physical impairment.

4. **Impairment**. The amount of permanent loss, or loss of use of, an organ, body part, or bodily function, as determined in accordance with the **Guides to the Evaluation of Permanent Impairment**. If the **Guides** do not measure the impairment, any other professionally recognized standards or system of evaluation may be used.
5. **Occupational Disease**. An illness or condition which develops over a period of time in response to repeated exposure to harmful or injurious stimuli.
6. **Retirement**. The claimant has voluntarily withdrawn from the work force and there is no realistic expectation that he or she will return to the work force.
7. **Time of Injury**.
    a. For purposes of coverage and jurisdiction and for sections 10, 12, and 13: the date on which the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability.
    b. For purposes of determining responsible EC: the date of last exposure to injurious stimuli prior to the disease becoming disabling.

4. <u>The 1984 Amendments</u>. The LHWCA Amendments of 1984 specifically addressed certain issues with respect to occupational disease cases. Disability, relative to a disease which becomes manifest after retirement, is defined as permanent impairment. The time of injury for purposes of determining the rate of pay and filing a claim for compensation is now defined as the date on which the employee becomes aware of the relationship between the employment, the disease and the death or disability. The pay rate for a retired employee is deemed to be his or her wage at retirement if the disease becomes manifest within one year of retirement, and the National Average Weekly Wage if the disease becomes manifest more than one year after retirement. A retiree who becomes impaired due to an occupational disease may receive 66 2/3 percent of his or her pay multiplied by the percentage of the impairment. This amount is not subject to an annual adjustment but can be increased to cover a worsening of the

condition.
The widow of a deceased employee whose employment related disease became manifest and caused death after retirement may receive 50 percent of the National Average Weekly Wage at the time of death. These benefits cannot exceed the decedent's wage at retirement.

The requirements for filing notice of injury and claim for compensation have been extended to one and two years respectively. These time periods are measured from the newly defined time of injury.

5. <u>Primary Case Review</u>.

1. **In addition to the normal procedures** for Primary Case Review (see PM 2-200), the DO should insure that the file contains sufficient evidence to make a determination on the following:
    a. The time of injury.
    b. The date of manifestation of the disease.
    c. The date of last injurious exposure.
    d. The date of disability.
    e. The date of death.
    f. The date and cause of retirement.
    g. The claimant's, or decedent's, wages in the fifty-two week period prior to retirement.
    h. Claimant's SSN.
2. **To assist in making these determinations** the CE should request the following information:
    a. A detailed history of the disease from the date it started;
    b. The way in which the employee was exposed to the implicated injurious stimuli and the length of exposure;
    c. Statements from any witnesses concerning the degree and length of exposure;
    d. The date the employee was last exposed to the injurious stimuli;

e. The date and circumstances when the claimant first became aware of a possible relationship between the disease and the employee's work; and

f. The names and addresses of all physicians and hospitals which have provided the employee with medical care for a disease which is related to exposure to the implicated injurious stimuli.

6. Secondary Case Review. For further information on occupational disease cases please refer to PM 3-400.

Chapter 2-0300, Screening

Paragraph and Subject	Date	Trans. No.
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1. Purpose and Scope	09/00	00-01
2. Policy	09/00	00-01
3. Categories of Cases	09/00	00-01
4. Screening	09/00	00-01

1. Purpose and Scope. This Chapter describes the procedures for screening cases on a daily basis and establishing priorities of case files in order to achieve maximum efficiency in the processing of claims under the LHWCA. It defines the categories of cases, and the supporting documentation that must be identified at the earliest date and timely acquired by the Claims Examiner (CE) or Claims Examiner Clerk (CEC) for effective primary and secondary reviews as prescribed in PM 2-200 and 3-300.

2. Policy. A CE or CEC should schedule duty time in such a manner as to be able to handle not only the routine type cases which require very little action or attention, but also cases of a more complicated nature.

3. Categories of Cases. The principal categories of cases are as follows:

1. **No-Lost-Time (NLT) Reports**. The 1984 Amendments removed the requirement for ECs to report injuries which did not result in loss of one or more shifts of work. It is DLHWC policy that these injuries are not to be jacketed into case files. (See PM 1-400.) However, **Industry Notice No. 63, May 8, 1987**, notified ECs that injuries compensable under the schedule

contained in sections 8(c)(1)-(20) of the Act would be jacketed even though the injury did not result in loss of one or more shifts of work. Therefore, most of the no-lost-time injury reports received will be reviewed by the mail and records personnel and discarded before jacketing, obviating initial review by the CE. The remaining no-lost-time cases fall into the next category of cases.

2. **Compensable NLT Cases**. In this category are cases involving schedule awards, disfigurements, third party action, or Notices of Controversion (Form LS-207, Exhibit 20, PM 10-200). Such cases may require requests for additional documents or reports. Usually, they can be processed in a very few minutes and can be placed in either the first or second stack explained in subparagraph 4a, below.
3. **Lost-Time (LT) Uncontested Cases**. These cases involve an injury which results in loss of time from work beyond the day or shift of injury and extending for more than three days. The EC must make payments periodically, promptly, and directly to the injured employee or survivors entitled to such benefits under the LHWCA (20 C.F.R. section 702.231). These cases may be satisfied by payments with or without a formal award. In certain instances, awards are paid as agreed settlements, (20 C.F.R. sections 702.241-243). These cases could be placed in either the third or fourth stack of cases mentioned in subparagraph 4a, below.
4. **LT Contested Cases**. These are cases where either the EC or the claimant/representative contests any action on a claim deriving from the injury or death of the employee under the LHWCA. It may consist of an ECs controversion of the right to compensation (20 C.F.R. section 702.251) or the claimant's contest of actions taken by the EC with respect to the claim (20 C.F.R. section 702.261). Such cases would be placed in the fourth stack of cases mentioned in subparagraph 4a, below.
5. **Death Cases**. These cases involve death benefits payable to the employee's survivors, covered by the LHWCA. For more detailed information on benefits and case determinations, see PM 2-202 and 3-302. Such cases would be placed in the third or fourth stack of cases (depending upon the degree of controversy) mentioned in subparagraph 4a, below.

6. **Other Cases**. These could be generally categorized as indicated in subparagraphs 3c, 3d, or 3e, but involve special issues and more complex evaluation/adjudication procedures as covered in PM 2-600, 3-302, 3-400, 3-500, 3-700, 4-200, 4-300, 4-500, 6-201, 6-202. Such cases would be placed in the fourth stack of cases mentioned in subparagraph 4a, below.

4. <u>Screening</u>. Under normal conditions, the CE inspects the case files by arranging three or four stacks of cases as follows:

1. **Organization for Screening**. Under normal conditions, the CE inspects the case files by arranging three or four stacks of cases as follows:
    a. Stack 1 (Not Critical or Complicated) -- Contains those cases involving no complications, which can be handled very quickly. Certain cases can be closed without further action and others may need only a call-up, awaiting receipt of additional documents prior to closing.
    b. Stack 2 (Information Required) -- Contains those cases in which the CE/CEC will need to take a specific action, but of such a nature that it will not require significant amounts of time. Example would be the preparation and dispatch of letters requesting a medical report, wage data, clarification of jurisdictional questions, etc.
    c. Stack 3 (Evaluation Required) -- Contains cases that require some study to determine the issues, action to resolve them, and possibly the preparation of correspondence to obtain data that is critical to resolution of the controversy. These cases can consume more time and may require the CE to consult with the DD.
    d. Stack 4 (Further Study) -- Contains those cases of a more complicated nature. They require intensive study, perhaps research, and in most instances, consultation with the DD. These may include cases being processed for adjudication by informal conferences or final disposition (e.g., issuance of compensation order, payment of legal fee, approval of section 8(i) settlements, section 8(f) applications etc.).

2. **Workload Scheduling**. After arranging the incoming cases as in subparagraph 4a, the CE needs to estimate the amount of time required for processing each stack. The determination of the sequence for working each stack may be made by the individual CE; however, sufficient time should be set aside to allow for completion of work on each stack.
    a. Routine Cases. Since the majority of cases usually fall in Stack 1, many examiners consider it more advantageous to work that stack initially to complete and remove from the desk the greatest number of cases in the shortest period of time.
    b. Other Cases. Usually, the greatest portion of the work day is devoted to processing of the more complicated and time-consuming cases, placed in stacks 3 and 4. (See PM 2-201.3 and 3-301.3 for in-depth review procedures.)
3. **Priorities of Cases and Documentation**. Each case file arranged for screening as described in subparagraph 4a, is inspected for the essential documents and/or information which has not yet been seen by any CE. The presence of such documents may elicit a variety of possible responses. By organizing the files and documents involved in this screening system, the CE/CEC is able to review and process those cases with the greatest urgency and establish a priority category for all cases each time they are reviewed. This system consists of the following categories, in order of priority:
    a. Documents pertaining to cases where payment of compensation has been stopped prematurely or contrary to regulations.
    b. Documents pertaining to a death case (e.g., Claim for Death Benefits, Form LS-262, Exhibit 32, PM 10-200 and claimant's SSN).
    c. Requests for issuance of a Compensation Order and Proof of Service.
    d. Documents pertaining to a claim, the validity of which is being controverted.
    e. Medical Reports (Forms LS-1, and LS-204, Exhibits 1 and 18, PM 10-200 or other applicable documents) where full or maximum

medical recovery from the reported injury is indicated, i.e., final medical reports.

f. Form LS-208, Notice of Final Payment or Suspension of Compensation Payments (Exhibit 21, PM 10-200).

g. Applications for section 8(f) relief.

h. Form LS-206, Payment of Compensation Without Award (Exhibit 19, PM 10-200).

i. Form LS-203, Employee's Claim for Compensation (Exhibit 17, PM 10-200) or other formal claim for compensation.

j. Form LS-202, Employer's First Report of Accident or Occupational Illness and/or Form LS-201, Notice of Employee's Injury or Death (Exhibits 16 and 15, PM 10-200), and/or other injury reports.

k. Form LS-222, Carrier's or Self-Insurer's Report on Rehabilitation (Exhibit 26, PM 10-200). (See PM 3-301.3g and OWCP Rehabilitation Procedure Manual.)

l. Other documents or information received, not included in any of the above categories, will be reviewed and assigned appropriate priority by the CE.

Chapter 3-0100, (Reserved)

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Chapter 3-0200, Determination of Pay: Section 10

Paragraph and Subject	Date	Trans. No.
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1. Purpose and Scope	09/00	00-01
2. General	09/00	00-01
3. Methods for Determining the Average Weekly Wage	09/00	00-01
4. Form To Be Utilized in Determining the Average Weekly Wage	09/00	00-01

1. Purpose and Scope. This Chapter provides an introduction to the determination of pay and adjustments pursuant to section 10 of the Act. The

following Chapters deal with this section of the Act in more depth. PM 3-201 deals with average weekly wage determinations, PM 3-202 deals with annual adjustments for PTD and death cases under section 10(f) of the Act, and PM 3-202 deals with adjustments to the compensation rate under section 10(h) of the Act.

2. General.

1. **The CE should determine the correct rate** of compensation, to which an injured employee is entitled as soon as possible, after the EC reports that payments have begun. The initial report of payments is made on Form LS-206, Payment of Compensation Without An Award (Exhibit 19, PM 10-200) and triggers this activity. Form LS-208, Notice of Final Payment or Suspension of Benefits (Exhibit 21, PM 10-200) may be substituted if the injured worker has returned to work.
2. **The starting point in calculating the rate** of compensation for disability or death is the injured employee's or deceased employee's average weekly wage. It is the basis of all benefit calculations except those for disfigurement under section 8(c)(20) and medical payments under section 7. The overriding objective is to arrive at a valid earning capacity at the time of injury.

3. Methods for Determining the Average Weekly Wage. Section 10 of the Act describes the basic methods for determining the injured worker's average weekly wage. Chapter 3-201 of the Procedure Manual describes in more detail the principal methods to be utilized.

4. Form To Be Utilized in Determining the Average Weekly Wage.

1. LS-202, Employers First Report of Injury (Exhibit 16, PM 10-200)
2. LS-206, Payment of Compensation without Award (Exhibit 19, PM 10-200)
3. LS-208, Notice of Final Payment or Suspension of Benefits (Exhibit 21, PM 10-200)
4. LS-426, Request to Employee for Wage Earnings Information (Exhibit 39, PM 10-200)
5. LS-537, Change in Compensation Based on Higher AWW (Exhibit 46, PM 10-200)

6. LS-557, Notice to Employee of Compensation Rate under the LHWCA (Exhibit 51, PM 10-200)

Chapter 3-0201, Average Weekly Wage

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5. Part-Time Employment	09/00	00-01
6. Determination of the Wages of a Minor	09/00	00-01
7. Additional Income Considered As Wages	09/00	00-01
8. Evaluating Wage Information	09/00	00-01

1. Purpose and Scope. This Chapter provides the procedures for making average weekly wage determinations. Further information regarding average weekly wage determinations in occupational disease cases can be found in PM 2-203.3 and PM 3-400.3.

2. Definitions.

1. **Average Weekly Wage**. The average weekly wage (AWW) is set at one fifty-second part of the employee's average annual earnings.
2. **Wages**. Section 2(13) of the Act defines wages as the money rate at which the service rendered by an employee is compensated by an employer under the contract of hiring in force at the time of injury, including the reasonable value of any advantage which is received from the employer and included for purposes of any withholding of tax under subtitle (c) of the Internal Revenue Code of 1954 (relating to employment taxes). The term wages does not include fringe benefits, including (but not limited to) employer payments for or contribution to a retirement, pension, health and welfare, life insurance, training, social security or any other employee or dependent benefit plan for the employee's or dependent's benefit, or another employee's dependent entitlement.

3. <u>Provisions of Section 10 for Determining AWW</u>. Section 10 of the Act provides three methods for calculating the employee's average annual earnings. One of these methods must be used to compute the average annual earnings of the employee. Section 10(d)(1) provides that the "average weekly wages of an employee shall be one fifty-second part of his average annual earnings."

1. **Worker Engaged in Employment All or Most of Year**. If the employee has worked in the kind of employment in which he/she was injured for substantially the whole of the preceding year, the average annual earnings for compensation will consist of 300 times the average daily wage of a 6-day worker or 260 times the average daily wage of a 5-day worker engaged in such employment. If a problem develops as to the precise meaning of the word "substantially," a certain amount of flexibility is granted by the nature of the word. The test is not to be applied mechanically but with a flexible view toward fairly reflecting the employee's probable future earning loss. It is intended to apply to work that is steady or permanent. Professor Arthur Larson gives the following example:
   In Tangorra v. National Steel, 6 BRBS 427 (1977), the Board concluded that the first step in determining the employee's correct average weekly wage was the calculation of the average daily wage. This is done by dividing the number of days actually worked into the total earnings for the 12 months immediately preceding the injury (for example $11,270 (total earnings) divided by 245 (total days worked) = $46.00 average daily wage). The resulting figure is then multiplied by 260 (if the employee was a "5 day worker") and divided by 52 weeks to obtain the correct average weekly wage ($46 x 260 / 52 = $230.00 P/W). If the employee was a "6 day worker" the $46 would be multiplied by 300 instead of 260 and then divided by 52 weeks.
2. **Worker Engaged in Employment Less than All or Most of Year**. If the employee did not work in the same employment during substantially the whole of the year before the injury, the same formula as applied in section 10(a) will be used and applied to the wage of an employee of the same class, working substantially the whole year, in the same or similar employment, in the same or a neighboring place on the days when so employed. The essential factor in

applying this provision is to determine whether the earnings of the chosen "similar employee" are sufficiently similar to those of the injured employee. If the selected employment produces an unrealistic result, flexibility again must be stressed and the application is not to be rigid and mechanical. The CE shall strive for agreement of the parties when the method described in this subparagraph cannot be strictly applied.

3. **Exceptional Conditions of Employment**. If neither of the methods outlined in subparagraphs 4a and 4b above can reasonably be applied, the DD or CE will consider the average annual earnings to be "such sum as, having regard to the previous earnings of the injured employee in the employment in which he was working at the time of the injury, and of other employees of the same or most similar class working in the same or most similar employment in the same or neighboring locality, or other employment of such employee, including the reasonable value of the services of the employee if engaged in self-employment, shall reasonably represent the annual earning capacity of the injured employee." There are a number of variables that might affect this application. This test provides even more flexibility than is seen in section 10(a) or (b). Section 10(c) is the catch all provision. It applies to seasonal, intermittent, discontinuous and other employment, which amounts to less than a full work year.

   See Matulic v. Director, OWCP, 32 BRBS 148(CRT)(9th Cir. 1998) for an application of section 10 to an unusual set of facts.

4. **Retired Employees**.
    a. Section 10(d)(2)(A) provides that if the time of injury occurs within the first year of voluntary retirement, the average weekly wage shall be one fifty-second part of his/her average annual earnings during the 52 weeks prior to retirement.
    b. Section 10(d)(2)(B) provides that if the time of injury occurs beyond one year after voluntary retirement, the average weekly wage shall be the National Average Weekly Wage (as determined under section 6(b) of the Act) at the time of injury.

c. If the employee retires due to the occupational injury, the post retirement provision does not apply. The claimant's AWW should reflect his/her wages prior to retirement. (See PM 2-203 for more information on the handling of occupational disease cases.)

4. Time of Injury Determinations. The average weekly wage is fixed at the time of injury, even if the disability begins subsequent to this date. In occupational disease cases, injury is defined as the date on which the claimant became aware or in the exercise of reasonable diligence or by reason of medical advice should have been aware of the relationship between the employment, the disease and the death or disability. In hearing loss cases, the date of last exposure to injurious stimuli prior to administration of a determinative audiogram is the relevant time of injury for purposes of calculating the average weekly wage. See **Ramey v. Stevedoring Services of America**, 31 BRBS 206(CRT)(9th Cir. 1998); **Mauk v. Northwest Marine Iron Works**, 25 BRBS 118 (1991). The "determinative audiogram" is that test which is determinative of the amount of permanent partial impairment for which the Claimant is being compensated.

5. Part-Time Employment. An employee's earning capacity is not limited solely to the earnings in the particular employment, which the employee was engaged in when injured but should be gauged by what the employee is capable of earning in all employment in which he/she was employed during the year prior to the injury.

6. Determination of the Wages of a Minor. If under normal circumstances the wages of an injured minor can reasonably be expected to increase during the period of disability, the employee's wage rate shall not be limited to the pre-injury earnings. The age of majority shall be 21 years of age.

7. Additional Income Considered As Wages. The following items have been held to be wages in certain conditions and should be included in the average annual wage calculation:

1. Overtime pay (if a regular and normal part of employment)
2. Vacation Pay
3. Container royalty payments
4. Tips and bonuses
5. Room and board
6. Car allowance

8. Evaluating Wage Information.

1. **General**.
    a. Upon receipt of Form LS-206 or Form LS-208, the CE should examine the wage information reported and compare it to the wage information reported on Form LS-202.
    b. If there is a discrepancy or payment of compensation is at a tentative rate, the CE should actively resolve this matter as soon as possible. To resolve the controversy the CE should send the claimant a form LS-426 or LS-557 for clarification.
    c. If the claimant responds with information that substantiates a change in compensation benefits, the EC is to be promptly notified. LS-537, Change in Compensation Based on Higher AWW (Exhibit 46, PM 10-200), may be utilized for this purpose. If the claimant fails to respond and compensation continues to be paid at a tentative rate or at an obviously incorrect rate, the EC is to be contacted and advised that the rate must be corrected.
2. **Resolution**. The average weekly wage determination should be fair and reasonable. Section 10(c) of the Act is to be utilized whenever there is a doubt. All parties must be willing to compromise. Under extreme circumstances an informal conference may need to be scheduled, but keep in mind there is ample case law available. The Desk Book should be consulted along with the Matthew Bender Benefits Review Board Service for the current case law on the subject.
3. **Exceptions**. There are always exceptions to every rule and wage information will not always fit neatly into the categories listed in sections 10(a), (b), and (c) of the Act. For instance the Outer Continental Shelf Lands Act presents special problems due to the nature of the working assignments. District Offices will find it necessary to work up local rules to deal with such situations. Certain Defense Base Act contracts may also involve unique work assignments and unique contractual arrangements concerning payments. The NO should be contacted whenever a situation arises that cannot be resolved.

Paragraph and Subject	Date	Trans. No.
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9. Unrelated Death	09/00	00-01
10. Application of Holliday Decision	09/00	00-01

1. Purpose and Scope. This Chapter provides the procedures for making the annual October 1 adjustments for those individuals receiving permanent total disability and death benefits. These individuals are entitled to have their weekly compensation benefits increased by a percentage determined by the Secretary of Labor based upon the increases in the National Average Weekly Wage (NAWW). These procedures apply to all cases entitled to October 1 adjustments whether payments are made by the Special Fund or by the EC.

2. Statutory Provisions.

1. **Section 6(b)(3)** of the Act provides that as soon as practical after June 30 of each year and no later than October 1 of each year, the Secretary shall determine the NAWW for the three consecutive calendar quarters ending June 30. This determination becomes the applicable NAWW for the period beginning October 1 of that year and ending with September 30 of the following year.
2. **Section 10(f)** provides that effective October 1 of each year, the compensation or death benefits payable for permanent total disability or death arising out of injuries subject to the Act shall be increased by the lesser of:
    a. A percentage equal to the percentage (if any) by which the applicable NAWW for the period beginning on such October 1, as

determined under section 6(b), exceeds the applicable NAWW, as so determined, for the period beginning with the preceding October 1; or

b. 5 percent.

3. **Section 10(g)** provides that the weekly compensation under section 10(f) shall be fixed at the nearest dollar. No adjustment of less than $1.00 shall be made, but in no event shall compensation for death benefits be reduced.

3. Cases to be Adjusted by National Office. On or about October 1 of each year, subsequent to the NAWW determination, the NO will compute and make adjustments on all cases on the Special Fund roll at that time. This will include sections 8(f), 18(b), and 10(h) cases (see PM Chapter 3-203 for further information). These individuals will receive direct adjustments from the Special Fund followed by a letter explaining the basis for the increase and the amount of the increase. A copy of the letter will be sent to the DO for review and filing. The DD should promptly notify the NO with respect to any discrepancies or changes. Such notification must be in writing.

4. Cases to be Adjusted by District Offices. During the month of October each DO, upon receipt of the necessary notification and information from the NO via a LHWCA Bulletin, will compute and have adjustments made for all permanent total disability and related death cases not listed in paragraph 3.

5. Procedures. The procedures described in the following paragraphs are to be followed in computing and implementing the annual section 10(f) adjustments. The steps included in these procedures are:

1. **Annual Bulletin**. Each year the LHWCA NO will issue a Bulletin providing the new NAWW, annual percentage increase and other information necessary to make the annual adjustments and distribution of Form Ltr. LS-521, Notice to Employer/Carrier and Payee/Beneficiary of Annual Adjustment in Weekly Compensation Rate (Exhibit 42, PM 10-200) revised for the current year's adjustment. The printed supply of the revised Form LS-521 will be sent to the DO in a separate mailing.
2. **Notification of EC**. Each DO notifies the appropriate Employer/Carrier of the section 10(f) increase and amount of adjusted weekly award and instructs them to pay the increased benefits (Form Ltr. LS-521 in duplicate). A thirty day call up will be placed on the case. The LS-521 will be sent to the local or

regional office paying benefits. This form letter instructs the EC to return a copy of Form Ltr. LS-521 to the DO after filling in the certification portion on the reverse side of the letter. The information to be returned indicates that the adjustment has been made and the date of the adjustment payment. The DOs will verify that the certification has been made and the date of the adjustment made. The EC should promptly be notified if the certification portion is incomplete or not completed. (See paragraph 7, below.)

3. **Notification of Chief Beneficiary/Payee**. At the same time that the DO releases the LS-521 to the EC, a copy will also be released to the chief beneficiary/payee. While the contents of the letter are primarily directed to the EC, a paragraph has been included which indicates to the chief beneficiary or payee that a copy of this letter serves as notification of the annual adjustment.

6. Annual Section 10(f) Bulletin. A LHWCA Bulletin will be issued each year as early as possible before October 1 notifying the DOs of the NAWW for the period applicable to that date and other information for adjusting PTD and related death cases under section 10(f). Since the amount to be adjusted and the percentage by which benefits are increased vary each year, examples of the current section 10(f) increase, including calculations will be provided as an enclosure to the Bulletin.

7. Procedures for Form Ltr. LS-521. Each year DOs will notify eligible beneficiaries and the EC of the appropriate section 10(f) adjustment. (See subparagraphs 5b and 5c, above.) The steps included in these procedures are:

1. **Prepare Form Ltr. LS-521** in quadruplicate.
2. **Provide all data required** at the top of the Form Ltr. LS-521, including the amount of weekly increase and the amount of the adjusted weekly award.
3. **Type Name and address of EC** on Form Ltr. LS-521. Since a copy of this letter is also to be sent to the claimant, it may be desirable to also type name and address of the payee under that of the EC. However, this is optional since such action may preclude the use of window envelopes.
4. **Send the original and one copy**. of Form Ltr. LS-521 to the EC. At the same time, send a copy to the chief beneficiary/payee.

5. **Place the fourth copy** of Form Ltr. LS-521 in the case file, indicating in some manner that Form Ltr. LS-521 was sent to both the employer/carrier and to the chief beneficiary/payee and the date sent.
6. **Place thirty day call-up**. on the case file.
7. **When the copy** of Form Ltr. LS-521 has been received from the EC by the DO and the certification portion verified as properly completed, and noted on the copy of the form letter, place the copy in the case file.

8. Follow-Up on Form Ltr. LS-521. If the form letter is not returned by the EC within thirty days from the date of notification, the insurer shall be queried as to the action taken or reason for failure to take action. (See subparagraph 7f, above.)

9. Unrelated Death. Under the provisions of Pub. L. No. 92-576, which became effective on November 26, 1972, section 9 provided that "if the employee who sustains permanent total disability due to the injury thereafter dies from causes other than the injury "the survivors are eligible to receive death benefits. However, the Director accepted the position of the Benefits Review Board in **Witthuhn v. Todd Shipyards**, 3 BRBS 146 (1976) and **Egger v. Williamette Iron and Steel**, 2 BRBS 247 (1975), that annual adjustments under section 10(f) do not apply to death benefits if the death was not causally related to the employment injury. This provision is applicable to unrelated deaths that occur between November 26, 1972 and September 27, 1984. Public Law No. 98-426 which became effective on September 28, 1984 amended section 9. There is no provision in the amended section 9 for the payment of death benefits to survivors when the claimant dies from unrelated cause while receiving permanent total disability benefits.

10. Application of Holliday Decision. Application of Holliday Decision. In the case of **Holliday v. Todd Shipyards Corp.**, 13 BRBS 741, 654 F.2d 415 (5th Cir. 1981), the United States Court of Appeals for the Fifth Circuit held that the initial permanent total disability rate should include all intervening section 10 (f) adjustments occurring during the period of previous temporary total disability.

Holliday was reversed in the Fifth Circuit, **Phillips v. Marine Concrete**, 23 BRBS 36(CRT)(5th Cir. 1990) and the Benefits Review Board found that it is no longer applicable in the D.C. Circuit, **Bailey v. Pepperidge Farm, Inc.**, 32 BRBS 76. However, it still remains applicable to cases arising in the Eleventh Circuit. It is our policy to apply Holliday only to those cases governed by the Eleventh Circuit.

In order to calculate benefits in accordance with **Holliday** note the following example. A claimant is injured on August 1, 1981 with an average weekly wage of $300.00 per week. He/she reaches maximum medical improvement on August 1, 1984 and is declared permanently and totally disabled as of that date. The claimant is paid temporary total disability benefits from August 1, 1981 through July 31, 1984 at the rate of $200.00 (66 2/3% of $300.00). Effective August 1, 1984, the claimant receives the benefit of the annual adjustments for 1981, 1982 and 1983 and would receive $240.00 per week. Effective October 1, 1984 the rate would increase to $252.00 per week. If **Holliday** were not applied to the case, effective August 1, 1984, the claimant would still receive $200.00 per week and on October 1, 1984, the rate would increase to $210.00 per week. In both examples once the **initial** rate for permanent total disability is established, each October 1, thereafter, the claimant's weekly entitlement is increased by the percentage increase in the NAWW (limited to a maximum of five per cent).

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1. Purpose and Scope. This Chapter provides the procedures for determining the amount of initial and subsequent compensation payable in those cases subject to section 10(h) of the Act.

2. History. When Congress enacted Pub. L. No. 92-576 on October 27, 1972, one of the primary purposes was to raise the benefit levels for those individuals receiving permanent total disability and death benefits. At that time, the maximum weekly compensation payable in these cases was $70.00 per week. In order to limit the impact of these increased benefits, it was established that fifty percent of the increased benefits would be funded annually by Congress and the remaining fifty percent would be obtained from an assessment of insurance carrier and self-insured employers. Initially these increased benefits were paid directly by the insurance carrier or self insured employer. Every six months, a claim for these additional payments was made to the NO. Reimbursement was directed to the ECs after verification of payment was made. Effective September

10, 1981, the direct payment of these benefits became the sole responsibility of the NO.

3. <u>Case Law</u>. The language in section 10(h) has led to considerable controversy and litigation.

1. **The BRB**, in **Silberstein v. Service Printing Company**, 2 BRBS 143 (1975), considered whether section 10(h)(1) was applicable to a person who was injured before but permanently and totally disabled after the 1972 amendments. The Board noted that it was:

   The Board is of the opinion that the intent and purpose of all of section 10(h) is to upgrade benefits for permanent total disability or death from injuries occurring prior to the effective date of the amendments of the Act.

   In addition, in this decision the Board held that the claimant is entitled to all cost of living increases between November 26, 1972 and the date the permanent total disability commences. Thus, if the claimant was injured in 1971 with an average weekly wage of $105.00 per week and a permanent total disability date of October 15, 1975 the rate would be $107.00 per week computed as follows:

   a. The ECs liability would be limited to $70.00 per week.
   b. The balance of the payment would be made by the Special Fund. In order to determine the Special Fund's liability and the rate of compensation claimant would receive on the effective PTD date, October 15, 1975, the computations would be as follows: The Special Fund liability would be calculated from November 26, 1972. The claimant would be entitled to increases of $17.87 on 11/26/72 which is 66 2/3% of the National Average Weekly Wage (NAWW) established for that date less the ECs maximum liability (2/3 x $131.80 = $87.87 - $70.00= $17.87). On 10/1/73, a 6.49% increase in the NAWW results in a $24.00 increase to the claimant ($87.87 + 6.49% = $94.00 (rounded) - $70.00 = $24.00). On 10/1/74 the claimant would begin receiving $30.00 more ($94.00 + 6.26% =

$100.00 (rounded) - $70.00 = $30.00). On 10/1/75 the claimant would begin receiving $37.00 per week from the Special Fund. The claimant's total payment would be $107.00 per week and his/her future annual increase would be based upon this amount (i.e. on 10/1/76: $107 + 7.59% = $115.00 (rounded), $70.00 paid by the EC and $45.00 paid by the Special Fund).

2. **In Luke v. Petro-Weld**, 12 BRBS 338 (5th Cir. 1980), the Court held that section 10(h) did not apply to injuries occurring after the date of enactment of the 1972 amendments, October 27, 1972. Section 10(h) would only apply to injuries occurring prior to the enactment date.
3. **While most section 10(h)** issues have previously been resolved by litigation, one issue still remains under consideration. In cases where the injury takes place prior to the enactment of the 1972 amendments but the death occurs after the 1972 amendments, the determination of the ECs liability is still in dispute. The Sixth Circuit, in **Director, OWCP v. Detroit Harbor Terminals, Inc.**, 850 F.2d 283, 21 BRBS 85(CRT)(6th Cir. 1988), held that the EC's liability was limited by the maximum in effect prior to the 1972 amendments. However, the First Circuit, in **Director, OWCP v. Bath Iron Works (Lebel)**, 885 F.2d 983,22 BRBS 131 (CRT)(1st Cir. 1989), cert. denied, 494 U.S. 1091 (1990), reversed the Board's determination that Section 10(h) applies where a post-1972 amendment death follows a pre-1972 amendment injury. The court held that because death benefits for a post-1972 death are calculated at the more generous post-1972 rates, it is unnecessary for the "gap-closing" provision of Section 10(h)(l) to apply. In view of these decisions, the Director has taken the position that the death is a new cause of action and therefore the ECs liability for basic compensation is determined in accordance with that date, with all future adjustments payable by the Special Fund under section 10(h). Given the conflict in circuit court decisions, cases of this nature should be referred directly to the NO for a determination as to the amounts payable by the EC and the Special Fund.

4. <u>National Office Issuances</u>. As time passes, the number of section 10(h) cases will diminish. However, all DDs and CEs should be aware of NO issuances

on this subject made since the 1972 amendments. A copy of any of the following issuances can be obtained from the National Office.

1. **OWCP Bulletin No. 10-73, 3/30/73**, Adjustment of Compensation for Total Permanent Disability or Death Prior to LS/HW Amendments of 1972.
2. **LHWCA Bulletin No. 2-75, 1/31/75**, Procedures for Providing sections 10(h)(1) and 10(f) Adjustments for Eligible Cases Involving Multiple Payees and Certain Cases Where the Widow Has Remarried.
3. **All Deputy Commissioners (LHWCA), 2/8/78**, Adjustment of Permanent Total Disability and Death Benefits in Cases When the Date of Injury Occurred Prior to January 1, 1947.
4. **Circular No. 80-14, 8/21/80**, BRB Decision on Deficiency Compensation and section 10(h)(2), **Waganer v. Alabama Dry Dock and Shipbuilding Co.**

Chapter 3-0300, Secondary Case Review

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1. Purpose and Scope. This Chapter serves as an introduction to the procedures for the secondary review of disability and death cases contained in the following two chapters.

2. Related Chapters. In Part 2 of the Procedure Manual, Chapter 2-201 and Chapter 2-202 describe the actions to be taken in the primary review of disability and death cases. The procedures in Chapter 3-301 and Chapter 3-302 take up where those procedures left off. They include and augment the procedures for the primary review of disability and death cases found in Part 2.

3. Definition. A secondary case is any open file which has previously undergone initial case review by the Claims Examiner (CE) or Claims Examiner Clerk (CEC). It comes up for secondary review when a call-up expires or a requested document or additional information is received. It remains a secondary case until all necessary action is completed and the case is closed.

Chapter 3-0301, Disability

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1. Purpose and Scope. This Chapter describes the procedures for the review of secondary disability case files by the Claims Examiner (CE) or Claims Examiner Clerk (CEC) after completing the initial primary case review. Secondary cases are jacketed cases which a CE/CEC has reviewed initially and in which at least one action has been taken. The second review of the file is made after additional information is received by the DO or when a call-up becomes due. These procedures augment those for primary case review in PM 2-201.

2. Routine Cases Review.

1. **Review for Additional Information at Call-Up Date**. As soon as new information is received, the CE shall review each document for adequacy. All medical reports should be evaluated with respect to adequacy (check to see whether a diagnosis has been made, the severity of the injury, the type of treatment rendered, prognosis, etc.). Form LS-1, Request for Examination and/or Treatment (Exhibit 1, PM 10-200) should be reviewed to see whether the medical report was timely filed (within ten days) by the physician, and whether it indicates the claimant was afforded free choice of a physician.
2. **Follow-Up Action for Additional Information**. If the review of the case file is based on an expired call-up because the CE is awaiting additional information

and the information has not been received, there should be a follow-up. If more than sixty days have elapsed without the receipt of a Form LS-204, Attending Physician's Supplementary Report (Exhibit 18, PM 10-200), or narrative report, the CE should request a medical report.

3. **Closure of Case**. Cases are closed when conditions exist as explained in PM 2-200.4 or when all payments have been made in accordance with a compensation order and Form LS-208, Notice of Final Payment or Suspension of Compensation Payments (Exhibit 21, PM 10-200) showing termination of payments is received and is verified by the CE. If Form LS-208 is correct, the CE sends copies of the form to the claimant or claimant's representative. The case is closed by changing the status in the LCMS. (For details on closing cases, see paragraph 12 below.)

3. In-Depth Case Review. Cases involving serious injuries, occupational diseases (see PM 2-203), or other complications require in-depth review as secondary cases. All the issues listed below must be considered. The balance of the Chapter (paragraphs 4 through 10) addresses situations which may or may not occur and must be treated accordingly.

1. **Determine Eligibility**. The CE/CEC considers the criteria set forth in PM 0-300 and continues the evaluation begun in the primary review, PM 2-201.
2. **Verify Compensation Rate (Wage Rates, AWW)**. The DD or CE shall review Form LS-206, Payment of Compensation Without Award (Exhibit 19, PM 10-200) to insure the correctness of payments to the injured employee. The employee's average weekly wage (AWW) shall be determined in accordance with section 10(a) through (d) of the Act (see PM 3-201). If Form LS-206 indicates that compensation payments are being paid at a tentative rate, and the EC reports that they have been unable to obtain data as to the employee's earnings through their usual channels to establish the exact amount of earnings, the CE/CEC shall send Form LS-426, Request to Employee for Wage Earnings Information (Exhibit 39, PM 10-200). When the information is received, the CE will determine the employee's correct AWW, and if it differs from the wage used by the employer/carrier, the CE shall advise the EC, using Form Ltr. LS-537, (Exhibit 46, PM 10-200), to adjust compensation payments

accordingly. The CE should verify that the correct AWW is entered into the LCMS. The CE should also check for the applicability of minimum/maximum rates payable pursuant to section 6(b) (Exhibit 26, PM 10-300).

3. **Consider Third Party Involvement**. The CE/CEC reviews the case and takes action, as required, in accordance with PM 3-600.
4. **Check for Controversion of Entitlement**. When the EC controverts the employee's entitlement to compensation as indicated in PM 2-201.3d and Form LS-207, Notice of Controversion of Right to Compensation (Exhibit 20, PM 10-200) is received in the DO, the CE shall send a Form LS-209, Request for Employee's Reply to Employer's Objections (Exhibit 22, PM 10-200) to the claimant within ten days. The claimant should be allowed thirty to sixty days to respond before taking action (e.g., schedule of informal conference). Where any installment of compensation is not paid within fourteen days of date due (unless controversion is filed within fourteen days of the knowledge of injury), a 10% penalty must be applied under section 14(e) of the Act unless such nonpayment is excused by the DD after a showing by the EC that owing to conditions over which it had no control, such payment could not be made within the period prescribed for the payment. If the controversion notice is filed more than fourteen days after knowledge of the injury, the 10% penalty shall apply to all compensation due up to the date of the untimely filing or the date of an informal conference held to discuss the contested issue(s), whichever occurs first. (See PM 8-202.) Furthermore, interest should be applied to each delayed installment of compensation in accordance with 28 U.S.C. section 1961. (See PM 8-201.)
5. **Consider Medical Evidence**. Each case file should include sufficient medical data so that the DD/CE can monitor the medical care received and to make the necessary determinations regarding compensation.
    a. **Initial Medical Reports**. Within ten days following the initial examination or treatment, the physician shall furnish a medical report on Form LS-1, Request for Examination and/or Treatment (Exhibit 1, PM 10-200) to the DD, with copies to the EC.

b. **Medical Questions**. In those cases where the DD/CE determines that there is a question regarding the necessity, character, or sufficiency of medical care being furnished the injured employee, the question shall be resolved as promptly as possible. Maximum use shall be made of available OWCP District Medical Advisors, or consultation with the attending physician. For further responsibilities of the DD/CE regarding the management of medical care for the injured employee, see PM 5-200.

c. **Obtaining Medical Reports**. If no initial medical report is received within thirty days, a request on Form LS-216, Request for Additional Reports (Exhibit 25, PM 10-200) shall be sent to the EC. If the EC fails to respond within thirty days, the CE shall make a follow-up request. If the attending physician fails to comply within an additional thirty days or continually fails to submit reports, the CE shall refer the case to the DD, stating the facts of the case along with a recommendation for further handling of the case. (See PM 5-300.)

d. **Medical Reports in Long-Term Disabilities**. Generally, medical reports should be required every thirty to sixty days. In cases of obvious long term disability (i.e., disabilities permanent in nature or permanent impairment), reports may be requested at ninety day intervals or longer, based on the circumstances.

e. **Final Medical Reports**. Such reports are required for all extended disability cases at the time maximum medical improvement is achieved. Where the potential for PPD exists, a report shall be requested indicating the percentage of PPD (impairment) using the AMA Guides where possible. Sections 7(e) and 14(h) procedures may be utilized to obtain medical information on permanent impairments resulting from injuries when disputes arise in such cases. (See PM 5-300, PM 5-400 and **LHWCA Program Memorandum No. 50, May 20, 1974**, regarding applicability of section 7(e).) A copy of the Program Memorandum can be obtained from the National Office, if needed.

f. **Hearing Loss**. In special evaluations for hearing loss cases, the claimant shall be referred to an impartial otologist for examination and determination as to the amount of hearing loss. This referral will be made after the CE insures that the case file contains as much information or evidence as is readily available or considered pertinent. Upon receipt of the otologist's report and contingent upon the findings, the DD/CE shall calculate the percentage of hearing impairment and render a recommendation for payment of a schedule award, notifying the interested parties of recommended payment of benefits. (See PM 3-401.)

6. **Consider Late Report (Employer)**.
    a. **Form LS-202, Employer's First Report of Accident or Occupational Illness**. (Exhibit 16, PM 10-200). Section 30(a) requires an employer to furnish a report of the injury which causes loss of one or more shifts of work or death. For procedures regarding the assessment of penalty for late reporting, see PM 8-302.
    b. **Form LS-208, Notice of Final Payment or Suspension of Compensation Payment**. (Exhibit 21, PM 10-200). Under section 14(g), an EC is given sixteen days after final payment of compensation to make a report (Form LS-208) of the payment to the DD, or is subject to a penalty in accordance with the procedures in PM 8-301.
7. **Consider Rehabilitation Potential**.
    a. **CE Referral Responsibility**. The CE's responsibility for the development of rehabilitation referrals is the foundation for a successful rehabilitation program.
        i. **"R" System Referrals (LS-222)**. The EC may, but is not required to, file Form LS-222, Carrier's or Self Insurer's Report of Rehabilitation (Exhibit 26, PM 10-200) whenever (i) the need for rehabilitation services is indicated or (ii) the injured individual receiving compensation has not returned to work within two months from the date of injury.

ii. **Rehabilitation Follow-up System**. To assist in the identification of cases with possible rehabilitation potential, LCMS automatically places a rehabilitation call-up on a case for "Initial Rehab Review" 120 days after the Pay Indicator is turned on for the first time. Running the "Rehabilitation Call-Up Schedules" under the Reports tab of LCMS will produce a list of those open cases with a rehab call-up falling within the period specified by the user.

A. **"R" Form (LS-222) Received**. The mail clerk attaches the yellow copy of the Form LS-222 to the case file. The CE/CEC notes any significant details. The white copy of the Form LS-222 is routed to the Rehabilitation Specialist (RS).

B. **"R" Form (LS-222) Not Received**. The claims examiner is responsible for the medical monitoring of cases in a TTD status for early indications of the need for rehabilitation. The claims examiner should refer the case to the Rehabilitation Specialist using Form OWCP-14 where the medical evidence indicates that the claimant cannot return to the job held when injured and is in need of rehabilitation services. If the claimant remains in TTD status for more than 120 days and the medical evidence is not sufficient to make a determination regarding referral, the claims examiner should then contact the employer/carrier to determine whether any rehabilitation effort has been initiated.

iii. **Other Referrals (OWCP 14)**. Occasionally, the CE will encounter a case that warrants consideration for rehabilitation and is not being monitored by the RS. For example, the employee was previously referred to the RS

but was terminated from monitoring by the RS and now has a change in medical or vocational condition. The CE should refer the case to the RS using Form OWCP 14, Referral to OWCP Rehabilitation (Exhibit 4, PM 10-200).

b. **Medical Rehabilitation**. The CE's identification of subsequent cases for rehabilitation begins with the receipt of Form LS-204, Attending Physician's Supplementary Report (Exhibit 18, PM 10-200) or other medical report. For further procedures regarding medical rehabilitation, see OWCP Rehabilitation Procedure Manual. The RS, after referral by the CE, initiates an evaluation for medical rehabilitation services when the employee's early return to work would be facilitated. The RS will coordinate with the CE as needed.

c. **CE Involvement in Rehabilitation Planning**.

   i. **TTD During Rehabilitation**. Injured workers have additional anxiety in planning for and undergoing rehabilitation programs when the length and amount of compensation payments are uncertain. The CE can eliminate this uncertainty by encouraging the EC to continue TTD payments during a vocational rehabilitation effort. See **Abbott v. Louisiana Ins. Guaranty Ass'n**. 27 BRBS 192(1993), aff'd, 40 F.3d 122,29 BRBS 22 (CRT)(5th Cir. 1994).

   ii. **Settlements During Rehabilitation**. Injured workers settling their claim during rehabilitation rarely effectively rehabilitate themselves. The CE should support and encourage workers to complete rehabilitation programs, once started. The CE should also advise the RS whenever a case in rehabilitation is settled. (See Olsen v. General Engineering & Machine Works, 25 BRBS (1991).)

8. **Consider Adequacy of Report Forms**. By this time in the case review process, the voids in the essential reports for the development of a case should be identified and pursued by the CE/CEC.

a. **Required Additional Information**. No more than thirty days elapse before a Form LS-216 (Exhibit 25, PM 10-200) or similar request is released for missing information. Such request shall receive a follow-up within thirty days.

b. **Required Information for Rehabilitation Cases**. Submission of Form LS-222 (Exhibit 26, PM 10-200) or "R" Form is voluntary and may be submitted within two months of injury when compensation is continued and the injured worker has not returned to work. If the claimant remains in TTD status for more than 120 days and the medical evidence is not sufficient to make a determination regarding referral, the claims examiner should then contact the employer/carrier to determine whether any rehabilitation effort has been initiated.

4. Failure To Pay Installment of Compensation.

1. **Policy**. If any installment of compensation payable without an award is not paid within fourteen days after it becomes due, there shall be added to such unpaid installment an amount equal to 10% of the amount due. This additional amount shall be paid at the same time as, but in addition to, such installment. Such nonpayment may be excused by the DD after considering evidence by the EC, owing to conditions over which the EC had no control, the installment could not be paid within the period prescribed for the payment. (See PM 8-202.)
2. **Assessment**. The DD shall take steps to insure payment of the compensation due, plus an additional 10% in any case in which:
    a. More than twenty-eight days have passed without an initial payment of compensation from the date the EC had knowledge of the injury or death, or
    b. Any subsequent installment of compensation payable without an award is not paid within fourteen days after it becomes due, and the DD does not excuse the nonpayment. A subsequent installment of

compensation as defined by section 14(b) of the Act is due as of the end of the installment period.

5. <u>Compensation Payments Without Award</u>.

1. **Compensation benefits, under the Act, shall be paid** by the EC periodically, promptly, and directly to the person entitled thereto without an award, except where the liability to pay compensation is controverted by the employer (see subparagraph 3d, above). For TTD, an employee is entitled to two-thirds of his/her AWW at the time of injury, subject to the maximum compensation rate (established under section 6 of the Act) which is in effect at the time of injury.
2. **The first installment of compensation** becomes due on the fourteenth day after the EC has knowledge of the employee's injury or death. In addition, the Act states that all compensation then due must be paid. The EC, making compensation payments must immediately notify the DD by submitting Form LS-206, Payment of Compensation Without Award (Exhibit 19, PM 10-200), which indicates that compensation is being paid. If the entire period of compensable disability for work is covered by a single payment, Form LS-208, Notice of Final Payment or Suspension of Payments (Exhibit 21, PM 10-200) may be submitted in lieu of Form LS-206. If the employee's disability for work did not exceed fourteen days, he/she is not entitled to compensation for the first three days of disability. After the first payment, compensation should be paid at intervals of two weeks, or otherwise as the DD directs. Upon receipt of Form LS-206, or other indication that payments are ongoing, the CE should insure that the payment status is properly entered into the LCMS.
3. **Where the claimant is entitled to compensation**, the CE should check the file in accordance with this paragraph, to insure that compensation payments without an award have been made.

6. <u>Compensation Status</u>. Check to determine if the employee has returned to duty or if he/she is actually being compensated. If the EC's first report of injury indicates that the claimant lost time from work, but does not give the date of the employee's return to duty or notice of commencement of payment, the CE to

whom the case is assigned shall request a report from the EC as to the claimant's status with respect to compensation. Form LS-216, (Exhibit 25, PM 10-200), should be used for this purpose. After the compensation status of the claimant has been established, the CE should update the LCMS to reflect the information.

7. <u>Annual Adjustments</u>.

1. **Applicability**. Cases in which long term disability has been established, either by the issuance of compensation orders or when the EC voluntarily continues compensation payments, must be reviewed on a regular basis. If a compensation order is entered, the CE verifies that the EC is making or continuing payments. If the compensation is not for PTD or a death case, a call-up for twelve months may be placed on the case. At the end of the period, the CE requests a summary of payments made by the EC, and extends the call-up. A determination regarding the onset of permanency should be made at the earliest possible date in extended disability cases to insure that claimants receive all annual adjustments to which they are due.
2. **PTD and Death Cases**. All PTD and death case files are pulled annually (October) for the purpose of having an adjustment made under section 10(f) of the Act by either the EC or NO, DLHWC. (See PM 3-202.) The LCMS can provide a listing of these cases.

8. <u>Computation of Compensation for Loss of Wage-Earning Capacity</u>.

Sections 8(c)(21) concerning permanent partial disability and 8(e) concerning temporary partial disability both basically provide that compensation for these classes of disability shall be two-thirds of the difference between the employee's average weekly wages (AWW) at the time of injury and the employee's wage-earning capacity (WEC) after the injury. Since the employee's post-injury earning capacity may be established several years after the injury and given the possible intervening times of rapid economic inflation or depression, it is necessary to adjust the post-injury WEC back to the time of injury before making a comparison to the employee's AWW (**see Bethard v. Sun Shipbuilding and Dry Dock Company**, 12 BRBS 691).

If the wages for the post-injury job at the time of injury are known, a direct comparison can be made. In some instances, they can be readily determined. For example, if the employee's post-injury job pays the minimum wage, then the

claimant's WEC for comparison purposes would be the minimum wage at the time of injury.

If, however, the post-injury wages at the time of injury cannot be so easily determined, adjustment should be made based on the change in the national average weekly wage (NAWW). In **Richardson v. General Dynamics Corporation**, 23 BRBS 327, the BRB held that where there was no evidence of the actual wages paid by the claimant's post-injury job at the time of injury, the percent increase in the yearly national average weekly wage (NAWW), due to its more accurate reflection of the increase in wages over time than the Consumer Price Index (CPI), should be applied to adjust the claimant's post-injury wages downward.

For example, an employee was injured in July 1996 and had an AWW of $500.00 per week. In February 2000, the employee establishes a wage-earning capacity of $300.00 per week. Comparing the NAWW at the time of injury ($391.22) with the NAWW in February 2000 ($450.64) produces an adjustment factor of .86814 ($391.22/$450.64 = .86814). Applying this adjustment factor to the current WEC of $300.00 results in a WEC at the time of injury of $260.44 ($300.00 x .86814 = $260.44). This adjusted WEC can then be compared to the employee's AWW to determine the compensation entitlement.

$500.00 - AWW

less **260.44** - Adjusted WEC

$239.56 - Loss of WEC x 2/3 = $159.71 per week

9. <u>Suspension of Payments</u>. In a non-controverted disability case in which the EC has been paying compensation without an award under sections 14(a) and (b), the EC should not stop or suspend the payment of compensation without notification to the DD. When a further medical examination shows some improvement in the injury-related condition, but there is continued disability for work, the EC should ask the DD for an informal conference in order to determine any future liability as contemplated by section 14(h). Suspension of payments unilaterally under the foregoing circumstance is not authorized or justified by the Act and a unilateral suspension of compensation is done at the risk of incurring liability for an additional assessment under Section 14(e) if it is eventually found that the suspension was not warranted.

10. <u>Suspension Of Compensation Contested By Claimant</u>.

1. **Actions to Resolve Contested Compensation**. The claimant may contest the stoppage of compensation, and submit medical evidence of his/her

continuing disability, or otherwise advise the CE either in writing, by phone, or by a personal visit to the DO, that he/she is not able to return to work. If the EC upon notification refuses to resume compensation, the CE may schedule an impartial medical examination or schedule an informal conference, whichever is appropriate, to attempt to resolve the differences in medical opinion or the extent of continuing disability. The CE should request the EC to pay for the examination. The Special Fund will pay only for those examinations involving Special Fund beneficiaries or examinations requested by the Director, DLHWC. (For EC liability and insolvency, **see LHWCA MEMO 56, March 31, 1977, LHWCA Bulletin No. 82-2**, and PM 6-202. Contact the National Office if a copy of these issuances is needed.)

2. **Informal Written Recommendation**. Upon receipt of the impartial examining physician's report, the CE reviews the case to determine whether an informal written recommendation is possible. Copies of the recommendation letter or memorandum and the impartial examiner's report are sent to all interested parties. At this time, a three week call-up requirement shall be placed on the file awaiting a response to the informal recommendation.
3. **Acceptance of Additional Compensation to Claimant**. If the informal recommendation is for payment of additional benefits to the claimant, and EC accepts it and submits Form LS-206 or LS-208 (Exhibits 19, and 21, PM 10-200) in compliance, the CE should check the form for accuracy of the payment(s). If Form LS-208 was required, after verification, the CE should send the appropriate copies of the form to the claimant and claimant's representative. If the recommended payment constitutes a final payment under section 14(g), the CE should also determine whether Form LS-208 was submitted within sixteen days after final payment was made. (See PM 8-301.) If the compensation status of the claimant changes, an entry must be made in the LCMS to reflect the new status.
4. **Controversion by EC of Informal Recommendation**. The EC is required to submit Form LS-207 (Exhibit 20, PM 10-200) or equivalent within fourteen days of the date of injury. If not, the EC may be subject to payment of additional compensation under section 14(e). The CE should immediately

determine whether the Notice of Controversion was timely submitted. If Form LS-207 is received, copies, with Form Ltr. LS-209 (Exhibit 22, PM 10-200), or by a cover letter prepared by the district office, are sent to the claimant and his/her representative within ten days of receipt of Form LS-207 or equivalent.

5. **Adjudication by Informal Conferences or Formal Hearing**. A period of thirty to sixty days is allowed for a response to controversion by claimant or attorney/representative before taking further action. Procedures have been established for handling disputed cases by informal conferences (PM 4-200), and if the differences cannot be resolved by this method, a case is to be referred for formal hearing by the Office of Administrative Law Judges (OALJ). (See PM 4-600.)

11. Suspension Or Termination.

1. **Requirements for EC**. Section 14(g) of the Act requires that within sixteen days after suspending or terminating payments of compensation, the EC shall send to the DD a Form LS-208 (Exhibit 21, PM 10-200) stating that such payments have been suspended or terminated, the total amount of compensation paid, the name of the employee and of any other person to whom compensation has been paid, the date of the injury or death, and the date (inclusive) to which compensation has been paid. For instructions regarding the assessment of a penalty for failure to submit report of final payment of the compensation, see PM 8-301.
2. **Review of Form LS-208 by CE**The guidelines and procedures are set forth below:
    a. **Review and Disposition of Compensation Status**. On receipt of Form LS-208 (Exhibit 21, PM 10-200), the CE checks the period and amount of compensation for correctness, and releases copies to the claimant and his/her attorney or representative. The action is noted on the file copy of the form by initials and date of release of the form. Also, at this time the compensation status should be changed in the LCMS to show that the case is no longer in compensation status. If the information on the form is incorrect (i.e., wrong dates, incorrect

number of days, or wrong compensation), the CE notes correction on copy four (employee's) and returns it to the EC with instructions to correct the error and return a corrected Form LS-208.

b. **Call-Up of Non-Controverted Case Files**. In non-controverted claims, a call-up ranging from three to six months may be placed on the case file for later review; however, the length of the call-up is at the discretion of the claims examiner, provided that:

   i. Call-ups are being reviewed as cases become due.

   ii. All initial data is available at the time the Form LS-208 is received.

   iii. No immediate action is indicated, notwithstanding the need for further development or consideration of the case in the future (e.g., evaluation of PPD, disposition of a third party action, etc.).

3. **Verification and Notification of Suspension to Claimant**. Form LS-208 will be reviewed and verified by the CE/CEC having responsibility for the case. If the payments reported are incorrect, the EC should be advised. If the payments reported are correct as to the period, weekly compensation, and total amount, the CE should send a copy of the approved form to the claimant, and note on the original copy in the file the date that the form was sent to the claimant. If the claimant may be entitled to further compensation (schedule award), a call-up should be placed on the file pending receipt of further information.

12. Call-Up After Second Review. After a second review of the case file, the CE determines when the file should be reviewed again, and places a call-up on the file. The periods between reviews are based on the CE's experience and judgement as to what further action is required.

13. Closing Compensation Cases.

1. **Conditions and Forms Required for Closurel**. In order to close a case file, Form LS-204, Final Medical Report (Exhibit 18, PM 10-200) or an optional narrative report and Form LS-208 (Exhibit 21, PM 10-200) should be available

for consideration. However, a case may be closed without obtaining a final medical report where all of the following conditions are satisfied:

a. The case is not controverted,
b. The disability is short-term (i.e., less than 15 days of disability),
c. There is no indication of permanent disability (including a scheduled loss),
d. No further adjudicatory action appears necessary, and,
e. Form LS-208 has been received, where appropriate.

2. **CE's Analysis and Actions in Closing Case**. The CE shall examine the Forms LS-204 and LS-208 to verify that they are complete. If no errors or omissions are discovered, and the CE believes that the claimant's injury could result in PPD, the CE shall prepare and release a Form Ltr. LS-403, Employee's Right to File Claim for Disability Compensation (Exhibit 38, PM 10-200) to the claimant, with a copy of Form LS-203. The Form LS-403 instructs the claimant to contact the DO if the claimant has a claim for compensation or permanency. This serves as a final check for the propriety of closing a case. The case file is returned to central file with a thirty to sixty day call-up, pending a reply. If no reply is received, the CE closes the case at the end of the thirty day period by changing the case status code in the LCMS.
3. **Exceptions to Closing Procedures**. There are exceptions to these closing procedures under the following circumstances:
    a. Cases where the claim is rejected or where the claimant is determined ineligible to receive compensation payments. This would include cases where it was determined by the DO or some higher adjudicative body that the claim was not under LHWCA jurisdiction. Under these circumstances, the case would be closed when an order to that effect is received by the DO. The DO has no requirement to issue an order covering such a decision, unless requested by any of the parties involved.
    b. Cases where the injured party makes no claim. The injured party usually will not have to file a claim to receive benefits under the LHWCA. In other rare circumstances, payments will not be

forthcoming without specific initiatives on the part of the injured party. Example:

i. Occasionally, an injury report is jacketed with less than three days disability in instances where the injury is such that the CE/CEC expects some claim for partial disability. However, the injured party may fail to respond to the dispatched Form Ltr. LS-504, Letter to Employee Explaining Rights (Exhibit 40, PM 10-200) and make no such claim. After a specified period of time to allow for such a response, the case file will be called up and closed by the CE.

ii. A claimant may agree with an EC's reasons for denying the right to compensation, via Form Ltr. LS-209, Request for Employee's Reply to Employer's Objections, (Exhibit 22, PM 10-200). If so, and the CE cannot dispute the EC's contention, the case file will be closed.

Chapter 3-0302, Death

Paragraph and Subject	Date	Trans. No.
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1. Purpose and Scope. This Chapter contains the procedures to be followed in handling secondary death cases. The initial development of primary death cases is covered in PM 2-202.

2. Death Benefits.

1. **General**. Death benefits are payable to eligible survivors if the injury or disease causes death. Compensation includes reasonable funeral expenses up to $3,000. A widow or widower can receive compensation at the rate of 50 percent of the Average Weekly Wage (AWW) of the deceased. Each dependent child is entitled to receive compensation at the rate of 16 2/3 percent of the deceased employee's AWW. Total death benefits may not initially exceed 66 2/3 percent of the deceased employee's AWW and are subject to the statutory limitations contained in section 6(b) of the Act on the date of death. However, the section 6(b) limit may be exceeded by the addition of section 10(f) increases. See PM 3-302.7 for more information on computing death benefits.

   A "child" shall include a posthumous child, a child legally adopted prior to the injury of the employee, a child in relation to whom the deceased employee stood in loco parentis for at least one year prior to the time of the injury, and a step child or acknowledged illegitimate child dependent upon the deceased, but does not include married children unless wholly dependent on him.

   The Board has held that the definition of the term "in loco parentis" is to be found in the laws of the pertinent state.

   Generally speaking, any person who takes a child of another into his/her home and treats it as a member of his/her family, providing parental supervision, support and education as if is were his/her own child, is said to stand in loco parentis. A person stands in loco parentis to a child when the person intends to assume toward the child the status of a parent. Examples can include, but are not limited to: supplying money for food and clothes; providing discipline; providing parental status/supervision, support and education, and statements to the fact that the child was considered by the decedent as his/her child or acknowledged as his/her child.

2. **Other Eligible Survivors** include dependent brothers, sisters, grandchildren, parents, and grandparents. The first three types of beneficiaries are entitled to twenty percent and the latter two, twenty-five percent. However, those beneficiaries are subordinate to the widow/widower and children; and can only receive an aggregate amount not more than the maximum percentage allowable. Thus a widow/widower and child would preclude other beneficiaries. A widow/widower without children would decrease a brother/sister's share from the twenty percent to sixteen and two thirds percent (see section 9(d) of the Act).
3. **Remarriage**. Upon remarriage, a widow or widower will receive a lump sum equivalent to two years compensation. Other survivors' benefit will be recomputed, effective as of the date of remarriage, and the lump sum is not to be treated as if it were periodic, that is, it does not count against the aggregate maximum, which is 66 2/3 of the deceased worker's wages. (**See LHWCA MEMO 59, March 6, 1979.**) Awards to children, brothers sisters, and grandchildren terminate when they reach eighteen years of age, but such compensation may be extended if a child is a student or is incapable of self-support. (See section 2(14) of the Act and **LHWCA MEMO 11, June 22, 1965.**) An amended order awarding benefits as a result of the remarriage is to be issued. Copies of the above-referenced LHWCA memos can be obtained from the National Office if needed.
4. **Dependent Beneficiaries**. Section 2(14) of the Act provides that the terms "'child,' 'grandchild,' 'brother,' and 'sister' include only a person who is under eighteen years of age, or who, though eighteen years of age or over, is (1) wholly dependent upon the employee and incapable of self-support by reason of mental or physical disability, or (2) a student as defined in paragraph (18) of this section."
5. **Student Benefit**.
    a. Section 2(18) defines the term "student" to include a person who is regularly pursuing a full-time course of study or training at certain specified classes of institutions, but not beyond the end of the semester or enrollment period after the person reaches the age of

twenty-three, or has completed four years of education beyond the high school level.

b. A child shall not be deemed to have ceased to be a student during
    i. any interim between school years if the interim does not exceed five months and he/she shows to the satisfaction of the Secretary that he/she has a bona fide intention of continuing to pursue a full-time course of study during the enrollment period immediately following the interim; or
    ii. periods of reasonable duration during which, in the judgment of the Secretary, he/she is prevented by factors beyond his/her control from pursuing his/her education.
c. A child shall not be deemed to be a student during a period of service in the Armed Forces of the United States.

3. <u>Compensation Orders</u>. At such time as the pertinent information is received and the payment of compensation has not been contested, a formal compensation order should be issued. If the case is contested, the procedures in Part 4, Case Adjudication are to be followed.

1. **Benefits for Children**. Where benefits are to be awarded for a child as defined in section 2(14), the order may provide for payment of benefits for a child eligible as a student by including the following or similar language:

   That compensation may be continued for a child after he/she reaches the age of eighteen, if he/she is a "student" as defined by the Longshore and Harbor Workers' Compensation Act at the time he/she reaches the age of eighteen, for so long as he/she continues to be a student within the requirements of section 2(18), but not beyond the end of the semester or enrollment period after he/she reaches the age of twenty-three, or has completed four years of education beyond the high school level.
2. **Benefits for Brother, Sister or Grandchildren**. Compensation orders awarding death benefits for brothers, sisters, or grandchildren, may provide for payment of benefits for such dependents eligible as a student, by including the

following or similar language:

That compensation may be continued for a brother/sister/grandchild after he/she reaches the age of eighteen, if he/she is a "student" as defined in the Longshore and Harbor Workers' Compensation Act, at the time he/she reaches the age of eighteen, for as long as he/she continues to be a student within the requirements of section 2(18), but not beyond the end of the semester or enrollment period after he/she reaches the age of twenty-three or has completed four years of education beyond the high school level.

4. Absence of Beneficiaries. If no eligible beneficiaries are found after a thorough investigation, a call-up shall be placed on the file to coincide with one year from the date of death. At that time, the DD will issue a compensation order in accordance with section 44(c)(1) of the Act, ordering the EC to pay $5,000 to the Special Fund. The EC is to be notified that a check is to be made out to the U.S. Department of Labor and forwarded to the DD. The DD will then forward the check with a memorandum and a copy of the compensation order to the Director, DLHWC.

5. Death Benefits to Students. The actions and documentation involved in such cases follow:

1. **Notice to Beneficiary of Benefit**. In any death case where a benefit is being paid on account of a child or other dependent under eighteen years of age, Form Ltr. LS-535, Notice to Guardian of Provision for Benefit Continuation (see Exhibit 44, PM 10-200) is to be sent to the person to whom the death benefit is being paid within three months after the dependent reaches the age of seventeen. This letter advises the recipient of the potential eligibility of the dependent for a continuing death benefit. ("Dependent" as used in this chapter and the form letters refers to a child or other individual named in 2(14) of the Act.)
2. **Notice to Parent/Guardian of Benefit**. Within sixty days before a "dependent" becomes eighteen years of age, Form Ltr. LS-536, Notice to Guardian of Requirement to Complete Form LS-266 (see Exhibit 45, PM 10-200) shall be sent to the parent or guardian, enclosing two copies of Form LS-

266, Application for Continuation of Death Benefit for Student (see Exhibit 34, PM 10-200).

3. **DD/CE Evaluation of Case**. Upon receiving a completed Form LS-266, bearing the certification of the official of the educational institution in which the dependent is enrolled, the DD/CE will determine whether the dependent is entitled to a continuing benefit as a "student." If the dependent is considered to be eligible, Form Ltr. LS-541, Recommendation to Employer/Carrier to Accept Continuation of Benefit (see Exhibit 47, PM 10-200) shall be sent to the EC paying benefits (or to the Director, DLHWC, if the case is being compensated under the War Hazards Compensation Act or from the Special Fund) enclosing one copy of Form LS-266.
4. **Failure to Authorize Benefit**. If the employer/carrier declines to continue the benefit or, if discontinued, declines to resume paying it, the DD/CE shall take appropriate action to resolve the question of the dependent's eligibility in accordance with the usual procedure for resolving disputed issues. (See Part 4, Case Adjudication.)

6. Death Benefits for Survivors of Disability Beneficiaries. Section 9 of the Act, as amended by Pub. L. No. 98-426 (enacted September 28, 1984) provides benefits to the survivors of an employee whose injury causes death. The apportionment for these benefits is described in paragraph 2, above. Thus, the survivors are eligible if the claimant dies immediately or if the claimant is eligible for temporary total disability or permanent total disability and subsequently dies as a result of the accepted occupational injury.

7. Computing Death Benefits.

1. **In computing death benefits**, the average weekly wage of the deceased shall not be lower than the National Average Weekly Wage prescribed in section 6(b) of the Act at the time of death. Thus, if the claimant's average weekly wage at the time of injury is less than the National Average Weekly Wage at the time of death, the latter wage is to be utilized. However, the total initial weekly benefits shall not exceed the lesser of the average weekly wages at the time of injury or the benefit the employee would have been eligible to receive utilizing the section6(b)(1) calculations.

2. **If the death is due to an occupational disease**, for which the time of injury, as determined by section 10(i) of the Act, occurred after the decedent had retired, the total initial weekly benefits shall not exceed one fifty-second part of the decedent's average annual earnings during the fifty two week period preceding retirement.

8. Funeral Expenses. Section 9(a) of the Act provides for a reasonable funeral expense not to exceed $3,000. The survivors are not entitled to a simple lump sum of $3,000 upon the death of the employee. The payment is to be made to the person or business who supplied the funeral service or related items or to the person or persons that paid for the service. The amount shall be limited to the actual expenses incurred up to $3,000. Form LS-265, Certification of Burial Expenses (see Exhibit 33, PM 10-200) must be submitted prior to the issuance of the compensation order awarding funeral expenses.

9. Change in Status of Beneficiary. Whenever the CE determines that there has been a change in the status of a beneficiary (e.g., death, remarriage, termination of eligibility because of age, etc.) the responsible provider of benefits, EC or Special Fund is to be notified immediately in writing. Otherwise incorrect payments will result. Reference PM Chapters 6-300.9 for verification of student status procedures.

10. Annual Adjustments. The procedures for annual adjustments under sections 10(f) and 10(h) of the Act in death cases are covered in PM Chapters 3-202 and 3-203.

11. Legislative History. Public Law No. 98-426, which was enacted on September 28, 1984, is applicable to any death that occurred on or after September 29, 1984 regardless of the date of the original injury. Public Law No. 92-576, enacted on October 27, 1972, is still applicable to deaths that took place between October 27, 1972, and September 28, 1984. This is significant since death benefits are payable in those cases where the claimant was entitled to permanent total disability benefits and died from unrelated causes. These unrelated death benefits are not subject to annual section 10(f) adjustments. In addition, there is no weekly maximum limitation on death benefits for deaths which occurred during this period in accordance with the Supreme Court's decision in Director, OWCP v. Rasmussen, 567 F.2d 1385 (9th Cir. 1978), aff'd, 440 U.S. 29, 9 BRBS 954 (1979). In addition, section 8(d)(3) of the Act prior to 1984, provided unrelated death benefits to survivors of employees who were receiving compensation for permanent partial disability pursuant to section 8(c)(21). Questions regarding which death cases may be subject to Pub. L. No.

92-576 and questions on how to handle deaths which occurred prior to the enactment of Pub. L. No. 92-576 should be referred to the NO.

Chapter 3-0400, Occupational Disease

Paragraph and Subject	Date	Trans. No.
Table of Contents	09/00	00-01
1. Purpose and Scope	09/00	00-01
2. References	09/00	00-01
3. Definitions	09/00	00-01
4. Evaluation of Evidence	09/00	00-01

1. Purpose and Scope. This Chapter introduces the general policies and procedures for handling secondary occupational disease cases. More specific information can be found in PM 3-401 (Hearing Loss), and PM 3-402 (Asbestosis). Chapter 3-300 (Secondary Case Review) also provides guidance on handling secondary cases in general.

2. References.

1. **The sections of the Act** pertaining to occupational diseases are: sections 2(10), 8(c)(23), 9(e)(2), 10(d)(2), 10(i), 12(a), and 13(b)(2).
2. **The sections of the regulations** pertaining to these diseases are: sections 702.212(b), 702.222(c), 702.601 to 702.604.
3. **The Law of Workmen's Compensation**, by Arthur Larson, Section 41.00.
4. **Guides to the Evaluation of Permanent Impairment**, published and revised from time to time by the American Medical Association.

3. Definitions.

1. **Average Weekly Wage**.
    a. Use the average weekly wage at the time of injury if this date is prior to retirement.
    b. Where the time of injury is after retirement and

i. Within the first year after retirement, use 1/52 part of average annual earnings in the fifty-two week period prior to retirement, or

ii. More than one year after retirement, use the National Average Weekly Wage at the time of injury.

2. **Date of Last Injurious Exposure**. The last date the claimant was exposed to the implicated harmful substance while working in employment covered by the LHWCA.
3. **Date of Manifestation**. The date the claimant becomes aware of the relationship between a disease and his or her employment or should have been aware of the relationship.
4. **Disability**.
    a. Where the time of injury is prior to retirement, disability is based upon a loss of earnings or earning capacity.
    b. Where the time of injury is after retirement, disability is based upon the amount of physical impairment.
5. **Impairment**. The amount of permanent loss, or loss of use of, an organ, body part, or bodily function, as determined in accordance with the **Guides to the Evaluation of Permanent Impairment**. If the **Guides** do not measure the impairment, any other professionally recognized standards or system of evaluation may be used.
6. **Occupational Disease**. An illness or condition which develops over a period of time in response to repeated exposure to harmful or injurious stimuli.
7. **Retirement**. The claimant has voluntarily withdrawn from the work force and there is no realistic expectation that he or she will return to the work force.
8. **Time of Injury**.
    a. For purposes of determining coverage and for sections 10, 12, and 13: the date on which the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability.

b. For purposes of determining identity of responsible EC: the date of last injurious exposure.

4. Evaluation of Evidence.

1. **General**. The CE must first determine: 1)whether or not the disease caused disability or impairment, and if so, when; 2)whether the date of manifestation was before or after retirement; and 3)whether the retirement was voluntary. From these basic facts, the claimant's entitlement may be established. The claimant must assist in this process by providing any information necessary to make these determinations.
2. **Time**.
    a. If the occupational disease does not cause immediate disability or death, the time to give notice of injury and make a claim for compensation are one year and two years respectively. These time periods extend from the time of injury as defined in subparagraph 3h(1), above. In making this determination, particular attention must be given to the medical evidence and the statement of the claimant regarding his/her awareness of the disease. The section 20(b) presumption aids the claimant in establishing the timeliness of his/her claim.
    b. If the disease immediately causes disability or death, the time periods to give notice and make a claim are thirty days and one year respectively. These time periods extend from the time of injury as defined in subparagraph 3h(1), above.
3. **Causal Relationship**. The claimant has the burden of making a **prima facie** case, i.e., submitting evidence of an injury and an accident, or working conditions, which could have caused the injury. To satisfy this initial burden, the claimant must submit a medical report which contains a diagnosis and evidence that he or she was exposed to the implicated injurious stimuli.
4. **Extent of Disability**. In addition to s 10, 12, and 13, the time of injury also affects the extent of the claimant's disability within the meaning of section 8.

a. If the time of injury was prior to retirement, the claimant's extent of disability is determined by the amount of lost wages caused by the injury. This may extend to total disability.
b. If the time of injury was after retirement, the claimant may not receive compensation for more than partial disability. While this disability may be based on 100% impairment of the whole person, the claimant is not entitled to annual adjustments under section 10(f) of the Act.
c. The time of injury does not similarly distinguish the type of death benefits to which a widow/widower is entitled.

5. **Responsible Employer/Carrier**.
    a. Employer during the last employment in which the claimant was exposed to the injurious stimuli prior to the date the claimant becomes aware of the disease and its relationship to employment.
    b. The carrier who insured the employer at the time of the last injurious exposure.
6. **Entitlement to Compensation**.
    a. Time of Injury Prior to Retirement and No Disability or Impairment:
        i. No injury for purposes of statute of limitations,
        ii. No need to file notice of injury,
        iii. No need to file protective claim,
        iv. Claimant eligible for medical treatment if required for condition causally related to factors of employment.
    b. Time of Injury Prior to Retirement and Disability:
        i. Compensation based upon loss of wages or earning capacity,
        ii. Compensation calculated in usual manner (i.e., TTD, PPD etc.),
        iii. Claimant can receive benefits for PTD with annual adjustments.
    c. Time of Injury After Retirement and No Disability or Impairment:

i. No injury for purposes of statute of limitations,

ii. No need for notice of injury,

iii. No need to file protective claim,

iv. Claimant eligible for medical treatment if required for condition causally related to factors of employment.

d. Time of Injury After Retirement and Disability:

i. For this class of claims disability means impairment, as measured by the AMA **Guides** (see subparagraph 3e, above),

ii. Convert all impairments to whole person amount,

iii. Multiply percent of whole person impairment times AWW times 66 2/3%, (see 20 C.F.R. section 702.604(a)).

Chapter 3-0401, Hearing Loss

Paragraph and Subject	Date	Trans. No.
Table of Contents	09/00	00-01
1. Purpose and Scope	09/00	00-01
2. Authority	09/00	00-01
3. Definitions and Terms	09/00	00-01
4. The 1984 Amendments	09/00	00-01
5. Evaluation of Claims for Hearing Loss	09/00	00-01
6. Loss of Hearing Determinations	09/00	00-01
7. Calculation of Hearing Impairment	09/00	00-01

1. Purpose and Scope. This Chapter contains the procedures for developing and adjudicating claims for loss of hearing allegedly due to employment covered by the LHWCA or an extension thereof. These instructions apply mainly to hearing loss caused by repeated exposure to excessive or harmful noise in the day-to-day work environment. Some of the procedures may apply to loss of hearing caused by a traumatic incident.

2. Authority. Section 8(c)(13) of the Act; 20 C.F.R. sections 702.212(a)(3), 702.221(b), 702.231, 702.441; 29 C.F.R. section 1910.95.

3. Definitions and Terms.

1. **Amount of Hearing Loss**. Hearing loss determinations are to be made in accordance with the American Medical Association's **Guides to the Evaluation of Permanent Impairment** using the frequencies of 500, 1,000, 2,000, and 3,000 Hz. A hearing loss may be monaural or binaural. See subparagraph 7b, below.
2. **Audiograms**.
    a. Determinative audiogram. The audiogram used to calculate the degree of hearing loss for compensation purposes.
    b. Audiograms performed before December 27, 1984 should include the following information:
        i. An indication of what equipment was used and the date calibrated and by whom;
        ii. The measurement scale used (ANSI, ISO or ASA);
        iii. A statement on the cooperation of the Claimant;
        iv. The claimant's physical condition should be evaluated to assure that no temporary shift occurred due to: (1) ear wax, or (2) a cold or other physical ailment;
        v. The date of the test and the date the claimant was last exposed to noise;
        vi. The name and qualifications of the person who performed the test;
        vii. Test results for both bone conduction and pure-tone air conduction studies.
    c. In addition to the information listed above, audiograms performed after December 27, 1984 must conform to the following standards (see 20 C.F.R. section 702.441(d) and 29 C.F.R. 1910.95):
        i. The audiometer must be calibrated according to current American National Standard Specifications for Audiometers,
        ii. Audiometric tests shall be pure tone, air conduction, hearing threshold examinations, with test frequencies

including, at a minimum, 500, 1000, 2000, 3000, 4000 and 6000 Hz. These frequencies are required by 29 C.F.R. section 1910.95(h)(1) (see 20 C.F.R. section 702.441(d)). Tests at each frequency shall be taken separately for each ear, and

iii. Audiometric examinations shall be administered in a room meeting the requirements for background noise listed in Appendix D of 29 C.F.R. section 1910.95.

3. **Average Weekly Wage Determinations**. As noted in subparagraph 3k, below, the date of last exposure to injurious stimuli prior to administration of a determinative audiogram is the relevant time of injury for purposes of calculating the average weekly wage. See **Ramey v. Stevedoring Services of America**, 31 BRBS 206(CRT) (9th Cir. 1998); **Mauk v. Northwest Marine Iron Works**, 25 BRBS 118 (1991). See also **Bath Iron Works Corp. v. Director, OWCP (Brown)**, 506 U.S. 153, 26 BRBS 151(CRT) (1993).
4. **Classes of Hearing Loss**.
    a. Conductive Loss. This loss is caused by a defect in the external or middle ear from disease or injury. It is never caused by excessive noise in the work environment.
    b. Perceptive Loss. This loss arises in the inner ear. It may be caused by prolonged exposure to excessive noise in the work environment or it may be caused by other factors, such as diseases of the brain, general or infectious diseases, drugs, or advancing age. For this reason, the CE's development of the evidence should consider whether some factor other than the claimant's employment may be one cause of the hearing loss.
    c. Mixed-Type Loss. In this class, the deafness is due to both kinds of loss - conductive loss and perceptive loss. An award of compensation is based upon the sum of both types of loss since the entire loss is compensable when any portion is work-related.
5. **Credit**.

a. Where the claimant has been compensated for a previous hearing loss, either under a state act or the LHWCA, the amount paid for the prior hearing loss is to be credited against any award which includes the prior loss. Section 3(e), Brown v. Bethlehem Steel Corp., 19 BRBS 200, aff'd on recon., 20 BRBS 26 (1987), aff'd in pert. part, 868 F.2d 759, 22 BRBS 47(CRT) (5th Cir. 1989).

b. Where the prior award was for a pre-employment hearing loss, the credit is to be applied against the Special Fund's liability. Blanchette v. General Dynamics Corp., 27 BRBS 58(CRT) (2d Cir. 1993).

6. **Occupational Disease**. Although hearing loss is an occupational disease it is not the type of long latency period occupational disease contemplated by Congress when it amended the Act in 1984. Unlike asbestosis, the symptoms of hearing loss occur simultaneously with the "disease." Therefore, hearing loss is not "an occupational disease which does not immediately result in...disability" within the meaning of section 10(i) of the Act. In view of this fact, "claims for loss of hearing, whether filed by current workers or retirees, are claims for a scheduled injury and must be compensated pursuant to section 8(c)(13) of the LHWCA, not section 8(c)(23)." **Bath Iron Works Corp. v. Director, OWCP (Brown)**, 506 U.S. 153, 26 BRBS 151(CRT) (1993).

7. **Presumptive Weight of Audiograms**. An audiogram shall be presumptive evidence of the amount of hearing loss on the date administered if all of the following requirements are met:

    a. The audiogram was administered by a licensed or certified audiologist, by a physician certified by the American Board of Otolaryngology, or by a technician, under an audiologist's or physician's supervision, certified by the Council of Accreditation on Occupational Hearing Conservation, or by any other person considered qualified by a hearing conservation program authorized pursuant to 29 C.F.R. section 1910.95(g)(3).

    b. The employee was provided the audiogram and a report thereon at the time it was administrated or within thirty days thereof.

c. No one produces a contrary audiogram of equal probative value (meaning one performed using the standards described in subparagraph 3b above) made at the same time.

8. **Responsible Employer/Carrier**.
    a. Employer during the last employment in which the claimant was exposed to injurious stimuli prior to the date the claimant receives an audiogram showing loss of hearing, and has knowledge of the causal connection between his or her work and the hearing loss.
    b. Carrier who insured the employer at the time of the last injurious exposure.
9. **Same Time**. This means within thirty days thereof where noise exposure continues or within six months where exposure to excessive noise does not continue.
10. **Threshold Shift**. The loss of sensitivity to sound. A threshold shift may be temporary or permanent.
11. **Time of Injury**. For purposes of pay rate determination, the time of injury is the date the claimant is last exposed to injurious noise prior to the determinative audiogram. **Bath Iron Works Corp. v. Director, OWCP (Brown)**, 506 U.S. 153, 26 BRBS 151(CRT) (1993). For purposes of notice provisions and statute of limitations provisions, the time of injury is the date the claimant receives an audiogram, with a report thereon, which discloses a hearing loss. Section 8(c)(13)(D). See **Mauk v. Northwest Iron Works**, 25 BRBS 118 (1991) for a discussion of how the time of injury is applied for purposes of sections 12 and 13 and AWW determinations.
12. **Whole Person Impairment**. The AMA **Guides** provide charts for the conversion of impairments of specific limbs and organs to impairment of the whole person. It is our policy to use the whole person impairment only where the claimant is receiving two or more awards based upon section 8(c)(23) of the Act. (See PM 3-400.5e) In cases being paid pursuant to section 8(c)(13), the award is to be based upon the amount of hearing loss.

4. <u>The 1984 Amendments</u>. The 1984 Amendments to the Act made a number of changes concerning hearing loss. Audiograms are presumptive evidence of the amount of hearing loss sustained as of the date it is taken if a three part test is met. The time periods for giving notice and filing a claim do not begin to run until the employee is given a copy of the audiogram and a report there on. The amount of hearing loss is to be determined in accordance with the AMA **Guides**, using the frequencies of 500, 1000, 2000, and 3000 Hz. The 1984 Amendments do not apply to claims filed under the 1928 District of Columbia Workmen's Compensation Act, **Keener v. WMATA**, 800 F.2d 1173 (DC Cir. 1986). As noted above, the AMA **Guides** provide for and further recommend the conversion of actual binaural hearing impairment to impairment of the whole person. The amount of actual binaural hearing impairment, however, is to be used in calculating awards under section 8(c)(13). Those cases should be distinguished from other occupational disease claims which may fall under the retiree provisions of section 8(c)(23), wherein it is the Director's position that the whole person impairment rating be used. (See PM 3-400.5e, and subparagraph 3f, above.) The 1984 Amendments also changed the apportionment formula for hearing loss claims where there was a pre-existing loss. Previously, the EC was responsible for the percent of hearing loss due to the second injury or 104 weeks, whichever was greater. Since most hearing loss awards did not exceed 104 weeks, EC's infrequently received section 8(f) relief. The Act now provides that the EC is responsible for the percent of hearing loss due to the second injury or 104 weeks, whichever is less.

5. <u>Evaluation of Claims for Hearing Loss</u>.

1. **Factors Influencing Hearing Loss**. The following are factors influencing damage to an ear by sound or noise.
    a. Intensity of Sound - Measured in Decibels. Exposure to noise of an intensity in excess of 85 decibels can prove damaging to the hearing. The intensity is determined by a noise-level meter. To the extent possible, the results of a reliable sound level survey of the work area should be obtained before a claim is adjudicated. This is especially important when multiple claims are filed against one employer.
    b. Frequency or Spectrum of Noise. Lower pitched sounds are less damaging to the ear. Those involving tones above 1,000 cycles per second are the most harmful and more likely to cause damage to hearing.

c. Continuity of Sound. Continuous noise is more harmful than intermittent sounds.
d. Duration of Exposure. Prolonged exposure has a cumulative effect on hearing loss.
e. Individual Susceptibility. All persons are not equally susceptible to harmful noise.
f. Fatigue or Temporary Loss. In many cases, a degree of the impairment is a form of "fatigue" or temporary loss (threshold shift). Since this temporary loss can only be distinguished from a permanent loss by the extent of its duration any hearing loss evaluation must be made 16 hours or more after the last exposure to noise.

2. **Action by DD/CE to Resolve Questions**. Since the time of injury does not occur until the claimant receives an audiogram and a report thereon, most hearing loss cases will contain some medical evidence. In the event that the claimant's audiogram conflicts with an audiogram performed by the EC or any other audiogram, the DO should attempt to resolve any questions by use of an impartial medical evaluation.
3. **Case Documentation for Referral**. Before a claimant is referred for an impartial medical evaluation it is desirable that the case contain as much of the following information or evidence as is readily available or considered pertinent:
    a. From the employee (as much of the following as the DD/CE considers pertinent):
        i. A statement or other information giving specific reasons the employee believes the hearing loss is due to the work.
        ii. A detailed description, in chronological order, of the particular work factors which the employee believes to be the cause of the hearing loss. The employee should also state whether any protective devices were used (such as ear defenders) describe the devices, and state the

approximate number of hours per day and days per week they were used.

iii. A statement indicating whether the employee had any ear or hearing problems prior to the employment alleged to be the cause of the loss, and, if so, full details of the problems, including dates, and the names and addresses of all physicians who examined or treated for the problems.

iv. Full details, if employee ever before filed a claim for workers' compensation or for similar benefits (e.g., Veterans Administration or State benefits), because of this, or any condition affecting the employee's ears or hearing. The information furnished should include the date of the claim, the name and address of the office where the claim was filed, and a description of any benefits received.

v. Originals or copies of all audiograms made by any physician or medical facility.

b. From the EC (as much of the following as the DD/CE considers pertinent):

i. The employee's complete work assignment record, showing the positions held and, if possible, inclusive dates of assignments, a description of the duties performed, the type of noise to which the employee was exposed, and the length of time such exposure on each assignment.

ii. A description of the employee's work sites, including a diagram showing the dimensions and layouts of the areas, and a discussion of the noise hazard at the time the employee was on duty.

iii. The safety precautions (such as providing ear defenders, noise suppressors, acoustical engineering, etc.) taken to eliminate or reduce noise hazards.

iv. A statement as to whether any other employees performing the same work under the same working conditions had similar complaints.

v. A copy of the employee's pre-employment medical examination.

vi. Medical records in the possession of the EC which show any ear trouble, and copies of all available audiometric tests (audiograms).

vii. The date and time the employee was last exposed to noise on the job. If the exposure is continuing, a statement should be made of that fact.

6. Loss of Hearing Determinations.

1. **Policies**.
    a. The most recent edition of the Guides to the Evaluation of Permanent Impairment, published and revised from time to time by the American Medical Association is to be used for hearing loss determinations.
    b. All audiograms must continue to show test results for bone conduction and pure-tone air conduction studies. Schedule award determinations should be made based upon the loss as shown by the air conduction studies only.
    c. An audiogram that shows a greater loss for bone conduction than air conduction may not be used to establish the degree of hearing loss, nor may it be used to corroborate other audiograms. Such an audiogram is unreliable and should be disregarded.
    d. It remains DLHWC policy to include any pre-existing hearing loss in the schedule award calculation, where factors of employment have aggravated that loss. If the pre-existing hearing loss was previously compensated, credit should be given for the dollar amount compensated.

e. If either of the parties disagrees with the recommendation of the district office the case should be referred for a formal hearing at the request of either party.

2. **Determinations**.

a. The statute requires that hearing loss determinations be made in accordance with the AMA **Guides**. (See section 8(c)(13)(E).) Procedures for determining the amount of hearing impairment are found in the **Guides**.

b. The **Guides** includes a method for calculating the percentage of binaural loss and this method must be used. The method uses the frequencies of 500, 1000, 2000, and 3000 Hz. Binaural hearing impairment is determined using the following formula:

5 x % hearing impairment % hearing impairment

Binaural Hearing Impairment, (%) = of better ear + of poorer ear/

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c. Using this formula, if the hearing loss does not exceed twenty-five decibels when the audiogram is based on an American National Standards Institute (ANSI) calibrated audiometer, there is no compensable loss. The Guides includes procedures for converting audiograms based upon the older ASA standard.

3. **Referral of Claimant for Hearing Evaluation**.

a. Conditions/Methods for Referral. If the EC has controverted the claim and the claimant has not been examined by an otologist, the DD/CE, after having obtained all of the available pertinent medical reports and factual information, (see subparagraph 5c, above) will, with the agreement of the parties, prepare a memorandum of the undisputed facts pertaining to the nature of the employee's employment, etc., for referral of the case to an otologist selected by the DD/CE for examination and evaluation. (With respect to opinions, reports, or conclusions of any prior examining physician concerning the nature

and extent of the impairment, its cause, etc., 20 C.F.R. section 702.411 should be observed.) After obtaining the otologist's agreement the DD/CE will refer the employee, the memorandum, and any other necessary information and reports. The examining otologist will be asked to examine and test the employee and furnish a report. The otologist should include in a report the date and hour of the employee's last exposure to employment related noise, which exposure must have been more than sixteen hours before the examination. The physician should also be instructed to make use of retesting and additional tests and techniques considered appropriate in those cases where it is determined that the results of the initial tests were inadequate or where the results appear to be inaccurate.

b. Restrictions. In no case will examination by a physician or medical facility be authorized unless the physician or facility can certify that no more than one year will have passed from the date the audiometer to be used was last properly calibrated until the date of the scheduled examination. Each physician or facility should be asked to include in the report of examination the date of calibration of each instrument used and by whom the calibration was performed.

c. Charges for Evaluation. The cost of the evaluation may be charged to the employer, or an insurance carrier. The cost of the examination may also be charged to the Special Fund in special circumstances and with the concurrence of the Director, DLHWC.

7. <u>Calculation of Hearing Impairment</u>.

1. **Applicability of Guidelines**. The phrase "permanent partial disability" in section 8(c) of the Act is interpreted to mean "permanent partial physical impairment". The same standards for evaluating such impairment are applied in all like cases. The AMA Guides are used as guidelines for evaluating all permanent physical impairments, including hearing loss.
2. **Methods of Calculation**.

a. The DD/CE will calculate the percentage of hearing impairment from the findings reported by the otologist, but in making a recommendation shall consider all relevant factors in the case. Loss of hearing may be monaural or binaural. If the claimant's hearing impairment is ratable in only one ear, it is to be compensated in accordance with section 8(c)(13)(A) of the Act, regardless of the type of causation. **Rasmussen v. General Dynamics Corp.**, 993 F.2d 1014, 27 BRBS 17(CRT) (2d Cir. 1993); **Garner v. Newport News Shipbuilding & Dry Dock Co.**, 955 F.2d 41, **reported unofficially** at 25 BRBS 122(CRT) (4th Cir. 1992).

   To obtain the degree of monaural hearing loss, the DD/CE will use the formula which deducts the hearing level threshold from the average measured frequencies, using the frequencies of 500, 1000, 2000, and 3000 Hz. This is the formula used in the AMA Guides. The "fence" or hearing threshold level of twenty-five db (using ANSI calibrated audiometers) should be deducted from the average of the measured frequencies. If the audiometer is calibrated using ASA-1951 standard, a fifteen db "fence" should be deducted from the average measured frequencies.

b. Binaural loss of hearing will be calculated using the following formula:

   5 x % hearing impairment % hearing impairment

   Binaural Hearing Impairment, (%) = of better ear + of poorer ear

   6

   The following is an example of a typical audiograms showing a neurosensory loss (monaural) using the AMA formula. For every decibel (db) that the estimated hearing level exceeds twenty-five db (ANSI), 1.5% monaural impairment is assigned.

CPS 500 1000 2000 3000

db loss 15 20 35 60

Average 130db / 4 = 32.5

Less the fence of 25 db = 7.5 db x 1.5%/db

% Loss = 11.25

c. The following computation illustrate how the percent of binaural loss is derived assuming a 10% monaural loss in the left ear and a 15% monaural loss in the right ear.

(5 x 10) + 15 = 10.8%

6

d. The DD/CE will then follow the procedure in subparagraph 7c, below. It should be noted that a recommendation on the amount of permanent partial disability is an administrative action as it relates to the claimant's entitlement. The DD/CE should consider all of the evidence of record in making this recommendation.

3. **Action Following Receipt of the Report**.

a. DD's Assessment of Otologist's Report. Upon receiving the otologist's report, if a reported finding of hearing loss was, in the otologist's opinion, related to the employment conditions alleged to have been the cause, the DD will calculate the percentage of hearing impairment from the otologist's findings according to the procedures outlined in subparagraph 7b(4).

b. Calculation of the Award.

i. Monaural Hearing Loss. The amount of monaural hearing loss is multiplied times the number of weeks contained in section 8(c)(13)(A) to determine the length of entitlement. This number of weeks is multiplied times the compensation rate (i.e. AWW x 2/3) to determine the amount of

compensation. The following is an example of the application of this formula:

11.25% monaural loss x 52 weeks = 5.85 weeks

5.85 weeks x $392 x 2/3 = $1,528.80

ii. Binaural Hearing Loss. If there is a binaural loss of hearing, the amount of binaural loss is multiplied times the number of weeks contained in section 8(c)(13)(B), and then times the compensation rate. The following is an example of the application of this formula:

10.8% binaural loss x 200 weeks = 21.6 weeks

weeks x $392 x 2/3 = $5,644.80

c. Recommendation. Using the figures derived from the calculations contained in subparagraphs 7b(4), and 7c(2), above as a guide, and taking into account such other factors as warrant consideration, the DD/CE handling the case will make a recommendation for payment of a schedule award and notify the parties as to the of payment of benefits.

It is important to also make a finding as to when the schedule award begins to run since this will obviously affect such determinations as whether the entire schedule is accrued and unpaid, whether continuing installment payments are warranted, and the amount of sliding/straight interest, if any, due on the unpaid compensation

i. Section 14(e). Since the Supreme Court's decision in **Brown** provides a time of injury for former employees which is often in the distant past, i.e., the last day of injurious workplace noise exposure, the entire schedule award may have run by the time of employer's knowledge, thereby making the entire amount penalty "then due" within the meaning of section 14(b) and (e) of the Act. Since the section 14(e) is triggered by a failure to pay compensation

when due, i.e., fourteen days after the employer has been notified pursuant to section 12, or the employer has knowledge of the injury, an employer who timely controverts or pays the full amount of compensation due within the period prescribed by section 14(b) will not be liable for a section 14(e) penalty even though the controversion or payment is made years after the compensable injury occurred.

ii. Like the section 14(e) penalty, interest for post-retirement hearing loss awards will not begin to accrue until the employer has been notified pursuant to section 12 or the employer has knowledge of the injury or death.
See **Renfroe v. Ingalls Shipbuilding Inc.**, 30 BRBS 101, 108 (1996) (en banc). In the **Renfroe** case, the last injurious exposure occurred in 1971 and the claimant's entitlement to a schedule award for hearing loss under section 8(c)(13) commenced at that time. However, the employer did not have knowledge of the injury until February 23, 1987. Since the entitlement to the schedule award began in 1971, the entire amount of the schedule was due and unpaid as of February 23, 1987, and the BRB held that interest was to be assessed on the entire amount beginning February 23, 1987. Since the entire amount of the schedule is past due, the period of entitlement has ended, and no additional payments are due, only the formula for "straight" interest (see PM 8-201) is applicable.
For the sake of this example, assume an interest rate of 6.09%, a total amount due of $363.19, and that payment was made on June 24, 1996.

Straight interest formula -- Interest = A * n * v

Interest = $363.19 * (bi-weekly periods during 02/23/87 - 06/24/96) * (.0609 / 26)

Interest = $363.19 * 243.57142 bi-weekly periods * .002342

Interest = $207.21

Depending on the date of maximum medical improvement (i.e., date of last injurious exposure) and the date of the employer's knowledge, interest may involve the application of both "straight" and "sliding" interest. See the following example:

Beginning date of the schedule award - December 9, 1999

Percent of binaural hearing loss - 42.7% (schedule should end on July 28, 2001)

Compensation rate - $347.00 per week

Date of the employer's knowledge of injury - March 1, 2000

Date of payment - May 9, 2000

Interest Rate - 6.0%

As of March 1, 2000 (the point at which interest is payable), that portion of the schedule from 12/09/99 through 03/01/00 (12 weeks x $347.00 = $4,164.00) would be accrued and unpaid, and subject to "straight" interest.

Interest = A * n * v

Interest = $4164.00 * (bi-weekly periods during 03/01/2000 - 05/09/2000) * (.06 / 26)

Interest = $4164.00 * 5.00000 bi-weekly periods * .002308

Interest = $48.05

That portion of the schedule award from 03/02/00 through 05/09/00 is subject to "sliding" interest.

Interest = **(B * r) * (p2-p)**

26 * 2

Interest = **($694.00 * 6.0%) * (24.29080 - 4.92857)**

52

Interest = **$41.64 * 19.36223**

52

Interest = **$806.24325**

52

Interest = $15.50

Total interest in this example would be $63.55 ($15.50 + $48.05). It is assumed that any further payments after 05/09/00 would be made by the EC in a timely manner and would not be subject to the payment of interest.

Another scenario would be that the EC did not make payment until after the period of schedule award had ended, e.g., payment was made in September 2001. In

this instance, the period from 03/02/00 - 07/28/01 would be subject to both "sliding" and "straight" interest.

iii. **Action of the Parties.**

A. Acceptance of the Recommendation. If the parties accept the recommendation, the usual procedure followed for awarding benefits to an injured employee having residual physical impairment shall be followed by the DD/CE (see PM 4-200.9).

B. Rejection of the Recommendation. If either party rejects the recommendation, a conference may be scheduled to determine whether agreement can be reached. Should the parties continue to disagree, procedures described in 20 C.F.R. section 702.316 and PM 4-600 shall be followed to refer the case for formal hearing by an Administrative Law Judge.

iv. **Failure to Agree as to Accepted Facts.** If the parties are unable to agree upon a body of facts as to the duration and extent of the claimant's exposure to noise at work, or if either the EC or the claimant refuse to furnish information on which the DD/CE can base a recommendation, the case shall be referred to the Office of Administrative Law Judges for formal hearing.

Chapter 3-0402, Asbestosis

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3. Applicability	09/00	00-01

4. Evidence to be Requested	09/00	00-01
5. Procedures	09/00	00-01
6. Recommendation	09/00	00-01

1. Purpose and Scope. This Chapter provides guidelines and procedures for developing and adjudicating claims of asbestosis allegedly resulting from a claimant's exposure to asbestos in the course of employment. PM 2-203 and PM 3-400 provide basic information on the development and handling of occupational disease cases in general as well as definitions of relevant terms.

2. Introduction.

1. **General Discussion**. Asbestos is a naturally occurring mineral fiber which has multiple industrial uses due mostly to its binding and heat retardant properties. From the early years of the Second World War, industrial use (and production) of asbestos fiber products increased dramatically in the United States. As a result it has been estimated that as many as eleven million living Americans have received some occupational exposure to the various asbestos mineral fibers.

   About 2/3 of all asbestos was used in the construction industry, particularly in ship construction, since asbestos is effective in insulating boilers, steam pipes, hot water pipes and nuclear reactors. Thus, many persons employed in shipyards have been exposed to asbestos. In addition, exposure may occur during the transporting of asbestos, both on board ships and in terminals.

   Exposure to asbestos fibers has been epidemiologically linked to a number of human diseases. Asbestosis, diffuse interstitial fibrosis of the lungs' parenchymal tissues, is the most commonly recognized disease related to such exposure. Recent evidence has suggested, however, that asbestosis may be one of the least frequently occurring asbestos related diseases. Asbestos exposure has also been shown to be a causal factor in a variety of pulmonary (pleural and parenchymal) and gastrointestinal disorders. Probably least recognized is the recently established relationship of this mineral fiber to carcinogenesis including the development of mesothelioma and bronchogenic carcinoma.

Mesothelioma, for instance, once an extremely rare human cancer, has been observed in significantly increased incidence in recent years. It is estimated that 85 to 90 percent of all diagnosed mesotheliomas are directly due to asbestos exposure. Some evidence also exists linking asbestos exposure to gastrointestinal carcinoma, but this relationship is less well documented.

2. **Causal Relationship**. Mere exposure to asbestos does not mean that an employee will contract a disease. Many workers remain unaffected. In order for a claim to be compensable, an employee must show that he or she has suffered some harm and that there were factors of employment capable of causing this harm. Once the employee meets this prima facie burden then the presumption contained in section 20 applies to link the harm with the claimant's employment.
3. **Entitlement to Compensation**. A distinction can be made between disability and impairment as follows:
    a. **Disability**. The partial or total loss of ability to earn wages.
    b. **Impairment**. The loss or loss of use of an organ, body part, or bodily function.

    An employee may show some evidence of asbestos exposure but not have suffered any harm or impairment. Ferruginous bodies ("asbestos bodies") in the sputum are indicative of exposure but do not demonstrate harm or the presence of active disease. Pleural plaques (on chest x-ray) constitute a typical example of abnormalities (harm) which may not cause any impairment or disability. An employee may also have impairment but no disability. This would occur where the employee has some reduction in pulmonary function but no reduction in earning capacity.

    The distinction between disability and impairment is relevant for cases where the time of injury is prior to voluntary retirement. If the time of injury is after retirement, disability means impairment.

3. <u>Applicability</u>.

1. **Eligibility**. Present and former employees of employers subject to the LHWCA as extended, and/or their survivors, may be eligible for LHWCA benefits if exposure to asbestos occurred in the course of employment and some identifiable harm resulted from the exposure.
2. **Benefits Provided**. Disability benefits provided by the LHWCA and its extensions in the case of a disease causally related to asbestos exposure which is accepted under the Act include:
    a. Compensation for wage loss or loss of wage earning capacity;
    b. Compensation for physical impairment, where the injured employee is retired at the time of injury;
    c. All medical, surgical, and hospital treatment, and medical supplies and services required by the occupational disease;
    d. Vocational rehabilitation where indicated; and/or
    e. Death benefits.
3. **Time Limits for Filing**.
    a. Generally, the law requires that a claim be filed within one year from the date the employee or claimant is aware, or by the exercise of reasonable diligence should have been aware, of the relationship between the employee's disease or death and his or her employment. In addition, the employee or claimant is required to notify the employer or former employer with whom the employee's last exposure to asbestos occurred, and the DD in the compensation district in which the last exposure to asbestos occurred within thirty days after the employee or claimant is aware, or in the exercise of reasonable diligence should have been aware, of a relationship between the employee's disease or death and his or her employment.
    b. However, in the case of an occupational disease which does not immediately result in disability or death, a claim shall be timely if filed within two years after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the

employment, the disease, and the disability or death. In these cases the employee or claimant is required to notify the employer or former employer and the DD, as noted above, within one year after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment the disease, and the disability or death.

c. Time limits for filing a claim do not begin to run against the claim of an injured employee or eligible dependents entitled to compensation if:
    i. The employer has knowledge of the injury or death; or
    ii. The employer has been given notice of injury or death; and
    iii. The employer fails, neglects or refuses to file a report of the injury or death with the DD.

    In this situation, time limits for filing a claim do not begin to run until the employer submits the required report.

4. <u>Evidence to be Requested</u>.

1. **From the Claimant**.
    a. A detailed history of the disease from the date it started;
    b. The way in which the employee was exposed to asbestos and the degree and length of exposure;
    c. Statement from any witnesses concerning the degree and length of exposure;
    d. The date the employee was last exposed to asbestos in his or her employment;
    e. The date and circumstances when the claimant first became aware of a possible relationship between the disease, any impairment/disability and the employee's work;

f. The names and addresses of all physicians and hospitals which have provided the employee with medical care for a disease which is causally related to exposure to asbestos;

g. A printout from the Social Security Administration, which shows the claimant's employment history; and

h. Information about any third party actions which have been filed, i.e., when filed and against whom.

2. **From Other Sources**.

   a. It is recommended that the claimant arrange for submission of medical admission and discharge summaries and full hospital reports for all periods of hospitalization for an asbestos-related disease, and medical reports from any hospital which provided outpatient treatment for such a condition.

   b. It is also recommended that the claimant be prepared to submit a medical report from each physician who has examined or treated the employee for an asbestos-related disease. Each report should include as much of the following as possible:

      i. Dates of examination and treatment;

      ii. History given to the physician;

      iii. Detailed description of the physician's findings;

      iv. Results of x-rays, pulmonary function tests, blood gas tests or other laboratory tests;

      v. Diagnosis;

      vi. Clinical course and treatment; and

      vii. The physician's opinion, with medical reasons, as to whether the disease is causally related to employment, either by direct cause, or by aggravation, acceleration or precipitation.

3. **Measure of Impairment**. Where the claimant has voluntarily retired, the level of compensation benefits is determined by the amount of impairment. Therefore, in appropriate cases, the claimant should be asked to submit a

report which contains the amount of pulmonary impairment measured in accordance with the American Medical Association's **Guides to the Evaluation of Permanent Impairment**.

5. <u>Procedures</u>. Claims for compensation or death benefits resulting from exposure to asbestos should be filed with the DO having jurisdiction over the state in which the exposure occurred. The claim should be served on the responsible EC which the Social Security printout should help establish. The DO should ask the claimant to submit the evidence listed in paragraph 4, above. When this evidence has been submitted, the DO should make the following determinations:

1. **Time of Injury**. When the disease became manifest.
    a. For purposes of coverage and for sections 10, 12, and 13: the date on which the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability.
    b. For purposes of determining the responsible EC: the date of last injurious exposure.
2. **Retirement**. Whether the claimant is still working or whether the claimant has voluntarily withdrawn from the work force with no realistic expectation that he or she will return to the work force.
3. **Method of Compensation**. Whether entitlement is based upon loss of wages or wage earning capacity (time of injury pre-retirement), or impairment (time of injury post-retirement).
    a. For loss of wages or earning capacity, entitlement is based upon the difference between the claimant's earnings and his or her average weekly wage on the date of injury.
    b. For entitlement based upon impairment, the whole person impairment as measured by the AMA **Guides** multiplied times the compensation rate.

6. <u>Recommendation</u>. After the evidence has been evaluated and a determination regarding entitlement has been made, the DO should make a

recommendation to the parties either for or against the payment of benefits. If either party disagrees with the recommendation, the case should be referred for formal hearing in accordance with the procedures contained in PM 4-600.

Chapter 3-0500, Settlements

Paragraph and Subject	Date	Trans. No.
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2. Policy	09/00	00-01
3. Section 8(i) Settlements	09/00	00-01
4. Commutations Pursuant to LHWCA Section 9(g)	09/00	00-01
5. Commutations Pursuant to DBA Section 2(b)	09/00	00-01

1. Purpose and Scope. This Chapter provides an introduction to settlements and commutations under the LHWCA and its extensions. Chapter 3-501 pertains to settlements under section 8(i) of the LHWCA. Chapter 3-502 covers commutations under section 9(g) of the LHWCA and section 2(b) of the DBA.

2. Policy. It is our policy to neither encourage nor discourage agreed settlements. It is the responsibility of the DD to insure that applications are complete, adequate, not procured by duress, and timely processed.

3. Section 8(i) Settlements.

1. **Settlement applications may be submitted** solely for compensation, solely for medical benefits or for compensation and medical benefits combined.
2. **Settlement may be considered** for any claim under the Act, including survivor benefits.
3. **Settlements may be "structured"** so that payments will extend over the lifetime of the claimant with an annuity policy used to provide continuing payments.

4. Commutations Pursuant to LHWCA Section 9(g).

1. **Commutations are limited** to death benefits for aliens or non-nationals of the United States, in the amount of 1/2 of the commuted future installments.

2. **An informal conference or formal hearing** is not required to authorize a lump sum payment.
3. **A compensation order** fixing the right of the beneficiary to compensation is required pursuant to section 702.142(d) of the regulations.
4. **All commutation calculations** are made by the National Office.
5. **Commutation, pursuant to section 9(g), is mandatory** upon request by the EC.

5. Commutations Pursuant to DBA Section 2(b).

1. **Commutations may be considered** for permanent total disability, permanent partial disability under section 8(c)(21), or death of aliens or non-nationals of the United States. Payment is for 1/2 of the commuted amount of future installments.
2. **Payment of a lump sum** does not release the EC of the responsibility to furnish future medical care.
3. **An informal conference or formal hearing** is not required to authorize a lump sum payment.
4. **All commutation calculations** are made by the National Office.
5. **Commutation, pursuant to DBA section 2(b), is mandatory** upon request by the EC.

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1. Purpose and Scope. This Chapter describes the procedures for processing and evaluating settlements under section 8(i) of the Act.

2. Policy. The Longshore and Harbor Workers' Compensation Act Amendments of 1984 changed the criterion for evaluating a settlement from "the best interests of an injured employee" to whether or not the settlement is "inadequate or procured by duress". The regulations concerning settlements may be found at 20 C.F.R. sections 702.241 to .243.

3. Role of the District Office. As a general rule, the DD/CE should neither encourage nor discourage agreed settlements. The DD/CE should, however, insure that the application is complete and determine whether both parties are represented by counsel. After a complete application has been submitted, the DD/CE is to determine whether it is adequate and/or has been procured by duress.

4. Types of Settlements.

1. **The parties may submit a settlement application** solely for compensation, or solely for medical benefits or for compensation and medical benefits combined. If either portion of a combined compensation and medical benefits settlement application is disapproved the entire application is disapproved unless the parties indicate on the face of the application that they agree to settle either portion independently.
2. **A settlement may be considered** for any claim under the Act, including section 48(a) and survivors benefits. However, an agreement among the parties to settle a claim is limited to the rights of the parties and to claims then in existence; settlement of disability compensation or medical benefits shall not be a settlement of survivor benefits nor shall the settlement affect, in any way, the right of survivors to file a claim for survivor's benefits. Only past claims for past discriminatory acts can be settled under section 48(a). Any settlement agreement that attempts to include a future section 48(a) claim would be invalid and should not be approved.

3. **A settlement may also be "structured"** in that payment of the agreed settlement may extend over the lifetime of the claimant and may even involve the use of annuity policies issued by life insurance companies to provide continuing payments. It is recommended that the following or similar language be contained in all structured settlement orders to assure that only upon the continued payment to the claimant of the agreed upon settlement shall the liability of the EC be discharged: "Upon payment of the aforesaid monies, the employer and carrier shall be forever discharged and released of any further liability for payment of compensation to the employee under the Longshore and Harbor Workers' Compensation Act". Should the carrier or any other party designated to make the continuing payments fail to make the payments, liability to make the payments shall revert to the original EC.

5. Required Information.

1. **The settlement application shall be a self-sufficient document** which can be evaluated without further reference to the administrative file. The application shall be in the form of a stipulation signed by all parties and shall contain a brief summary of the facts of the case to include:
    a. a description of the incident,
    b. a description of the nature of the injury to include the degree of impairment and/or disability,
    c. a description of the medical care rendered to date of settlement, and
    d. a summary of compensation paid and the compensation rate or, where benefits have not been paid, the claimant's average weekly wage.
2. **The settlement application shall also contain** the following:
    a. A full description of the terms of the settlement which clearly indicates, where appropriate, the amounts to be paid for compensation, medical benefits, survivor benefits and representative's fees. Such fees shall be itemized as required by 20 C.F.R. section 702.132.

b. The reason for the settlement, and the issues which are in dispute, if any.
c. The claimant's date of birth and, in death claims, the names and birth dates of all dependents.
d. Information on whether or not the claimant is working or is capable of working. This should include, but not be limited to, a description of the claimant's educational background and work history, as well as other factors which could impact, either favorably or unfavorably, on future employability.
e. A current medical report which fully describes any injury related impairment as well as any unrelated conditions. This report shall indicate whether maximum medical improvement has been reached and whether further disability or medical treatment is anticipated. If the claimant has already reached maximum medical improvement, a medical report prepared at the time the employee's condition stabilized will satisfy the requirement for a current medical report. A medical report need not be submitted with agreements to settle survivor benefits unless the circumstances warrant it.
f. A statement explaining how the settlement amount is considered adequate.
g. If the settlement application covers medical benefits, an itemization of the amount paid for medical expenses by year for the three years prior to the date of the application shall be included. A statement in the application to the effect that the employer/carrier has not paid for any medical treatment in the past three years is not sufficient. The parties should be required to provide an itemization of all medical treatment expenses paid in the last three years, whether paid by employer/carrier, Medicare, other health plans or by the claimant, as well as itemization of all unpaid medical bills.

   An estimate of the claimant's need for future medical treatment as well as an estimate of the cost of such medical treatment shall also

be submitted which indicates the inflation factor and/or the discount rate used, if any. The DD may waive these requirements for good cause. The case file must contain a memo explaining the "good cause" basis for waiving this requirement. However, for settlements that come within the Medicare pre-approval threshold (see paragraph 12.a., below) greater scrutiny should be given to determine if the proposed settlement is adequate, and waiver of such medical documentation is not appropriate.

h. Information on any collateral source available for the payment of medical expenses. Medicare and Medicaid are not acceptable collateral sources of medical care.

6. <u>Submission of the Application</u>. When the parties to a claim for compensation, including survivor benefits and medical benefits, agree to a settlement they shall submit a complete application to the DD. The application shall contain all the information outlined in paragraph 5 above, and as provided by 20 C.F.R. 702.243(a), shall be sent by certified mail, return receipt requested or submitted in person, or by any other delivery service with proof of delivery to the DD. Submission by facsimile (fax) is not specifically authorized by the regulation and is not considered to reasonably fall under the umbrella of a “delivery service with proof of delivery.” Further, since section 8(i)(1) provides that a settlement application will be deemed automatically approved unless it is specifically disapproved by the DD within 30 days of its submission, being able to establish when the application was received by the DD is important. While a sender can confirm that a fax was transmitted successfully, the sender cannot confirm that the DD actually received the settlement application. A settlement application submitted to the DD by fax should not be accepted and the parties should be advised to submit the application in a manner consistent with 20 C.F.R. 702.243(a).

Failure to submit a complete application shall toll the thirty day period mentioned in section 8(i) of the Act until a complete application is received, (see subparagraph 9c, below).

7. <u>Initial Review</u>.

1. **Timeliness**. Section 8(i) of the Act now requires the approval of a settlement within thirty days unless it is found to be inadequate or procured by duress.

Settlements must therefore be considered as soon as possible after receipt. Action to either approve, disapprove, or toll the thirty day period is to be taken within twenty-five days of receipt of the application.

2. **District Director Initial Review**. When a settlement application is received and date stamped in the mail room it should be taken to the DD immediately. The DD should review the settlement to determine if there is anything which would require the thirty day period to be tolled. The DD shall initial and date the first page of the settlement application when reviewed. At this time the DD should also review the application to determine if the threshold requirements for Medicare pre-approval of settlements are met, and to determine whether to issue appropriate notice to the parties (see paragraph 11 and 12, below).

8. Evaluation.

1. **General**. When presented with a settlement, the DD shall review the application and determine whether, considering all of the circumstances, including where appropriate, the probability of success if the case were formally litigated, the amount is adequate. If the DD has any questions regarding the adequacy of the settlement, particularly in those cases where the claimant is not represented, the DD should personally meet with the claimant or, where this is not possible, discuss the terms of the settlement with the claimant by telephone.
2. **Basic Adequacy Criteria.** . The criteria for determining the adequacy of a settlement shall include, but not be limited to:
    a. The claimant's age, education and work history;
    b. The degree of the claimant's disability or impairment;
    c. The availability of the type of work the claimant can do; and
    d. The cost and necessity of future medical treatment (where the settlement includes medical benefits).
3. **Additional Adequacy Criteria**.
    a. If a case is being paid pursuant to a final compensation order, and there are no substantive issues in dispute, an additional criterion

must be used to evaluate the adequacy of a settlement, see 20 C.F.R. section 702.243(g). A settlement amount which does not equal the present value of future compensation payments commuted, computed at the discount rate specified below, shall be considered inadequate unless the parties to the settlement show that the amount is adequate.

b. The probability of the death of the beneficiary before the expiration of the period during which he or she is entitled to compensation shall be determined according to the most current United States Life Table, as developed by the United States Department of Health and Human Services, which shall be updated from time to time.

c. The discount rate shall be equal to the coupon issue yield equivalent (as determined by the Secretary of the Treasury) of the average accepted auction price for the last auction of 52 weeks U.S. Treasury Bills settled immediately prior to the date of the submission of the settlement application. Effective December 21, 2000, the U.S. Treasury discontinued the sale of 52 week U.S. Treasury Bills. The weekly average 1-year constant maturity Treasury yield for the calendar week preceding the date of submission of the settlement application may be used in its stead.

d. For settlements submitted involving injuries covered by section 8(c)(1)-(20) of the Act, where there is only one medical opinion, e.g., the treating physician's, the settlement should not be based on a lower percent than that established by that physician. A proposed settlement for a lesser amount should be considered inadequate and should be rejected.

4. **Voluntary Termination of Employment as a Condition of Settlement**. Occasionally the parties to a settlement will include in the settlement application a stipulation that the claimant agrees to voluntarily resign from his/her employment as a condition of the settlement. Section 8(i) itself provides the district director with authority to disapprove settlement proposals containing termination of employment language whenever the circumstances

of the case support a determination that the termination provision renders the settlement “inadequate” or results from “duress”. However, various factors are problematic toward defending such settlement denials on appeal. Among those are the difficulty on appeal of overcoming the voluntary resignation language when the claimant is represented by counsel, the historical trend toward a more liberal acceptance of settlements in amendments to the statute, and the lack of court cases specifically prohibiting the inclusion of voluntary resignation language in a section 8(i) settlement agreement. Therefore, defense of a denial based solely on termination of employment language is unlikely to prevail on appeal. Evaluation of settlement proposal should take into consideration all of the circumstances of the case as they relate to the statutory provisions of adequacy and lack of duress. Consequently, settlement applications are not to be denied based solely on the fact that they contain termination of employment language.

9. Decision.

1. **Approval**. Approval of a settlement is to be done by compensation order. This order must be served within twenty-five days of receipt of the settlement application.
2. **Disapproval**. The disapproval of a settlement is to be done by a written statement, over the signature of the DD, which fully describes the grounds for the denial. This statement is to be served by certified mail within twenty five days of receipt of the application. The denial statement must advise the parties of their right to request a formal hearing before an ALJ, or to submit an amended application to the DD. If the parties request a formal hearing, the procedures outlined in PM 4-600 are to be followed. At the time of referral for formal hearing, a copy of the written statement denying the settlement is to be transmitted to the OALJ with the pre-hearing statements.
3. **Toll the Thirty Day Period**. Both the Act, under section 8(i), and the regulations, at 20 C.F.R. section 702.243(b), provide that if the parties are represented by counsel, as defined under 20 C.F.R. section 702.241(h), the settlement shall be deemed approved unless specifically disapproved within

thirty days after receipt of a complete application. It is therefore important that all settlement applications be carefully reviewed within the thirty day period and the parties promptly notified by regular mail of any deficiency. The thirty day period provided for in the Act and the regulations does not begin until the deficiency is corrected, 20 C.F.R. section 702.243(b). The notice of deficiency is to specifically suspend the running of the thirty day period.

10. Calculation of 30 Day Period. The thirty day period for consideration of a settlement application shall be calculated from the day after receipt. If the last day of this period is a holiday or occurs during a weekend, the next business day shall be considered the thirtieth day.

11. Medicare and Workers' Compensation Medical Payments. Section 1862(b)(2) of the Social Security Act provides that Medicare payments may not be made for any item or service to the extent that payment has been made or can be reasonably expected to be made under a workers' compensation law. The Medicare Secondary Payer Statute (42 U.S.C. sec. 1395y(b)(2)) was enacted in 1980 to prevent the burden of such expenses, which should be paid by other insurance plans, including workers' compensation, from being shifted to Medicare. Pursuant to this statute, in recent years the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare, has undertaken a comprehensive effort to ensure that Medicare does not pay for expenses covered under a primary payer plan, and to collect money owed to Medicare for the payment of such expenses.

The Medicare Secondary Payer Statute provides, in part, that Medicare may not pay for an individual's medical treatment if payment can "reasonably be expected to be made promptly" under workers' compensation. In such instances, Medicare is the "secondary payer" while the insurance company or some other responsible party remains the "primary payer." This statute further provides that, in the event Medicare does pay such expenses, those expenses shall be paid subject to reimbursement.

12. Medicare and Section 8(i) Settlement. The private parties must take into consideration Medicare's interests in structuring the settlement. In general, this interest involves ensuring that the parties do not use the terms of the settlement to evade the employer's lawful responsibility for the medical treatment of the employee's work-related injury or illness. If the private parties do not account for Medicare's interests, Medicare may later refuse to cover some, or all, of the claimant's medical expenses for treating his or her work-related injury or illness. The parties may also be sued by the Department of Health and Human Services

for improperly shifting medical expenses from the legally liable employer or insurance carrier to Medicare. For these reasons, special attention must be paid to section 8(i) settlement applications submitted for approval which include settlement of medical benefits. Claimants and their representatives should be made aware that settlements under the LHWCA are subject to Medicare requirements in certain cases.

1. **Medicare requires pre-approval** . of workers' compensation settlements if either one of the following is true.
    a. Any settlement, regardless of amount, if the claimant is currently entitled to Medicare; or
    b. Any settlement greater than $250,000, AND the claimant may reasonably expect to become eligible for Medicare within 30 months of the settlement date.
2. **Notice to Claimants and Representatives**. The DD has no authority to require the parties to a section 8(i) settlement to obtain Medicare pre-approval, nor to deny the settlement as inadequate absent such pre-approval. The DD's authority extends only to ensuring that a settlement is not "inadequate or procured by duress." However, for the protection of the claimant, who may be unwittingly relying on Medicare to pay all or part of his future work-related medical expenses, it is the duty of the DD to alert the settling parties to Medicare's pre-approval requirements and to the potential loss of Medicare benefits. The DD should encourage the parties to consult with CMS for answers about their legal obligations under Medicare. Therefore, when a settlement application is received in the district office, as a part of the "initial review" of the application by the district director (see paragraph 7, above), the following steps should be taken.
    a. The DD shall review the application to determine if either of the two requirements for Medicare pre-approval of settlements involving medical benefits are applicable (see paragraph 12.a., above).
    b. If it appears that the Medicare pre-approval requirements apply, a copy of the information leaflet "Notice to Claimants and Representatives: Settling Claims" (Exhibit 28, LHWCA PM Ch. 10-300) should be immediately sent to all parties to the settlement,

including both the claimant and his representative, and the representative of the employer/carrier. In the case of an unrepresented claimant, the DD should ensure that the claimant understands the consequences of a section 8(i) settlement without Medicare pre-approval, and if he/she still wishes to proceed, extra care should be taken to ensure the adequacy of the medical settlement.

The district office should develop an appropriate cover letter for transmitting the Notice. The cover letter should contain a request that the parties acknowledge having considered Medicare requirements as they may pertain to the settlement. The following language is recommended: "It is requested that the parties review the enclosed Notice and the provisions of the Medicare Secondary Payer Statute, and advise this office within ten days that consideration has been given to Medicare requirements for pre-approval of workers' compensation settlements." A sample cover letter can be found at PM Exhibit 29 (LHWCA PM Ch. 10-300). The district office cannot require the parties to respond to such a request, nor toll the thirty-day period for failure to do so. However, special care must be taken in review of the medical evidence in any application involving medical settlement cases. Failure of the parties to provide the required historical medical treatment information and estimate of need for future medical treatment as required (20 CFR 702.242(a)(7)), constitutes an incomplete application and could result in denial of the application on ground of inadequacy (see paragraph 5.b.(7), above).

3. **Referral to OALJ**. If the parties to a disapproved settlement request a hearing before an ALJ pursuant to 20 CFR §702.243(c), and the reason for disapproval is inadequacy of the medical settlement, the DD should so indicate on the transmittal letter. A copy of the written statement which was sent to the parties denying the settlement, is to be transmitted to the OALJ with the pre-hearing statements (see paragraph 9.b., above).

Chapter 3-0502, Commutations

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1. Purpose and Scope. This chapter describes the procedures and requirements for processing requests for commutation of benefits under Section 9(g) of the Longshore and Harbor Workers' Compensation Act (LHWCA) and Section 2(b) of the Defense Base Act (DBA). Under the LHWCA, the DBA, and the implementing regulations, commutation is permitted only for benefits paid to people who are not United States citizens, not United States residents, and not Canadian residents. Additionally, commutation is limited to LHWCA death benefits, DBA death benefits, and DBA benefits for permanent total or permanent partial disability.

2. Statutory and Regulatory Authority.

1. **Statutory Authority**.

    a. **LHWCA Commutations**. The 1984 amendments to the LHWCA deleted the section of the Act (former section 14(j)) that provided for commutation of disability benefits. Section 9(g) of the LHWCA limits commutations to death benefits only.

    33 U.S.C. § 909(g) If the injury causes death, the compensation therefore shall be known as a death benefit and shall be payable in the amount and to or for the benefit of the persons following…Aliens: Compensation under this chapter [this Act] to aliens not residents (or about to become nonresidents) of the United States or Canada shall be the same in amount as provided for residents, except that dependents in any foreign country shall be limited to surviving wife and child or children, or if there be no surviving wife or child or

children, to surviving father or mother whom the employee has supported, either wholly or in part, for the period of one year prior to the date of the injury, and except that the commission [Secretary of Labor] may, at its option or upon the application of the insurance carrier shall, commute all future installments of compensation to be paid to such aliens by paying or causing to be paid to them one-half of the commuted amount of such future installments of compensation as determined by the commission [Secretary of Labor].

b. **DBA Commutations**. Section 2(b) of the DBA permits commutation of benefits in case of death and for permanent total and permanent partial disability. However, temporary disabilities, no matter how long in duration, are not subject to commutation.

   42 U.S.C. § 1652(b) Compensation for permanent total or permanent partial disability under section 8(c) of the Longshoremen's and Harbor Workers' Compensation Act, or for death under this Act to aliens and non-nationals of the United States not residents of the United States or Canada shall be in the same amount as provided for residents, except that dependents in any foreign country shall be limited to surviving wife and child or children, or if there be no surviving wife or child or children, to surviving father or mother whom the employee has supported either wholly or in part, for a period of one year immediately prior to the date of the injury, and except that the Secretary of Labor may, at his option or upon the application of the insurance carrier shall, commute all future installments of compensation to be paid to them one-half of the commuted amount of such future installments of compensation as determined by the Secretary.

2. **Regulatory Authority**.

   a. **20 C.F.R. § 702.142** - Commutation of payments; aliens not residents or about to become nonresidents.

i. Pursuant to section 9(g) of the Act, 33 U.S.C. 909(g), compensation paid to aliens not residents, or about to become nonresidents, of the United States or Canada shall be in the same amount as provided for residents except that dependents in any foreign country shall be limited to surviving spouse and child or children, or if there be no surviving spouse or child or children, to surviving father or mother whom the employee has supported, either wholly or in part, for the period of 1 year prior to the date of injury, and except that the Director, OWCP, may, at his option, or upon the application of the insurance carrier he shall, commute all future installments of compensation to be paid to such aliens by paying or causing to be paid to them one-half of the commuted amount of such future installments of compensation as determined by the Director.

ii. Applications for commutation under this section shall be made in writing to the district director having jurisdiction, and forwarded by the district director to the Director, for final action.

iii. Applications for commutations shall be made effective, if approved by the Director, on the date received by the district director, or on a later date if shown to be appropriate on the application.

iv. Commutations shall not be made with respect to a person journeying abroad for a visit who has previously declared an intention to return and has stated a time for returning, nor shall any commutation be made except upon the basis of a compensation order fixing the right of the beneficiary to compensation.

b. **20 C.F.R. § 704.102** - Commutation of payments to aliens and nonresidents.

Authority to commute payments to aliens and nonnationals who are not residents of the United States and Canada, section 2(b) of the Defense Base Act, 42 U.S.C. 1652(b), though separately stated in this Act, is identical in language to section 9(g) of the Longshoremen's Act. Thus, except for the different statutory citation, the LHWCA regulation at § 702.142 of this subchapter shall apply.

3. General Provisions.

1. **District Director Authority**. The District Director (by delegation from the Secretary of Labor and the Director, OWCP under 20 C.F.R. § 1.2(e)) at his or her own option, or upon application by the Employer/Carrier (E/C), may commute benefits. Objection by the claimant is no bar to the execution of the commutation.
2. **Formal Hearings**. The Office of Administrative Law Judges (OALJ) lacks authority to hear any dispute regarding the Director's commutation actions and thus, a formal ALJ hearing is neither required nor permitted prior to issuance of a commutation order. Rather, the Secretary has reserved commutation authority to the Director, and the Director's commutation actions are final. 20 C.F.R. § 702.142(b); Omar v. Al Masar Transportation Co., 46 BRBS 21, 26 (2012).
3. **Medical Care**. Payment of a commuted lump sum does not relieve the E/C of the responsibility to furnish medical care needed by the injured employee as a result of his work-related injury. (However, the issue of future medical care may be resolved by a section 8(i) settlement agreement. See Procedure Manual 3-501.)
4. **Bifurcated Commutation**. It is the policy of the DLHWC that commutations will only be considered if all benefits due can be commuted. If there are multiple beneficiaries, all benefits must be commuted at the same time. No attempt will be made to bifurcate the calculation of the commutation to allow for commutation of benefits to one beneficiary if benefits for all beneficiaries cannot be commuted.

5. **Temporary Status**. Commutations shall not be made with respect to a person journeying abroad for a visit who has previously declared an intention to return and has stated a time for returning. See 20 C.F.R § 702.142(d).

4. Processing a Request for Commutation.

1. **Application from the Employer/Carrier**. Consistent with 20 C.F.R § 702.142(b), an application for commutation of benefits must be made in writing.

   A claimant and/or the claimant's authorized representative may not seek commutation of benefits directly from the DLHWC; he/she must contact the E/C to initiate such action. Only the E/C or the Director may initiate commutation.
2. **Review by the District Director**. Upon receipt, the District Director or his/her designee (Claims Examiner) will review the commutation application to determine if a commutation can be considered.

   As outlined in 20 C.F.R. § 702.142(d), a commutation must be based on a Compensation Order that has fixed the right of the beneficiary to compensation. However, in some instances a Compensation Order has not been issued when the request for commutation is received.

   a. If a Compensation Order has not been issued, but signed (and translated if necessary) stipulations are in the file, the District Director may proceed with referral to the National Office as outlined in paragraph 4c. Thus, only one Compensation Order is needed (after the commutation has been calculated). It is unnecessary to issue one Compensation Order prior to the referral and another after the approval and calculation have been completed.
   b. If signed stipulations are not received before or at the same time the commutation is requested, or if additional documentation is needed, the District Director will advise the E/C to submit the signed stipulations or the necessary documentation.

c. If the request for commutation is denied, the District Director will inform the E/C and provide the rationale for the denial. These cases are not referred to the DLHWC Director.

3. **Referral to the DLHWC Director**. Once the District Director determines that a commutation can be considered, he/she will prepare a memorandum for the DLHWC Director recommending approval.

   This memorandum, which is to be made part of the case file, must include the full name(s) and birth date(s) of each beneficiary, the nature of the injury and the weekly compensation rate. The case file should contain the necessary supporting documentation, e.g., marriage and birth certificates for beneficiaries, evidence of the average weekly wage that supports the stated compensation rate, etc.

   In cases where the supporting documentation is in a language other than English, a translated version of the referenced document must be provided.

4. **Director's Review**. Upon receipt of the memorandum from the District Director, the DLHWC Director (or his/her designee) will review the case file documentation.

   a. **If the Director concurs** that the evidence in the file supports commutation of benefits, the commuted amount will be calculated. The memorandum documenting the calculation will be placed in the case file, and the District Director will be notified.

      The District Director will then issue a Compensation Order for the commuted benefits. The compensation order should contain a complete finding of facts, including the following:

      i. The injury or death is covered under the Defense Base Act, 42 U.S.C. § 1651.

      ii. An employer/employee relationship existed as supported by employment contract, statement of employer/supervisor, or other documentation establishing relationship.

iii. A description of how and where the injury or death occurred and how it arose out of and/or occurred in the course of employment.

iv. Average weekly wage.

v. If permanent disability is claimed, the Maximum Medical Improvement date and the initial compensation rate.

vi. If death benefits are claimed, the name, relationship, date of birth, and residency of each beneficiary.

vii. The initial benefit rate for each beneficiary.

viii. The total amount of the commutation, and in case of death, the allocation of the award for each beneficiary.

ix. The effective date of the commutation and a statement that "All benefits accrued prior to this date must be paid in full."

b. **If the Director does not concur** with the recommendation for commutation, a memorandum declining the commutation request and outlining the deficiencies will be placed in the case file, and the District Director will be notified. The District Director will notify the E/C of the deficiencies and request additional information as necessary. Once the deficiencies are clarified, the District Director may resubmit the commutation to the Director for consideration.

c. **The Director may also provisionally approve** a commutation in instances where the essential elements necessary for the commutation are available, but further documentation is needed. For instance, if a birth certificate is missing for a beneficiary, the commutation can be provisionally approved pending receipt of the birth certificate. Provisional approvals such as this should be considered only when the deficiency can be addressed by receipt of a specific document. Should the requested documentation result in a change in the commuted amount(s), resubmission of the commutation to the Director is required.

5. <u>Commutation Calculation</u>. Commutations of all future installments of compensation shall be in the amount of one-half of the commuted future installments.

1. **Effective Date**. 20 C.F.R § 702.142(c) provides that applications for commutations shall be made effective on the date received by the District Director but that a later date may be used if shown to be appropriate on the application. When processing commutations, the date "received" is the date of the memorandum from the DLHWC Director (or his/her designee) to the District Director approving the commutation.

   All benefits accrued prior to this effective date must be paid by the E/C at the full rate, without commutation. Benefits paid after this effective date may be credited against the commuted amount.
2. **Discount Rate**. The discount rate to be used shall be equal to the coupon issue yield equivalent (as determined by the Secretary of Treasury) of the average accepted auction price for the last auction of 52 week U.S. Treasury Bills settled immediately prior to the date of submission of the commutation application, rounded to the nearest one-half percent. The discount rate used is the same as the discount rate used for settlement calculations. See 20 C.F.R. § 702.243(g).
3. **Adjustments under §10(f) of the LHWCA**. Annual adjustments, effective October 1st of each year for permanent total disability and death benefit calculations, are considered in the commutation calculation. Future §10(f) increases are also considered; however, since future rates have not yet been determined, the §10(f) rate in effect during the year of the commutation is the rate used for the remainder of the years (as determined by life expectancy). See Logara v. Jackson Engineering Co., 35 BRBS 83 (2001).
4. **Life Expectancy**. Effective March 23, 2015, all calculations for commutations are to be made using the life expectancy tables developed by the World Health Organization (WHO). The DLHWC uses the data provided in these tables to determine life expectancy based on a beneficiary's country of residence, gender and age (as of the date of commutation).

Note - Prior to the effective date above, the DLHWC used the United States Life Tables produced by the United States Department of Health and Human Services for commutation calculations, borrowing from the settlement provisions outlined in 20 C.F.R. 702.243(g). However, the DLHWC has determined that life expectancy tables specific to the United States are not the best indicator of life expectancy in foreign countries and that the tables provided by the WHO provide a more accurate determination of life expectancy. See LHWCA Transmittal 15-01 for more background regarding this updated policy.

5. **Dependents**. Under the DBA, dependents in any foreign country are limited to a surviving wife and child or children, or if there is no surviving wife or child or children, to a surviving father or mother whom the employee has supported either wholly or in part, for a period of one year immediately prior to the date of the injury or death. Benefits for children are calculated to end at the age of 18, unless there is proof at the time of the commutation that the child is a student as defined in the LHWCA. See 42 U.S.C. § 1652(b).
6. **Credit**. In some cases, the E/C paying the commutation will request a credit against its commutation liability for monies paid to the claimant or beneficiaries. The Act allows the E/C to take credit only in specifically defined circumstances:
    a. **Under §33(f)**, if the person entitled to compensation institutes proceedings against a third party on account of the same injury for which compensation is payable under the Act and receives compensation, the E/C may offset any third party recovery against its liability under the Act.
    b. **Under §14(j)**, if the person entitled to compensation receives advance payments of compensation from the E/C, the E/C is entitled to offset those advance payments against its liability under the Act.
    c. **Under §3(e)**, if the person entitled to compensation receives compensation for the same injury or death under any other workers' compensation statute, the E/C is entitled to offset those payments

against its liability under the Act. See Lee v. Boeing Co., Inc., 7 F.Supp. 2d 617 (D. Md. 1998).

The burden of establishing the credit is on the E/C claiming it. Reviewing courts have adhered strictly to the letter of the Act's credit provisions in characterizing various payments made to foreign nationals. For instance, in some cultures, a criminal offender may make unsolicited payments to a victim or the victim's family as a form of apology or retribution. Such payments may not be construed as credits under the Act.

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1. Purpose and Scope. This Chapter addresses situations in which an employee is injured during the course of his/her employment and the injury is caused by the action or the negligence of a third party. The DD/CE should identify these cases as early as possible in the adjudication process so as to simplify procedures and insure that all the parties in interest are aware of their responsibilities.

2. Basic Procedures. When the CE first becomes aware of the existence of a third party claim or civil suit, the injured employee is to be notified via Form LS-526, Letter to Employee Explaining Need for Employer's Approval (Exhibit 43, PM 10-200). A diary action in the LCMS is required when this form is sent. In addition, four copies of Form LS-33, Approval of Compromise of Third Person Cause of Action (Exhibit 10, PM 10-200) are to be attached to Form LS-526.

Receipt of the properly executed Form LS-33 requires a diary action in the LCMS.

3. Employee Options. When an employee sustains an occupational injury that is caused by the negligence of a third party, the employee need not elect between a compensation remedy and a third party civil suit. Employees may do one of the following:

1. **Employees may elect to file a claim** for compensation; or
2. **Employees may file a civil suit** against the third party for negligence; or
3. **Employees may elect to pursue both actions** simultaneously.

4. Purpose of Section 33. Section 33 is designed to prevent injured employees from receiving benefits under the Act and proceeds from a successful negligence suit, in effect double recovery for the same injury. It is also designed to insure that the subrogation interests of ECs and the Special Fund are fully protected. It is also designed to protect the injured worker when he/she settles a third party negligence action for an amount which is less than he/she would otherwise be entitled to receive in compensation benefits.

5. Section 33 Time Limits. An employee must pursue any third party action against the negligent party within six months of accepting a compensation award or the right is assigned to the employer. Award, as used in this instance, means compensation order. The employer then has ninety days to commence a third party action. If the employer does not institute an action during this ninety day period the right reverts to the employee.

6. Distribution of Third Party Action Proceeds. The EC has first dollar recovery rights against the "net amount" (i.e. the gross amount less reasonable attorneys' fees and expenses reasonably incurred) recovered in a third party action. If the recovery is less than the compensation benefits due, the employee is entitled to be paid the difference by the EC. However, if the third party recovery is greater than the benefits due, the EC is not only entitled to credit the recovery against past payments/obligations but also against any future liability for which it may be responsible. The employee is entitled to retain all the proceeds remaining from the third party recovery after the past and future credits, noted previously, have been applied.

7. Medical Benefits. In addition to a credit for all compensation payments, the EC is entitled to a credit for all past and future medical payments made under section 7 of the Act. Thus, the injured employee is responsible for the payment of his/her medical expenses as long as proceeds remain from the third party action.

The employee should be advised to submit these paid medical bills to the EC so that appropriate reductions to the remaining third party proceeds can be made.

8. Rights of the Special Fund. To insure that claimants will continue to receive SF benefits, the parties of interest must submit form LS-33 for the N/O review and the Director's signature.

In addition to the LS-33, a statement outlining the specifics of the distribution must be furnished to include:

Gross Recovery

Attorney Fees

Costs and Expenses

Employer/Carrier lien (as agreed)

20 Percent of Gross Recovery (claimant's share as allowed by the Special Fund)

Special Fund Lien(taken after claimant's share is determined)

Any remaining balance will be applied as a credit to the claimant's future compensation.

Section 33(g)(3) of the Act specifically provides the Special Fund with a "lien upon the proceeds of any settlement obtained from or judgment rendered against a third person" whenever any funds have been disbursed under section 44. However, the EC retains first dollar recovery rights which must be satisfied before the Special Fund will assert its lien. Negotiations on behalf of the Special Fund will be conducted by the Director, DLHWC. Therefore, any questions raised by the parties in interest regarding the position of the Special Fund in any third party case should be referred directly to the NO. Due to the complexity of such negotiations, each case will be individually reviewed by the Director before a determination is made.

Please refer to **Waganer v. Alabama Dry Dock and Shipbuilding Co.**, 12 BRBS 582 (1980), (**LHWCA CIRCULAR 80-14, August 21, 1980**, a copy of which may be obtained from the National Office if needed), for guidance on how to calculate deficiency compensation in cases being paid under section 10(h) of the Act. The Director, DLHWC, must execute Form LS-33 in all Special Fund cases involving third party settlements.

9. Consent. Section 33(g)(1) of the Act requires the written approval of the employer and carrier for any settlement which is less than the amount to which the employee would be entitled to under the Act. If written approval is not received before the settlement, the employee's right to future compensation is terminated. Form LS-33 is used to obtain this written approval. Reference the Supreme Court's decision in **Cowart v. Nicklos Drilling**, 26 BRBS 49(CRT)(1992). This decision clearly outlines the obligations of the claimant.

10. Third Party Action Against a Vessel. Under section 5(b) of the Act, a claimant may file a third party action against a vessel. If the claimant's employer is also the vessel owner, the claimant can sue the employer for negligence and also collect compensation benefits from the employer. **Jones and Laughlin Steel Corp. v. Pfeifer**, 462 U.S. 523 (1983). However, if the claimant is employed by the vessel to provide stevedoring services, no third party action is permitted if the injury is caused by the negligence of persons providing stevedoring services to the vessel. In addition, no third party action is permitted for employees hired to provide ship building, repairing or breaking services if the employer is the "owner, owner pro hac vice, agent, operator, or charterer of the vessel."

11. Regulatory Requirements. Section 702.281 of the regulations requires that the employer and the DD are to be promptly notified whenever any action is taken against a third party for the injuries sustained by the employee. Any settlement and its conditions are to be reported regardless of the amount. In addition, as described above, written approval must be obtained from the employer whenever the third party settlement amount is less than the compensation due. Failure to notify the employer and obtain written approval when required relieves the EC of the liability for future compensation. It is imperative that the claimant and his/her representative be aware of their obligations under sections 33(g)(1) and (2) of the Act.

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1. Purpose and Scope. This Chapter provides procedures for reporting instances of known or suspected fraud or abuse under the Longshore and Harbor Workers' Compensation Act (LHWCA) and its extensions. Instances of known or suspected fraud or abuse are to be investigated by the Office of Workers' Compensation Programs (OWCP) and reported to the Regional Solicitor if the allegations pertain to program matters in which private sector or Special Fund monies are involved. If the allegations pertain to Federal employees or contractors, if paid from Government funds, they are to be reported in accordance with the procedures contained in section 8900 of the ESA Manual of Administration.

2. Policy. The detection and prevention of fraud or abuse in the Longshore Program is of the highest priority. Complaints of alleged fraud or abuse may be brought to the attention of the DO by Employers, Carriers, or other parties. All OWCP personnel are responsible for reporting actual or suspected fraud or abuse, through appropriate channels to the Department of Labor.

3. Statutory Provisions. Section 31(a)(1) of the Act provides that any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under the Act shall be guilty of a felony, and on conviction thereof shall be punished by a fine not to exceed $10,000, by imprisonment not to exceed five years, or by both.

Under section 31(c), the same penalties apply to an employer, his duly authorized agent, or an employee of an insurance carrier who knowingly and willfully makes a false statement or representation for the purpose of reducing, denying, or terminating benefits to an injured employee, or his dependents . . . .

Other provisions pertaining to fraud or abuse include sections 15(a), 28(e) and 38(a) and (b) of the Act.

4. Types of Fraud or Abuse Not Covered by These Procedures. Types of Fraud or Abuse Not Covered by These Procedures. The procedures contained in this chapter do not apply to known or suspected instances of fraud, abuse, or criminal conduct by or involving OWCP personnel, contractors, or under the War Hazards Compensation Act which involve the payment of government funds. These are to be reported in accordance with the procedures contained in section 8900 of the ESA Manual of Administration.

5. Procedures.

1. **Receipt of Report or Information of Suspected Fraud or Abuse**.

a. A suspected instance of fraud or abuse in a LHWCA claim will, in general, be reported to the CE or DD by the Employer or Insurance Carrier. The report may be made verbally or by letter. If reported verbally, the informant should be requested to submit a written statement of the suspected violation and to provide supporting information or documents that led to the discovery or suspicion.

b. Instances of alleged fraud or abuse in LHWCA claims may also come to light in the course of formal hearings before an Administrative Law Judge, who may, in the Decision and Order, refer the matter to the OWCP for appropriate action on the information. Such referrals should be carefully considered by the DD and RD, and should be investigated if warranted by the facts.

2. **Action by Person Receiving Complaint**. If the verbal or written report is made to a CE, he or she will immediately prepare a memorandum for the DD, describing in detail the known or suspected violation. If additional investigation or material is needed to support the allegation, it should be indicated if the person making the complaint will conduct the investigation or provide any additional material that may be needed.

3. **Action by the DD**Upon receipt of the complaint, the DD will review the information or evidence (including the case file) and will forward the complaint to the RD by narrative memorandum which shall include a summary of the complaint and other relevant information from the case file and the DD's recommendation regarding prosecution and the kinds of additional investigation, if any, that may be needed to resolve the matter. The RD will then refer the matter to the Regional Solicitor for review and concurrence of the proposed actions and guidance regarding any additional investigation which may be appropriate. The Regional Solicitor will refer the matter back to the RD for implementation of the proposed investigation by the DD if the matter is not in posture for referral to the U.S. Attorney. The DD will direct or conduct the investigation as follows:

    a. If the complaint was made by the employer/carrier, they should be requested to furnish whatever evidence is needed to support the

complaint so that a decision can be reached regarding referral for prosecution.

b. If the employer/carrier will not provide the needed evidence, or if the complaint was made by a person known to the claimant who is not willing or is unable to furnish the necessary evidence to support the complaint, all relevant information should be obtained from this person and the DD should attempt to obtain the needed evidence as outlined in subparagraphs d and e, below. If a surveillance investigation of a claimant is needed to support the complaint, or some other form of on site visit is needed, the use of Wage and Hour investigators or FBI agents should be considered. See subparagraphs e(5) and e(6), below.

4. **Kinds of Evidence Required**The kinds of evidence needed to support the fraud allegation will differ from case to case depending on the nature of the allegation. It is important, however, that as much evidence as possible be obtained in each case so that a successful prosecution will be possible. The listing below identifies some of the kinds of evidence that should be obtained to support prosecution of a fraud allegation.

    a. A completed Form LS-200, Report of Earnings, or similar sworn wage statement, covering the period of any alleged employment while in receipt of compensation benefits. It is important that this evidence be obtained in every case of this nature, if possible. The DD, employer/carrier, or National Office for those cases being paid benefits from the Special Fund, may request the claimant to complete an LS-200.

    b. Payroll records covering the period of any alleged employment while in receipt of compensation benefits.

    c. Written statements, interrogatories, or depositions from individuals having knowledge of the alleged fraud or of a claimant's activities which relate to the fraud allegation.

    d. Income tax returns.

e. Reports from private investigative agencies which may include surveillance films of the claimant.

f. Reports from credit reporting agencies.

g. Sworn testimony given at administrative hearings.

h. Documentary evidence submitted at administrative hearings.

i. Material contained in other Federal compensation, State compensation, or insurance case files.

j. Medical records and/or medical receipts.

5. **Methods of Obtaining Information**. The following methods may be used to obtain the information or evidence needed to properly evaluate a complaint:

    a. Written correspondence.

    b. Telephone calls.

    c. Subpoenas. Subpoenas may be issued by the DD to obtain medical records, payroll records or other documentary evidence.

    d. Informal conferences. Conferences may be held to obtain information and material. If an overpayment of compensation exists, a conference may also be appropriate to determine whether and how the overpayment will be recovered.

    e. Wage and Hour Investigators. If an on site visit is needed to obtain evidence, or to conduct a surveillance of a claimant, the use of Wage and Hour Investigators should be considered. The RD for OWCP should request this kind of assistance directly from the RD for the Wage and Hour Division.

    f. Federal Bureau of Investigation Agents. Depending on the nature of the complaint, or the inability to obtain information or evidence by other means, the use of FBI agents may be considered. If it is not possible to obtain the needed evidence in any other way, the matter should be referred to the Regional Solicitor who will determine if a request should be made to the U.S. Attorney's Office for FBI assistance in the investigation pursuant to section 31(a)(2) of the

Act. All such referrals to the U.S. Attorney's Office shall be made by the Regional Solicitor.

6. **Action at Conclusion of Investigation**. After the investigation has been concluded, and all relevant evidence has been obtained, the DD will refer the matter to the RD by narrative memorandum which shall include a summary of the facts obtained from the investigation, along with copies of all evidence obtained, and his/her recommendation regarding whether the facts warrant referral to the U.S. Attorney for prosecution or whether no basis exists for prosecution and the investigative file should be closed. The matter will then be referred by the RD to the Regional Solicitor for review and concurrence/rejection of the proposed recommendation. If the facts support prosecution, the Regional Solicitor will refer the matter to the U.S. Attorney for appropriate action. If he/she concurs with a recommendation that no basis exists for prosecution, the investigative file may be closed.
7. **Maintenance of Fraud Complaint and Other Evidence**.
    a. All original information, documentation, and evidence concerning the known or suspected instance of fraud or abuse is to be placed in a manila folder, separate from the case record, and in a secure file cabinet. These investigative files are to be maintained alphabetically by the name of each individual.
    b. Any reports or confidential information gathered by an agency such as the Federal Bureau of Investigation concerning claimants should be maintained in these files. Such information remains the property of that agency and is subject at all times to its control.
    c. Records containing information gathered in connection with investigations concerning possible violation of federal law are to be maintained in a separate system of records, established by DOL/ESA 26. Records maintained in connection with criminal investigations are exempt from disclosure under the Freedom of Information Act, pursuant to section 3(j)(2) of the Privacy Act. See 55 Federal Register 7126-7127 (February 28,1990). Access to these

records should be limited to those OWCP and SOL personnel whose official duties require such access.

d. Any request for the disclosure of information in these files should be referred to the Director, DLHWC. Either the Regional Solicitor or the Associate Solicitor for Employee Benefits must also be contacted before any disclosure is made.

8. **Subpoenas Served on OWCP Personnel**. Occasionally, subpoenas will be served on individuals by name and will require the appearance of the named individual as custodian of a case file about whom there is also an investigative file of the type specified in subparagraph 5g, above. Usually, the individual subpoenaed will be the DD, but it could be a CE or any other person who might have access to the case record. Anyone receiving or being served a subpoena should refer it to the DD for immediate referral to the Regional Solicitor for guidance in releasing the information requested. Any subpoena served on a National Office employee should be immediately referred to the Associate Solicitor for Employee Benefits to determine whether the procedures set forth at 29 C.F.R. section 2.20, et seq., have been complied with.

Chapter 4-0100, (Reserved)

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Chapter 4-0200, Informal Conferences

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1. Purpose and Scope. This chapter establishes guidelines and procedures for scheduling and conducting informal conferences for the purpose of resolving issues. It also includes guidance with regard to the Program's established timeframes and coding requirements for tracking informal conference requests.

2. Regulatory Authority. The regulations at 20 C.F.R. 702.311 empower the District Directors (DDs) to resolve disputes with respect to claims in a manner designed to protect the rights of the parties and to resolve such disputes at the earliest practicable date through informal conferences. In addition, 20 C.F.R. 702.312 through 702.316 establish certain guidelines for conducting informal conferences.

3. Overview. The purpose of a conference is to amicably resolve disputes whenever possible, to narrow the outstanding issues, and to simplify subsequent proceedings. Informal conferences have proven successful in resolving contested cases, and even in those instances where all issues have not been resolved, they have established their value by narrowing the issues, thus simplifying the formal hearing procedure.

Usually one of the parties requests an informal conference to assist with dispute resolution; however, it is also proper for a DD or Claims Examiner (CE) to schedule an informal conference without a formal request from any of the parties if the facts justify the scheduling.

Conference attendance in person is preferred when possible, but the parties may also attend via tele/web conference at the discretion of the DD or CE.

4. Parties Involved. The claimant, the claimant's representative, and the representative of the Employer/Carrier (E/C) constitute the parties present at an informal conference. Also present is the DD or CE.

Except in unusual circumstances, all parties in interest should be present, whether in person or via tele/web communication, and have the authority to resolve the outstanding issues. No other parties should be present at the conference unless the DD or CE considers their presence essential to the proceedings; however, other staff members may be present for training purposes.

5. <u>Tracking the Informal Conference Request</u>. All requests for informal conferences are tracked in the Longshore Case Management System (LCMS). Documentation in the case file to support LCMS coding is required for all aspects of dispute resolution, including the informal conference process.

1. **Code "rqcr" (request for conference received)** must be entered in LCMS when a request for conference is received. The date of receipt of the request is the date of the code.
2. **Disputes identified** in the conference request should be coded in LCMS at that time if they are clearly identified; the date of dispute is the date of receipt of the informal conference request. If the nature of the dispute is not clear, it may be coded at a later date. In all instances though the dispute should be coded by the time the conference is held (or, if no conference is held, by the time a recommendation is issued).
3. **If the DD or CE schedules an informal conference** without a formal request from any of the parties, the "rqcr" code must still be entered to trigger the tracking in LCMS. The case file must be documented to show why the conference is being scheduled, and this can be done in the Conference Scheduling Notice (see paragraph 6); separate documentation is not required. The code and the date of this documentation should match.
4. **The entry of "rqcr" triggers the 15 day action** requirement discussed in paragraph 6.

6. <u>Actions Required Within 15 Days of Receipt</u>. Within 15 days following receipt of the request for a conference, the DD or CE must review the case file and take one of three actions: schedule the conference, issue written recommendations without convening the parties, or notify the parties that the conference will not be scheduled until certain conditions are met or additional documentation is submitted such that the case is in posture for a productive conference.

1. **Scheduling the Conference**. If the case is in posture for a conference, the Conference Scheduling Notice must be sent to the parties. As required by 20 C.F.R. 702.313, this notice must be retained in the case file

a. **Code “cnfo” Conference Notice (for office) or “cnft” Conference Notice (for telephone)** must be entered in LCMS when the Conference Scheduling Notice is issued. Code “cnfo” should be used if any party is scheduled to attend the conference in person. Code “cnft” should be used if all of the parties are scheduled to participate by phone. The date of the code is the date the Notice is released to the parties.

   Entry of the “cnfo” or “cnft” code satisfies the requirement for an action within 15 days of receipt of the request for a conference and stops the 15 day clock.

b. **The informal conference must be held within 45 days** from the date of receipt of the request for a conference, but the informal conference cannot be scheduled with less than 10 days' notice to the parties, unless the parties agree to an earlier date.

c. **The Notice** must provide the date, time and place of the conference, and also identify the issues. See 20 C.F.R. 702.313 and 702.321(b)(1)(i).

d. **The Notice may include a request for the parties' positions** on the disputed issues or request that the parties have certain documentation available at the time of the conference. The DD or CE may also provide initial comments pertaining to noted deficiencies so that the parties can be as prepared as possible to resolve the issues at the time of the conference.

   This discretionary practice is suggested to induce the parties to focus on the issues, to identify those issues on which there is agreement or disagreement, and to summarize their positions in advance of the conference. For example, the E/C may be asked to summarize payments made up to the date of informal conference.

e. **If permanency or death is an issue** raised by the parties or identified by the DD or CE prior to the conference, The Notice must

include notice to the parties that a complete application for section 8(f) relief is to be submitted before or at the conference. The notice should include reference to the Director's absolute defense under 8(f)(3) of the Act, i.e., failure to submit a fully documented 8(f) application at or before the informal conference may result in the Director asserting the absolute defense to the liability of the Special Fund. (See 20 C.F.R. 702.321(b)(1)(i) and PM 6-201.)

Even if the parties do not specifically raise permanency as an issue, this language should still be included if the information in the case file indicates that the claimant's condition has reached a permanent state.

If the E/C indicates that more time is needed for submission of the application and that a complete package cannot be submitted prior to the conference, the DD or CE has the discretion based on the circumstances in the case, to provide an extension of the date for submission of the application. See 20 C.F.R. 702.321(b)(2).

2. **Recommendation Without Convening the Parties Simultaneously**. When the DD or CE determines that the case file contains sufficient evidence from both parties regarding the issues in dispute, and the parties have no new evidence to submit, it may not be necessary to require the parties to participate simultaneously in a joint conversation, and the CE may issue written recommendations based on the case file information. For example, if the disputed issues are date of maximum medical improvement and degree of ratable permanent impairment on a scheduled injury, and both the claimant and E/C have submitted their final medical reports, the DD or CE may determine that recommendations can be issued without convening the parties.
    a. **The written recommendation should clearly outline the issues**, state the positions of the parties, describe the evidence considered and provide a clear recommendation with rationale. The recommendations should be impartial, unbiased, and reference the evidence of record which formed the basis for the recommendations.

Statutory/regulatory citations and/or case law may also be included, if applicable, in support of the recommendations.

b. **The letter issued should state that the recommendations** are being issued in lieu of an informal conference.

c. **Code "rwoc" (recommendation without conference)** must be entered in LCMS if this action is taken. The date of the code is the date of the recommendation.

   Entry of the "rwoc" code satisfies the requirement for an action within 15 days of receipt of the request for a conference and stops the 15 day clock.

d. **If permanency or death is an issue** issue raised by the parties or identified by the DD or CE in the conference request, the recommendation must include notice to the parties that a complete application for section 8(f) relief is to be submitted by a given deadline. The notice should include reference to the Director's absolute defense under 8(f)(3) of the Act, i.e., failure to submit a fully documented 8(f) application by the deadline, may result in the Director asserting the absolute defense to the liability of the Special Fund. (See 20 C.F.R. 702.321(b)(1)(i) and PM 6-201.)

   Even if the parties do not specifically raise permanency as an issue, this language should still be included if the information in the case file indicates that the claimant's condition has reached a permanent state.

   If the E/C indicates that more time is needed for submission of the application and that a complete package cannot be submitted by the given deadline, the DD or CE has the discretion based on the circumstances in the case, to provide an extension of the date for submission of the application.

3. **Case Not in Posture for an Informal Conference**. If the case is not in posture for a productive conference on the disputed issues, a Conference Deferral Notice must be issued. Issuance of the Deferral Notice demonstrates that the request for conference has been given due consideration by the District Office but a determination has been made that additional information is needed.

   Note, however, that prior to issuing a Deferral Notice the CE should consider whether a conference can be scheduled as requested to avoid any unnecessary delays, especially if there is a hardship (e.g. if the claimant is unable to work and is not receiving compensation) or if the desired evidence will be extremely difficult to obtain (e.g. medical treatment notes from overseas). When scheduling the conference, the CE can ask that the parties submit any necessary additional evidence prior to the conference date; this practice can facilitate timely conferences.

   a. **Code "cndf" Conference Deferred (additional evidence requested)** must be entered in LCMS when the Deferral Notice is issued. The date of the code is the date of the Deferral Notice.

      Entry of the "cndf" code satisfies the requirement for an action within 15 days of receipt of the request for a conference and stops the 15 day clock.

   b. **The Conference Deferral Notice must**:

      i. Acknowledge the request for conference.

      ii. List the disputes for which the conference was requested.

      iii. Notify the parties of the reason why the case is not ready for conference. If additional evidence or documents are needed, the letter must list them or instruct the parties as to what actions need to be taken before a conference will be scheduled. If the request is not specific or it is overly broad in nature, the letter should specifically request that the issues be defined.

iv. Notify the parties that unless the required evidence is submitted or other necessary actions are completed within 30 days, the request for conference is deemed denied without further notice.

c. **If the documents requested in the Conference Deferral Notice** are received within the submission period, the DD or CE must determine whether the information submitted in response to the Deferral Notice is sufficient to proceed.

i. If the case is now in posture for an Informal Conference, the Conference Scheduling Notice should be issued and the LCMS code “cnfo” Conference Notice (for office) or “cnft” Conference Notice (for telephone) should be added. See paragraph 6a.

When scheduling a conference after issuing Deferral Notice, the conference should be scheduled within 30 days of the notice (within 30 days of the “cnfo” or “cnft”).

ii. If the case is still not in posture for conference, the DD or CE should notify the parties of the deficiency in the evidence or otherwise explain why the conference is not being scheduled.

iii. One of these actions should be taken within 15 days of the end of the submission period outlined in the Deferral Notice.

d. **If no documentation has been received within the submission period**, the CE should review the file within 15 days of the end of the submission period outlined in the Conference Deferral Notice to determine whether a recommendation can be made on any of the disputed issues based on the evidence in the file.

i. If a recommendation can be issued, the CE should issue the recommendation at that time. See paragraph 6b.

ii. If a conference was requested, but the party who requested the conference did not submit evidence in response to the Deferral Notice, the dispute should usually be considered closed at that point for LCMS tracking purposes.

iii. If new evidence is received after the deadline given in the Deferral Notice, a conference should not be automatically scheduled unless a party submits a new request for conference. At that time, a new "rqcr" must be entered to trigger a new 15 day action requirement. If there is any ambiguity, the CE should contact the party who submitted the evidence to determine whether a conference is being requested.

Note - If evidence is received late and a request for a conference was not specifically made, the DD or CE may still initiate a conference at his/her discretion and explain why in the Conference Scheduling Notice. See 5c in this chapter.

e. **The DD or CE may also use the Conference Deferral Notice form letter** (and coding) if he/she determines that the injured worker should be scheduled for a DLHWC directed independent medical examination (see 20 C.F.R. 702.408). The CE should outline the issue(s) and why the examination is being scheduled in the letter, and then take action within 15 days to schedule the examination. The examination date should be as soon as possible.

Within 15 days of receipt of the report from the examination, the CE should proceed with either scheduling the conference within the parameters outlined in this paragraph or issuing a recommendation.

7. <u>Conference Request Withdrawn Prior to Scheduling</u>. If the requesting party asks to withdraw the request for conference before the conference is scheduled, and the CE determines that no further action is needed with respect to the

conference request, the request for a conference can be closed in LCMS as outlined below.

1. **If the party requesting the withdrawal** has copied all interested parties on the submission no further action is required by the office since all parties would be aware of the status of the request.

   Code “cnfp” (conference postponed/cancelled/withdrawn) must be entered in LCMS to stop the 15 day clock. The date of the code is the date the letter was received.
2. **If one of the interested parties was not copied on the correspondence**, the DD or CE should issue a letter notifying the parties of the withdrawal, including notice that no conference will be scheduled unless a new request is submitted. For example, a letter confirming the withdrawal of a conference request would state, “the claimant’s request dated [ ] for conference on the issues of [ ] has been withdrawn, no conference will be scheduled unless a new request is submitted.”

   Code “cnfp” must be entered in LCMS to stop the 15 day clock. The date of the code is the date of the letter issued by the office.
3. **The dispute(s) should usually be considered closed** at that point for LCMS tracking purposes.

8. <u>Cancelling/Postponing a Scheduled Conference</u>.

1. **Cancelling a Conference**. Previously scheduled conferences may be cancelled upon request of the parties and when the DD or CE determines that no further action is needed with respect to the conference request.
   a. **Code “cnfp” (conference postponed/cancelled/withdrawn)** must be entered in LCMS to stop the clock for conducting the conference. The date of the code is the date of receipt of the letter/call requesting cancellation.
   b. **The CE must document the file with the reason** for cancellation if it is not clear based on a letter or call already in the file and notify the

other interested parties if they have not already been notified by receiving a copy of the cancellation request.

c. **The CE should determine whether any tracked disputes** in LCMS can be closed at this time and update LCMS accordingly.

2. **Postponing/Rescheduling a Conference**. Scheduled conferences may be postponed and rescheduled at the request of one or both parties for good cause.

    a. **Code "cnfp" must be entered** in LCMS to stop the clock for conducting the conference. The date of the code is the date of receipt of the letter/call requesting postponement or rescheduling.

    b. **Upon receipt of the agreement of the parties to reschedule**, code "cnfr" (conference rescheduled) must be entered in LCMS to start a 30 day clock for holding the conference. When rescheduling a conference, it should be scheduled within 30 days of the "cnfr".

9. <u>Preparing for the Informal Conference</u>. Prior to the conference, the DD or CE should review and become familiar with both the case file and the legal issues to be resolved. In complicated cases, it may be helpful to outline the issues to be discussed, questions to be asked or specific areas to be developed as well as noting the applicable case law.

The DD or CE should determine if there is any additional compensation due under section 14(e) (added 10% of overdue compensation payable without an award, PM 8-202); or a penalty due under section 30(e) (penalty for employer's late report of injury, PM 8-302), or interest payable on past due installments of compensation (PM 8-201). If so, these issues should be added to the other issues to be discussed at the conference.

10. <u>Conducting the Informal Conference.</u>

1. **Conferences should be kept informal** and shall not be stenographically recorded nor shall sworn testimony be taken. (See 20 C.F.R. 702.314(a).) It is the responsibility of the DD or CE conducting the conference to guide the discussion toward achieving the ultimate purpose of the conference which is to amicably resolve the issues in dispute. The DD or CE conducting the conference should provide the parties in interest with the benefit of the DD's or

CE's special knowledge, experience, and expertise when pointing out strengths and weaknesses in both parties' positions.

2. **Conferences should be directed towards dispute resolution**. The conference should begin promptly and focus on narrowing and resolving the contested issues. For example, the DD or CE may control the initial phase of the conference, immediately after the parties have stated their positions, by clarifying those areas which are not at issue and by obtaining oral stipulations. The parties may then focus on the disputed issues.
3. **If the claimant is unrepresented**, care should be taken to ensure that the claimant's rights are fully protected. If necessary, the purpose of the proceeding should be fully explained and any questions the claimant may have should be answered. Prior to concluding the conference, the DD or CE should ensure, to the extent possible, that the claimant fully understands what has transpired and what will happen next, e.g., a recommendation will be issued, or a formal hearing will be necessary, etc.

   However, the DD or CE is not the claimant's legal advisor. If the facts of a particular case are such that it is obvious that the claimant needs legal assistance, the claimant may be referred to available legal resources outside DOL. Nevertheless, it is the responsibility of the DD or CE to explain the portions of the Act relevant to the case in question.
4. **If a claimant, who was previously unrepresented, appears with an attorney** or other representative, the attorney or other representative must comply with the provisions of 20 C.F.R. 702.131 by filing a notice of representation. The attorney or other representative must be instructed that any fee request must be submitted for approval pursuant to 20 C.F.R. 702.132.
5. **If the issue of permanency is first raised at the informal conference**, the DD or CE must establish a date certain when the employer's fully documented application for section 8(f) relief must be submitted pursuant to 20 C.F.R. 702.321(b)(1)(ii). This date should also be transmitted in writing in the informal conference memorandum. This action is essential to preserve the Director's

defense under Section 8(f)(3) which protects the Special Fund from untimely requests for 8(f) relief.

6. **Codes "cnho" Conference Held (in office) or"cnht" Conference Held (by telephone)** must be entered in LCMS. Code "cnho" should be used if any of the parties attended the conference in person. Code "cnht" should be used if all of the parties participated by phone. The correct conference held code, to distinguish between in-person and completely telephonic conferences should be used regardless of how the conference was originally scheduled to occur.
7. **At the conclusion of the conference**, dispute codes should be updated in LCMS as needed. It is possible that some dispute codes may need to be added based on new issues raised at the conference. It is also possible that a previously identified dispute may need to be coded out if the issue was no longer in dispute at the start of the conference.

   Issues still in dispute at the start of (and during) the conference should remain open in LCMS until a resolution code can accurately be entered.

11. <u>Memorandum of Informal Conference</u>. Regardless of whether disputed issues are resolved at the conference, a thorough record of the conference must be documented and placed in the file. Copies should be sent to all parties in interest. (See 20 C.F.R. 702.316.)

1. **Timeframe**. The memorandum of informal conference must be released within 10 calendar days after the conclusion of the conference regardless of whether the parties agree or disagree on any or all of the disputed issues.
2. **Agreement at Conference**.
    a. **Conference Memorandum Content**. In order to provide a complete record of the conference the Memorandum of Informal Conference should provide an outline of the issues presented, describe the evidence considered and state the positions of the parties. If at the conclusion of the conference, there was agreement on all matters with respect to the claim, 20 C.F.R. 702.315(a) states that the

memorandum should also embody the agreement between the parties.

b. **Compensation Order Requested**. If any party in interest requests that the agreed disposition be embodied in a compensation order, the order should be prepared, within thirty days of the agreement, for signature by the DD. If a compensation order is requested, the DD may ask that stipulations embodying the agreed upon facts be submitted prior to issuance of the order.

3. **No Agreement at Conference.**

   a. **Conference Memorandum Content**. Like conference memoranda in cases where there is agreement, in order to provide a complete record of the conference, the Memorandum of Informal Conference should provide an outline of the issues presented, describe the evidence considered and state the positions of the parties. If there was no agreement between the parties, 20 C.F.R. 702.316 outlines that the memorandum must also contain clear recommendations, with rationale, for resolution of the disputed issues.

   b. **Recommendations.**

      i. The recommendations should be impartial, unbiased, and reference the evidence of record which formed the basis for the recommendations. Statutory/regulatory citations and/or case law may also be included, if applicable, in support of the recommendations.

      ii. A recommendation that the private parties “settle” their disputes should not be the sole recommendation made.

      iii. The DD or CE should apply the presumptions contained in section 20(a) of the Act, where appropriate, in evaluating the evidence to support a recommendation.

   c. **The parties should be advised that they have fourteen (14)** calendar days to accept or reject the recommendations as required by 20 C.F.R. 702.316.

    d. **If payments were delayed or late**, the conference memorandum should include recommendations for any additional compensation or interest due.

4. **If the issue of permanency was first raised at the conference** and the employer intends to request section 8(f) relief, the memorandum of informal conference must include a specific date deadline for submission of the E/C's application and the notice that failure to submit a timely application may result in the absolute defense to the liability of the Special Fund. (See 20 C.F.R. 702.321(b)(1)(ii).)
5. **Code "cnfm" (Conference Memorandum Issued)** must be entered in LCMS to indicate that the Conference Memorandum was released. The date of the code is the date the memorandum is issued.

   Entry of the "cnfm" code stops the clock on the 10 day timeframe for issuing the Informal Conference Memorandum.
6. **Agreed Upon Post-Conference Actions**. In some instances, the parties may agree to certain prescribed post-conference actions as part of the dispute resolution process. In this case, the Memorandum of Informal Conference should clearly define the responsibilities of the parties and state specific dates by which actions are expected. For example, the parties may agree at the conference to resolve the issues of nature and extent of disability by means of an independent medical examination to be obtained, post-conference, from a doctor selected by the DLHWC. Or the parties may agree that an additional report is required from the treating physician, or additional wage information is required from the employer, etc.
    a. **If post-conference actions are agreed upon**, the Memorandum of Informal Conference should include this portion of the conference discussion and any agreements reached. The memorandum should describe the actions to be performed by the parties and establish a deadline for completion of the medical evaluation, submission of the report, etc.

The parties should be advised that if the post-conference actions are not completed or the anticipated documentation is not received by a date certain, a final recommendation will be issued based on the evidence in the file.

b. **If an exam is to be scheduled by the DLHWC**, the CE should take action within 15 days to schedule the examination. The examination date should be as soon as possible.

c. **Code "cnfm" must be entered** in LCMS to show that this interim conference memorandum was issued. This type of memorandum should still be issued within 10 days of the conference.

d. **Within 15 days of receipt of the anticipated documentation**, the DD or CE should issue additional recommendations in a supplemental memorandum based on the new medical evidence. The LCMS code "rwoc" must be entered on the date of release of the memorandum to show that additional recommendations were issued.

e. **If the additional evidence is not received by the date specified**, the DD or CE should issue recommendations based on the existing record. This action should be taken within 15 days of the deadline date provided in the initial conference memorandum. The LCMS code "rwoc" must be entered on the date the recommendation was issued.

7. **Resolution Coding**. The appropriate LCMS resolution code(s) must be entered once the evidence demonstrates that the dispute has been resolved.

12. <u>Referral for Hearing</u>. If the recommendation is rejected in full or in part by any of the parties, and there is no indication that further conferences would be productive, the case should be promptly referred to the Office of Administrative Law Judges (OALJ) for a formal hearing. If requested, the case should also be referred prior to scheduling the conference if one of the parties requests such action and does not wish to proceed with a conference. Refer to PM 4-600 for instructions on the proper procedure for the referral to the OALJ.

Paragraph and Subject	Date	Trans. No.
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1. Purpose and Scope. This Chapter outlines the basic provisions for approving or disapproving the withdrawal of a claim which was properly filed under section 13 of the Act. (See 20 C.F.R. section 702.225.)

2. Before Adjudication of a Claim. A claimant (or an individual who is authorized to execute a claim on his/her behalf) may withdraw a previously filed claim, with the approval of the DD or designee, when the following circumstances exist:

1. **The claimant files with the DO** handling the claim a written request stating the reason(s) for withdrawal;
2. **The claimant is alive at the time his/her request** for withdrawal is filed;
3. **The DD approves the request** for withdrawal as being for a proper purpose and in the claimant's best interest; and
4. **The request for withdrawal is filed** on or before the date that OWCP makes a determination on the claim.

3. After Adjudication of a Claim. A claim for benefits may be withdrawn by a written request filed after the date the District Director makes a determination on the claim, provided that:

1. **The conditions enumerated** in subparagraphs 2(a) through (c), above, are met; and
2. **There is repayment by the claimant** of any benefits previously paid because of the claim that is being withdrawn or it can be established to the satisfaction of the OWCP that repayment of any such amount is assured.

4. Effect of Withdrawal of Claim. Where a request for withdrawal of a claim is filed and the request is approved, the withdrawal is without prejudice to the filing of another claim, subject to the time limitation provisions of section 13 of the Act. The 84 amendments eliminated the need for protective claim filings in occupational disease cases--see Section 13(b)(2) of the Act.

5. Action by DD/CE on Withdrawal of Claim.

1. **The DD/CE should not approve** a request for the withdrawal of any claim when it can reasonably be concluded that the claimant or representative has requested the withdrawal for the purpose of arriving at an unauthorized settlement (i.e., one not approved by the OWCP). The parties are to be advised that settlements can only be authorized under section 8(i).
2. **Upon receipt of a withdrawal request**, the DD/CE should meet with the claimant and the claimant's representative, if any, and discourage such request unless there exists no reasonable probability that upon adjudication the claim can be established. If a personal meeting with the claimant or representative is not feasible due to cost or time considerations, the DD/CE may discuss the request by telephone or by written communications with the claimant and/or representative.
3. **The employer/carrier must be advised** that if they enter into any settlement agreement that is not in compliance with 20 C.F.R. sections 702.241 to .243 (also see PM 3-500), it will be considered only as an advance of compensation and that the claim will remain open indefinitely as long as Form LS-203, Employee's Claim for Compensation (Exhibit 17, PM 10-200) has been filed with the DD.
4. **While the DD cannot prevent** a claim from being withdrawn, such request should not be approved in writing unless:
    - it is apparent that the claim is without merit,
    - there exists no reasonable probability that the claimant will be successful if the claim is formally adjudicated, or,
    - there is no reason to suspect there will be an unauthorized settlement. If such criteria are met and the claim is withdrawn with the approval of the DD, and the claimant still accepts or enters into

an outside settlement, the DD, having acted in good faith based on the facts of the particular case, need not be concerned with the claimant's action.

5. **Following a meeting**, telephone conversations, or written communications with the claimant or the claimant's representative in connection with such a request, a memorandum should be prepared for the file which discusses the nature of the conversations, the position and action taken by the DD/CE.
6. **When approving or disapproving a withdrawal** of a claim the DD must make a written finding of fact that the withdrawal is/is not for a proper purposes and is/is not in the best interests of the claimant. This record is subject to review by the Benefits Review Board.

6. Authority of the ALJ. It has consistently been held that administrative law judges may also approve, disapprove or remand withdrawals of claims. There have been some exceptions. Therefore, the DD should review the current state of the law in his/her Circuit before making a definite statement. The DD should refer to 20 C.F.R. section 702.225 for the specific language regarding withdrawal of a claim.

Chapter 4-0400, Delegation of Authority

Paragraph and Subject	Date	Trans. No.
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1. Purpose and Scope. This Chapter describes the respective authority of the Secretary of Labor; Director, OWCP; DLHWC Director; District Director (DD); and the GS-12 Claims Examiner (CE) to administer the provisions of the Longshore Act and its extensions. The DD's authority, in particular, has been the subject of legal decisions rendered by the Benefits Review Board and the various Courts of Appeal, in part because the LHWCA assigns certain duties to that position (rather

than the Secretary) albeit under that official's predecessor name of "deputy commissioner." As explained in subpart 2 below, this Chapter also serves as the formal action establishing and memorializing delegations of authority (making memoranda or correspondence unnecessary) for certain duties, functions, and tasks from the Director, OWCP to the DLHWC Director or DDs, from the DLHWC Director to the DDs, and from the DDs to the GS-12 CEs. Responsibilities delegated to non-GS12 CEs will be specifically memorialized in writing by the DD.

2. Delegation of Authority. Congress has designated the Secretary of Labor to administer the LHWCA, 33 U.S.C. § 939(a), and the Secretary has designated the Director, OWCP, as administrator of the Act and its extensions, 20 C.F.R. § 701.201; Secretary's Order No. 10-2009, 74 FR 58834-01, 2009 WL 3782825 (F.R.). Previously, before performing certain duties on behalf of the Secretary of Labor or the Director, OWCP, it was customary for the DLHWC Director, the DD, or CEs to be specifically delegated authority, with those delegations memorialized by memorandum or letter. This Chapter now serves as the official Delegation of Authority and enumerates the specific types of authority, functions, and duties which may be delegated to the DLHWC Director, the DD, and CEs. Of particular significance, this Chapter specifically memorializes the delegation of authority to GS-12 CEs for certain enumerated duties of the DD, including some functions allocated by the statute to the "deputy commissioner." See subpart 4 below. This Chapter memorializes the power of the DD to delegate his authority to other OWCP officials during temporary absences or for specific duties. For all delegations, this Chapter also confirms that a higher level position has the power to revoke the authority of a lower level position, if deemed necessary.

- Signature Authority: Each official, whether a Director, District Director, or CE, should sign decisions and correspondence with their own name and title as the author. For example, where the CE has signature authority to release a decision, their 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 the one with signature authority. The CE's name and title should appear at the end of the decision, if they authored the decision, along with the name and title of the DD, or designee with signature authority. See Exhibit 1, Quick Reference Signature Authority, for a list of who may author various types of decisions.

3. Legal and Historical Perspective.

Section 39 of the Longshore Act delegates to the Secretary of Labor the authority to administer the Act, with certain limited exceptions. 33 U.S.C. 939(a). The Secretary, by Secretary's Order, and also by regulation, has delegated responsibility for administration of the Act to OWCP. 20 C.F.R. 701.201; Secretary's Order No. 10-2009, 74 FR 58834-01, 2009 WL 3782825. Section 39 also assigns administrative functions to the DD (in terms to the "deputy commissioner"). The program regulations recognize that a DD's powers may be delegated to a designee, such as a CE. *See* 20 C.F.R. 701.301(a)(7).

Although the 1972 amendments (P.L. No. 92- 576), Section 19(d) of the Act, withdrew from the DD (then called "deputy commissioners") the adjudicatory power to conduct hearings and gave this authority to administrative law judges, certain specific adjudicatory powers have remained either under the sole responsibility of the DD or jointly shared with administrative law judges. These powers include, but are not limited to, the authority to approve section 8(i) settlement agreements, to issue compensation orders when the parties agree, to issue supplementary orders declaring default, to issue certain orders relating to medical care, and to award attorney fees under Section 28. On July 12, 1990, the Secretary of Labor changed the title of deputy commissioner to District Director. 20 C.F.R. 702.105.

4. <u>Delegation to Administer Certain Duties under the Act from DD to CE</u>.

GS-12 Claims Examiners (CEs) are delegated the authority to:

1. **Call and Hold Informal Conferences**. The regulations at 20 C.F.R. 702.311 through 702.319 provide specific guidelines for conducting informal or pre-hearing conferences. It has been determined that the holding of an informal conference is discretionary on the part of the DD and that an informal conference recommendation may be made without a conference in certain circumstances. *Matthews v. Jeffboat, Inc.*, 18 BRBS 185 (1986). *See also* PM 4- 200 and the Resource Center for more information on informal conferences. CEs have authority to schedule and preside over informal conferences.
2. **Issue Recommendations**. CEs have authority to respond to correspondence and to generate correspondence as the circumstances in the case may require with exceptions noted in the rest of this chapter. CEs have authority to issue written recommendations following an informal conference.
3. **Penalty Assessment under Section 14(g): Employer notices of final payments of compensation**. The CE has authority to assess a civil penalty in

the amount established in accordance with the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 for failure to submit a timely Form LS-208. *See also* PM 8-301.

4. **Settlement Application Approval for Represented Claimant**. Sections 8(i)(1) and (2) of the Act give the DD and administrative law judges joint authority to approve or disapprove agreed settlements. CEs have authority to approve requests for Section 8(i) settlements but ONLY when the Claimant is represented by legal counsel and the comprised agreement is adequate and not procured by duress. In all other cases, the DD must consider the proposed settlement. *See Richardson v. Huntington Ingalls, Inc.*, 48 BRBS 23 (May 22, 2014), 2014 WL 2649645, BRB No. 13-0476.
5. **Settlement Application Deny or Deficient for all Claimants**. A CE has authority to declare a proposed settlement deficient and deny the settlement. The CE must take appropriate procedures in accordance with PM 3-0501.
6. **Issue Compensation Orders Upon Agreement of the Parties**. If there is no factual or legal dispute, a compensation order may be issued by the DD or CE.
7. **Issue Certain Orders Not Requiring Agreement of Parties**. Absent an agreement by all parties in interest or a request for an order under 20 C.F.R. 702.315, the DD is generally not empowered to issue a compensation order. However, DDs and CEs, as delegated, have authority to issue an order without agreement on certain subjects within the discretion of the DD such as change of physicians, ordering an independent medical evaluation, ordering medical treatment, and awarding attorney's fees for work performed before OWCP.
8. **DOL Vocational Rehabilitation Services**. The CE has authority to undertake the development of all Vocational Rehabilitation Service requests, encumber funds, and approve the disbursement of funds to rehabilitation providers.
9. **Refer cases to the Office of Administrative Law Judges (OALJ) or the Benefits Review Board (BRB)**. The regulation at 20 C.F.R. 702.316 provides that if the DD is satisfied that any further informal conference (PM-4-200) would be unproductive or if any party has requested a hearing, the case shall be prepared for transfer to OALJ. The CE has authority to transfer cases to

OALJ. A case may also be referred for a formal hearing without first holding an informal conference if the CE believes that a conference would be wholly unproductive or a party requests the referral (see *Ingalls Shipbuilding, Inc. v. Asbestos Health Claimants*, 17 F.3d 130, 28 BRBS 12(CRT) (5th Cir. 1994). *See also Ingalls Shipbuilding, Inc. v. Director, OWCP*, 102 F.3d 1385 (5th Cir. 1996) and PM-4-600.

Upon proper party request, the CE has the authority to transfer a case to the BRB in instances where a direct appeal to the BRB is appropriate such as to seek review of an order regarding attorney fees, or medical issue within the discretion of the DD.

10. **Order Payment to Special Fund Under Section 44(c)(1)**. The CE has authority to issue an order to an employer requiring payment of $5,000, as compensation to the Special Fund, whenever it is determined that there is no person under the Act entitled to compensation for the death of an employee which would otherwise be compensable under the Act. *See also* PM 3-0302.
11. **Award of Agreed Attorney Fees**. A CE has authority to issue orders approving agreed upon attorney fees when requested by the parties. All contested fee orders must be decided by the DD. Section 28 of the Act provides the DD, or designee, with the authority to review and approve attorneys' fees for services performed at the DD level. Sections 702.132 through 702.135 of the regulations provide specific language concerning this authority. *See also* PM 4-500.
12. **Service of Orders**. ALJs do not serve compensation orders following the issuance of their decisions. Instead, ALJs send compensation orders to the DD for filing and service on the parties. PM-4-600. CEs have authority to serve compensation orders by sending, by certified mail, a copy to all parties who have not submitted a valid service waiver on record, *i.e.*, LS-801 and LS-802. CEs have authority to e-mail compensation orders to parties that have submitted forms waiving service by certified mail.

13. **Calculate Benefits when Ordered by ALJ**. CEs have authority to perform calculations of compensation benefits in accordance with ALJ decisions and orders awarding benefits.
14. **LS-33 Approve or Deny**. The responsibility to review and investigate the compromise of third person causes of action under Section 33 of the Act is performed in the Office of the DD. *See* PM 3-0600. The CE is authorized to approve or deny settlements entered into between LHWCA beneficiaries and third persons within the meaning of Section 33 as well as to negotiate credits and liens in favor of the Special Fund resulting from such third party actions.
15. **Disfigurement Award Determinations**. The CE has authority to make awards to injured employees for disfigurement under Section 8(c)(20).
16. **Special Fund--Deny Payment per Sections 8(f), 18(b) or 32(a)**. CEs have authority to deny applications for section 8(f) relief. If the evidence does not support the application, section 8(f) relief will be denied by the CE. The Director is not bound by the stipulations of the private parties, and will not accept stipulations if they are unreasonable or not supported by the evidence of record. Relief under section 8(f) is not available to an employer who fails to properly secure the payment of compensation by insuring or self-insuring in compliance with Section 32(a) of the Act, 33 U.S.C. 932(a); 33 U.S.C. 908(f)(2)(A); 20 C.F.R. 702.321(b)(3). See also PM Chap. 6-0201.
17. **Special Fund--Change Address or EFT**. When the District Office receives a written request for change of address or new banking information for Electronic Fund Transfers, the CE has authority to update the payment record but all updates require another CE or DD to certify the change.
18. **Special Fund--Authorize Medical Care up to $3,000**. Any decision to authorize medical evaluation or treatment for an individual Claimant where the Special Fund is providing medical benefits may be authorized by the CE up to $3,000.00 per service. Authorizations for a greater amount must be granted by the DD.
19. **Special Fund--Suspension for Failure to Attend a Medical Exam**. CEs have authority to suspend benefits for the claimant's failure or refusal to attend

a medical exam. Such decisions will be made by issuing an Order Suspending Compensation pursuant to Section 7(d)(4).

20. **Special Fund--Suspension for Failure to Return Form LS-200/LS-267/LS-266**. If, in a case being paid by the Special Fund, a claimant fails to return a form LS-200/267 to the District Office, the District Office has broad discretion to investigate and take action to obtain a signed form before pursuing forfeiture (the loss of benefits) pursuant to 20 C.F.R. 702.286. CEs have authority to determine whether reasonable efforts to contact claimant have been unsuccessful and claimant's failure to contact the District Office or return a completed form necessitates a temporary suspension of compensation. If a CE decides that a suspension of benefits is in order, the CE is authorized to issue a compensation order suspending benefits. However, if there is a conflict over any issue relating to suspension any party may request a formal hearing before an Administrative Law Judge. Also see PM Chap. 6-0300.
21. **Special Fund--Reinstate Suspended Benefits NTE 4 weeks**. Any decision to reinstate suspended Special Fund benefits must be approved by the DD unless the suspension time is less than four (4) weeks. In cases of suspension for less than four weeks, CEs are authorized to reinstate benefits.
22. **Special Fund--Prepare Reconciliations**. The CE is delegated authority to calculate the liability of the Special Fund and the self-insured employer or insurance carrier, following the receipt of a Form LS-208, Notice of Payments. If the employer has overpaid compensation during the period for which the Special Fund subsequently assumes liability, the CE will calculate and prepare a reimbursement to the employer. Payment to the employer, however, must be approved and certified by the DD.
23. **Special Fund--Prepare Overpayment/Underpayment Adjustments**. In cases where the Special Fund is assuming liability to pay compensation pursuant to section 8(f) and the employer/carrier (E/C) has overpaid the amount of compensation due to the claimant, the District Office is authorized to make adjustments to correct the erroneous payments. This paragraph explicitly overrules PM Chapter 6-0203.5 which provides that the National

Office is tasked with rectifying an overpayment by the E/C. Instead, this task is now delegated to DDs, and CEs authorized to prepare the payment record.

24. **Special Fund--Prepare SF Payments**. To prepare a payment from the Special Fund, the Longshore payment approval process shall be documented by the following procedure: CEs complete a Payment Record and, if necessary (for cases where OWCP has agreed to, accept liability for payment of compensation by the Special Fund), an Order awarding benefits. The CE performs the calculations for payment and creates the payment record. The DD must then approve and transmit the payment to Treasury for SF obligation to pay. For payments in excess of $300,000, the National Office will approve and transmit payment.

5. Delegation to Administer Certain Duties under the Act from Secretary of Labor, Director, OWCP and DLHWC Director to the District Director.

District Directors (DD) are delegated the authority to:

1. **Perform all duties listed above for GS-12 Claims Examiners.**
2. **Penalty Assessment under Section 30(e): Employer Report**. DDs have the authority to impose a civil penalty in the amount established in accordance with the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 when any employer, insurance carrier or self-insured employer *knowingly and willfully fails or refuses* to send the first report of injury required by Section 30. See also PM 8-302. CEs have authority to investigate possible civil penalty assessments, but the DD must impose a penalty under Section 30(e). PM 8-0302(9).
3. **Commutation**. DDs have the authority to commute benefits under Section 9(g) of the LHWCA and Section 2(b) of the Defense Base Act (DBA). Commutation is permitted only for benefits paid to people who are not U.S. citizens, not U.S. residents and not Canadian residents. Commutation is limited to LHWCA and DBA death benefits and DBA benefits for permanent total or partial disability. *See also* PM 3-0502.
4. **Small Vessel Facility Certification**. DDs have the authority to grant a certificate, pursuant to Section 3(d) of the Act, exempting from coverage under

the LHWCA injuries incurred in certain locations by employees working at a facility engaged in the business of building, repairing, or dismantling exclusively small vessels. DDs have authority to review and investigate the application for certification under Section 3(d). See 20 C.F.R. 702.171 through 702.175.

5. **Special Fund – Grant section 8(f) relief**. The DD will, after receiving approval from the National Office, notify the parties in writing that an E/C's application for Section 8(f) relief has been granted. *See* PM Chap. 06-0201.
6. **Special Fund – Obligate Payment**. Where an E/C is on the National Office list of accepted insolvent entities, the DD may obligate payment under Sections 18(b) and 32(a).
7. **Special Fund – Settlement**. Where an E/C is on the National Office list of accepted insolvent entities, the DD may enter an agreement to settle a claim pursuant to Section 8(i), issue a compensation order approving settlement, and obligate payment under Sections 18(b) and/or 32(a) up to $300,000 without National Office approval.
8. **Special Fund--Section 22 Modification**. In cases where the Special Fund is paying compensation pursuant to Sections 18(b) or 32(a), the DD is authorized to issue a compensation order modifying an award where proper under Section 22. In cases where the Special Fund is paying compensation under Section 8(f), the DD will advise the parties to initiate modification proceedings. If the private parties agree to modification, upon receipt of the parties' stipulated agreement, the DD retains discretion whether to also agree to obligate the Fund to accept the terms of such modification.
9. **Special Fund – Authorize Payment for Medical Care**. A DD who orders a medical examination under Sections 7(e) or 14(h) of the Act is authorized to charge the cost of the examination or review to the employer, carrier, or the Special Fund established by Section 44 of the Act. 20 C.F.R. 702.412. The cost of an examination or review under section 7(e) will be paid by the Special Fund only where (1) the examination involves a Special Fund beneficiary and (2) the examination was requested directly by the DD or the National Office

DLHWC. *See* PM 5-200.11. The DD is authorized to approve and make payment for such an examination on behalf of the Special Fund.

10. **Special Fund--Reinstate Suspended Benefits**. Any decision to reinstate suspended Special Fund benefits that exceeds 4 weeks must be approved by the DD.
11. **Special Fund—Terminate Benefits**. Any decision to terminate or suspend Special Fund benefits must be certified by the DD, except where delegated to a CE.
12. **Special Fund—Certify Reconciliations**. Any decision to reconcile an individual Claimant file, following the receipt of a Form LS-208, Notice of Payments, with resulting calculations for restitution of benefits paid by the Special Fund, must be approved by the DD.
13. **Special Fund – Certify Overpayment/Underpayment Adjustments**. The DD is authorized to make adjustments to the benefits payable by the Special Fund. The CE prepares the payment record for the adjustment and refers it to the DD to process an overpayment or underpayment of disability benefits.
14. **Special Fund—Certify SF Payments**. The DD is authorized to obligate the Special Fund to make payments up to $300,000, in certain circumstances. The CE initiates the payment by preparing the payment record for the DD to certify for transmission to treasury for payment.
15. **Supervision of Medical Care**. Section 7(b) of the Act gives the Secretary the authority to supervise the medical care of injured employees. The regulation at 20 C.F.R. 702.407 provides the DD with the direct authority to supervise the medical care of the injured employee to include the issuance of proper Orders for Medical Care. *See also* PM 5-200.
16. **Defaulted Payments**. Under the provisions of Section 18(a) of the Act, the DD shall issue a supplementary order in the case of default by the E/C in the payment of compensation due under an award that is not paid within thirty days after the compensation is due and payable. *See also* PM 6-202.
17. **Section 14(f) Additional Compensation**. Under the provisions of Section 14(f), the DD is empowered to investigate whether compensation payable under the terms of an award has been paid within ten days of the filing of the

award. If it is found that the E/C is in default, the DD enters a supplemental order declaring the amount of the default under Section 18(a) and awarding the Claimant twenty percent in additional compensation pursuant to Section 14(f). The regulation at 20 C.F.R. 702.350 contains further guidance on this issue. *See also* PM 8-203.

18. **Subpoenas Duces Tecum**. The DD may, upon proper request, issue a subpoena for the production of documents. Form LS-226a (Exhibit 27, PM 10-200) may be used for this purpose. This is an area of controversy in view of *Maine v. Brady-Hamilton Stevedore Co.*, 18 BRBS 129 (1986). However, unless instructed to the contrary, the DD may continue to issue subpoenas.
19. **Congressional correspondence**. The DD is empowered to investigate and respond to all inquiries posed by Congressional entities and the Office of the Secretary of Labor (Exec Sec). However, after a case is referred to the Office of the Administrative Law Judges (OALJ), Congressional inquiries should be forwarded to the Chief Judge, OALJ, after the appropriate member of Congress has been advised of the referral of the particular inquiry. *See* PM 4-600.5
20. **FOIA requests**. The DD is designated as a Disclosure Officer and is empowered to respond to FOIA and Privacy Act Requests received directly from a FOIA Requester or other Privacy Act Requester. *See* PM 1-0600.

6. Delegation to Administer Certain Duties under the Act from Secretary of Labor and Director, OWCP to DLHWC Director.

The Director, DLHWC is delegated the authority to:

1. **Approve National Average Weekly Wage (NAWW) Adjustments**. The Secretary and Director, OWCP hereby delegate to and provide the DLHWC Director with authority to determine the NAWW as referenced in Section 2(19) of the Act. The DLHWC Director, as delegated, determines the national average weekly wage (NAWW) each fiscal year. *See* Section 6(b)(3) of the Act.

   The Secretary and Director, OWCP hereby delegate to and provide the

Director, DLHWC authority under Section 910(f) of the Act to calculate and disseminate the annual adjustment of minimum and maximum compensation rates. Industry Notice and related attachments are provided to the DD's and Longshore stakeholders.

2. **Assess and Adjust Penalties**. The Secretary and Director, OWCP hereby delegate to and provide the DLHWC Director authority to assess and adjust the penalties imposed under the LHWCA. The Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 requires agencies to adjust the levels of existing civil monetary penalties annually based on inflation.
3. **Authorize Insurance Carriers and Self-Insured Employers**. The Secretary and Director, OWCP hereby delegate to and provide the Director DLHWC authority to: authorize self-insured employers to secure the payment of compensation and insurance carriers to insure employers under Section 32; sign a Certificate of Authority, LS-571; and to determine the amount of security to be deposited with OWCP by authorized entities.
4. **Grant Waiver of Application of the DBA**. The Secretary and Director, OWCP hereby delegate to and provide the DHLWC Director authority to, upon the application of the head of any department or other agency of the United States, waive application of the DBA with respect to any applicable contract, work location, or class of employees.

Exhibit 1: Quick Reference Signature Authority

GS-12 CLAIMS EXAMINERS, excluding Special Fund unless noted

- Call and Hold Informal Conferences
- Issue IFC Recommendations
- Penalty Assessment under Section 14(g)
- Settlement Application Approved for Represented Claimant
- Settlement Application Deny or Deficient for all Claimants
- Compensation Orders for Joint Stipulations
- Issue Certain Orders Not Requiring Agreement by Parties

- DOL Vocational Rehabilitation Services
- Refer Cases to ALJ or BRB
- Order Employer/Carrier Payment to Special Fund Under 44(c)(1)
- Award Agreed Attorney Fees
- Serve Orders
- Calculate Benefits when Ordered by ALJ
- Approve or Deny Form LS-33 Compromise of Third Person Cause of Action
- Make Disfigurement Award Determinations
- Special Fund--Deny Payment per Sections 8(f), 18(b) or 32(a)
- Special Fund--Change Address or EFT
- Special Fund--Authorize Medical Care up to $3,000 per service
- Special Fund—Suspension of Compensation Payments for Failure to Attend a Medical Exam
- Special Fund--Suspension for Failure to Return Form LS-200/LS-267/LS-266
- Special Fund--Reinstate Suspended Benefits NTE 4 weeks
- Special Fund--Prepare Reconciliations
- Special Fund--Prepare Overpayment/Underpayment Adjustments
- Special Fund--Prepare SF Payments

Where a CE does not have signature authority, they prepare the analysis and proposed decision and refer it to the DD for final determination and signature.

NOTE: A District Director may individually grant or revoke signature authority to a Claims Examiner for the items listed under the “Claims Examiner.”

DISTRICT DIRECTORS

- All items listed under GS-12 CE
- Penalty Assessment under Section 30(e)
- Commutation
- Small Vessel Faculty Certification
- Special Fund--Grant Section 8(f) Relief
- Special Fund--Obligate Payment NO Insolvent E/C list 18(b)& 32(a)

- Special Fund—Settlements up to $300,000
- Special Fund--Approve Section 22 Modification
- Special Fund--Authorize Payment for Medical Care
- Special Fund--Reinstate Suspended Benefits
- Special Fund--Terminate Benefits
- Special Fund--Certify Reconciliations up to $300,000
- Special Fund--Certify Overpayment/Underpayment Adjustments
- Special Fund--Certify SF Payments up to $300,000
- Supervision of Medical Care
- Defaulted Payments
- Section 14(f) Additional Compensation
- Subpoena Duces Tecum
- Congressional Correspondence
- FOIA requests

NOTE: The Director, OWCP or Director, DLHWC or Branch Chief may individually grant or revoke signature authority to a District Director for the items listed under the District Director

DIRECTOR, DLHWC

- Approve NAWW Adjustments
- Assess and Adjust Penalties
- Authorize Insurance Carriers and Self-insured Employers
- Grant Waiver of Application of the DBA

NOTE: The Secretary of Labor, or designee, or Director, OWCP may grant or revoke signature authority to the Director, DLHWC for the items listed under the Director, DLHWC.

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1. Purpose and Scope. This Chapter provides the procedures for considering applications regarding fees for legal services and determining the amount of and liability for such services.

2. Right to Representation.

1. **Claimants in disability or death cases**, employers, and insurance carriers may be represented in any informal proceeding by an attorney or other person previously authorized in writing to perform such services. The authorization of a claimant's representative must be submitted to the DO, and the claimant's signature must appear on the authorization.
2. **Not withstanding the above**, the Longshore Act Amendments of 1984 provided that the Secretary of Labor shall annually publish a list of individuals who are disqualified from representing claimants under the Act (See PM 5-600 for debarment procedures). Such individuals are not authorized to represent claimants and the Act prohibits the DD, administrative law judges, Benefits Review Board or any courts from approving fees for representing Longshore Act claimants (See section 31(b)(1) of the Act, and 20 C.F.R. section 702.131(b).)

3. Liability for the Legal Fee. Generally, if a claimant retains the services of an attorney, the fee for such services is the liability of the claimant (i.e., is a lien on his/her compensation). However, in disputed claims, the attorney fee frequently is assessed against the employer and is paid in addition to compensation. Fees for services by other than attorneys are neither assessed against the EC nor made a lien on the claimant's compensation. Nevertheless, claimants are responsible for the payment of these fees also (See subparagraph 3c, below). The following describes situations when an attorney fee should be assessed.

1. **Fee When Carrier Declines to Pay Compensation**. Under section 28(a), if an EC does not pay any compensation within thirty days after receiving written notification of a claim being filed, and the case is later settled at the informal level in favor of the claimant, the DD/CE must assess the fee for an attorney against the EC. The DD shall issue a compensation order, as required under this section of the Act, awarding a reasonable attorney's fee, in addition to the award of compensation, against the EC. In such cases, the legal fee shall not be a lien on the compensation due. Upon successful prosecution of a claim, the BRB has held that the employer must pay attorney's fees under § 928(a) of LHWCA for services performed before employer controverted the claim (See Liggett v. Crescent City Marine Ways & Drydock Co. 31 BRBS 135, October 16, 1997).
2. **Fee Where Voluntary Payment Made, But Controversy Arises Over Amount of Additional Compensation.**
    a. If the EC voluntarily pays compensation without an award and a controversy develops over the amount of additional compensation (if any) to which the claimant may be entitled, the DD/CE shall, within ten days of knowledge of the controversy, set the case for an informal conference. Either at the conference or afterwards, the DD/CE is to recommend in writing the disposition of the matter. If the claimant has utilized the services of an attorney during this period to obtain additional compensation, any additional legal fee (based on efforts to obtain additional compensation) is to be assessed against the EC.
    b. If a recommendation relating to the degree or length of disability is not accepted by either or both parties, and the claimant utilizes the services of any attorney and the EC thereafter agrees to pay additional compensation, an attorney fee shall be based solely on the difference between the amount awarded and the amount tendered or paid. The fee under these circumstances is to be assessed against the EC.

c. If a controversy develops over the amount of additional compensation to which the claimant may be entitled as described in subparagraph 3b(2) and the claimant has utilized the services of an attorney before an informal conference has been held on the controversy, the DD/CE shall assess the EC only for that portion of the attorney fee which is related to services performed after the initial informal conference. For service performed before the initial conference, the DD/CE shall approve the attorney fee as a lien on the compensation due.

d. Where the EC voluntarily pays compensation, but a controversy develops over length or degree of disability, section 28(b) of the Act also provides that the attorney fee may be a lien on the compensation due in the following situation. Where the EC agrees to submit the case for impartial medical examination as authorized under section 7(e) of the Act, and accepts the recommendation to pay compensation based upon the degree or length of disability found by the independent medical report, an attorney fee which is approved must be a lien upon the compensation due.

e. The EC is to be assessed the attorney fee only in the situations described in subparagraphs 3a, 3b(1), 3b(2), and 3b(3). In all other cases, the attorney fee is to be a lien on the compensation due. The exception to the situations above is provided in paragraph 3b(4).

3. **Lay Representatives**. Under sections 28(a) through 28(d), fees approved for claimant representatives other than attorneys at law are never to be assessed against an EC, and such fees may not be made liens upon the compensation due under awards. In spite of the fact that a non-attorney representative's fee is not protected by sections 28(a) through 28(d), section 28(e) requires prior approval of fees for all representatives, whether they are attorneys or non-attorneys.

4. <u>Review of DD Fee Awards</u>. In an ordinary case when entitlement to compensation under the Act is in dispute, the controversy is referred from the DD to the OALJ for formal resolution. The Benefits Review Board (BRB) has held,

however, that in certain situations, including disputes over attorney fee awards before the DD, the dispute is typically not within the adjudicatory power of the ALJ and therefore should be appealed directly to the BRB. The Board has outlined three basic principles regarding whether an DD's actions should be reviewed by an ALJ or the BRB. Glenn v. Tampa Ship Repair and Dry Dock, 18 BRBS 205 (1986). First, review of discretionary acts of the DD must be undertaken by the Board. Second, the proper route for appeal of the DD's determination of strictly legal issues is directly to the Board. Finally, when a dispute involves questions of fact, the case must be referred to an administrative law judge. (See LHWCA Circular 87-01, November 14, 1986.) These three principles can be applied to DD attorney fee awards in the following manner:

1. **Discretionary Issue**. The determination of whether an attorney fee is adequate for work performed before the DD is discretionary. The DD evaluates the itemized hours and hourly rate contained in the fee application and issues a compensation order. An appeal of this award would be heard by the Board.
2. **Strictly Legal Issue**. The DD may also determine the liability for the fee, i.e., whether the claimant or employer is liable (See paragraphs 3 and 4, above). This is not a discretionary issue in that it depends on a legal interpretation of section 28. If no disputed questions of fact are involved in the fee award, an DD determination of fee liability should be appealed directly to the Board because it is a strictly legal issue.
3. **Question of Fact**. The only time an attorney fee dispute before the DD should be referred to an ALJ is when a non-discretionary finding of fact must be made, e.g., the date of employer's controversion, whether the employer refused the written recommendation of the DD regarding additional compensation, whether the claim was controverted, etc.

5. <u>Penalties/Sanctions</u>. In all cases where the claimant is successful in the prosecution of a claim, the amount of legal fees payable either by the claimant or the EC is subject to the approval of the person before whom the services were performed. A contract for a stipulated fee may not be recognized. No fee may be approved if the claimant is not successful in prosecuting the claim (See Brattoli v. International Terminal Operating Co., 2 BRBS 57 (1975), and Timmons v. Jacksonville Shipyards, Inc., 2 BRBS 125 (1975) for explanation of successful prosecution of claim).

1. **Under section 28(e), a person who receives a fee**, other consideration, or any gratuity on account of services rendered as a representative of a claimant (unless the consideration or gratuity is approved by the person before whom the services were performed), or who makes it a business to solicit business for an attorney or for himself in respect of any claim under the Act, is upon conviction thereof, subject for each offense to a fine of not more than $1,000, or by imprisonment for not more than one year, or by both fine and imprisonment. 20 C.F.R. section 702.133.
2. **If a DD receives information** suggesting or alleging that a person violated the provisions of section 28(e) in a case, the DD shall collect whatever additional information can be obtained relating to the alleged violation, and forward the information with an explanatory memorandum to the Director, DLHWC. The Director will in turn notify the office of the Associate Solicitor and request appropriate legal advice and/or action against the person(s).

6. Application for Legal Fees. An attorney or other representative seeking a fee for services performed on behalf of a claimant with respect to a claim filed under the Act must make application for approval of the fee to the person before whom the services were performed. The application must be supported by an itemization, in duplicate, showing the date(s) on which such services were performed, a brief description of the services, the time spent on each, and the amount of fee requested. Where questions arise as to the propriety of the amount of fee requested, the representative may be asked to also include a description of the professional status (attorney, paralegal, law clerk, secretary) of each person performing such work and the normal billing rate and hours expended for and by each such person. If the itemization is not self-explanatory, the person approving the fee shall require the applicant to submit a supplemental statement explaining the basis for the charges. When the fee is to be assessed against the EC, a copy of the application for the attorney fee and the fee recommended shall be sent to the EC for comments/objections prior to the issuance of an order by the DD.

If the EC agrees, the DD shall review the fee application and issue a compensation order awarding a reasonable attorney fee. If the EC disagrees, the DD shall evaluate the evidence provided by the EC in conjunction with the fee application and issue a compensation order awarding a reasonable attorney fee (See paragraph 7, below for factors to be considered in determining a reasonable fee).

7. Determination of Reasonable Legal Fee.

1. **In determining whether a fee is reasonable**, a number of factors must be considered. A partial list of factors is provided in subparagraph 7b, below, but it is not all-inclusive. Although there may be a broad agreement on the factors to be considered in setting fees, in practice the standards of what is appropriate compensation for claimant's counsel vary markedly from one State to another (The Law of Workmen's Compensation, Arthur Larson). The variation is reflected not only in statutory limits but also in administrative and judicial decisions.
2. **The following factors should be considered** in determining a reasonable legal fee (See 20 C.F.R. section 702.132):
    a. Usefulness and necessity of the representative's services to the claimant.
    b. Nature and complexity of the claim.
    c. Actual necessary work performed (the itemization showing the dates on which services were performed, brief descriptions of services, time spent on each, and the amount of fees requested. Time spent in preparation of a fee application is a appropriate factor to be considered in the determination of a reasonable attorney fee). (See LHWCA Circular No 97-01).
    d. Amount of benefits involved.
    e. Customary local charges for similar services.
    f. Professional qualifications of the representative.
    g. When the fee is to be assessed against the claimant, the financial circumstances of the claimant are also to be taken into account.
    h. Enhancement for extraordinary delay in receiving payment. (See Anderson vs. Director 30 BRBS 67 (CRT) and LHWCA Circular No 97-01).
    i. Whether the fee is reasonable in relation to the results obtained. [(See Bullock v. Ingalls Shipbuilding 27 BRBS 90, July 16, 1993, for

a decision of the two-prong test under Hensley vs. Eckerhart 461 U.S. 424 1983).]

3. **In considering the factors above**, emphasis is given to the factor in subparagraph 7b(1), above. Before considering the other factors, the necessity or usefulness of the representative's services should be considered. If the necessity for the service is questionable, the fee should be kept to a minimum. Many States prescribe, by statute or administrative regulation, the maximum dollar or percentage amount which can be charged. Others permit a sliding scale which allows certain percentages on various portions of the award.

   Since almost all States in one way or another regulate the amount of legal fees for claimants' representatives, any person approving a legal fee under this act should be aware of the various States' workers' compensation laws governing attorney's fees in that DO's jurisdiction.

4. **If the requested fee is reduced**, the DD must advise the attorney or representative in writing of the reduction, and state the reason(s) for the reduction. This may be stated in the compensation order approving the fee or in a letter accompanying the compensation order; however, any change must be justified. The recipient of a fee for representation of a claimant, if dissatisfied with the amount awarded, may appeal to the Benefits Review Board (BRB) for a review of the award.
5. **In the absence of collusion**, when the parties in arm's length settlement negotiation have reached an agreement on the amount of the fee which is the responsibility of the employer/carrier, the DD should approve the fee unless it is clearly excessive (*Ballard v General Dynamics*, 12 BRBS 966 (1980) and *Watkins v Ingalls*, 26 BRBS 179 (1993)).

8. <u>Compensation Orders</u>. All attorney and representative fees are to be approved by compensation order. The only exception to this rule is in those instances where there is a settlement which is deemed approved when not specifically disapproved within thirty days after submission, as provided under section 8(i) of the Act. The regulations, at section 702.241(e), provide that an attorney fee which is included in a settlement agreement approved in this

manner, shall also be considered approved by the DD, administrative law judge, Board or court.

9. Special Fund Liability. Based upon U.S. Court of Appeals decisions on this issue it is now generally well settled that the Special Fund cannot be held liable for attorney fees (See also PM 6-203.6).

Chapter 4-0600, Referrals for Formal Hearings

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1. Purpose and Scope. This Chapter establishes guidelines and procedures for preparing cases for referral to the Office of Administrative Law Judges (OALJ) for formal hearings.

2. Authority. Section 702.316 of the regulations provides that if the District Director (DD) is satisfied that any further informal conference (PM 4-200) would be unproductive or if any party has requested a hearing, he/she shall prepare the case for transfer to the Office of the Chief Administrative Law Judge. A case may also be referred for a formal hearing without first holding an informal conference if the parties agree to the referral and the DD believes that a conference would be totally unproductive.

3. Case Preparation. A case is prepared for transfer in the following manner:

1. **Identification of Parties**. In any case in which the named employer is a corporation and has failed to secure the payment of compensation by obtaining either insurance or authorization to pay compensation directly, the

DD shall name the president, secretary, and treasurer of the corporation as parties.

2. **Pre-Hearing Statement**. The DD furnishes each of the parties or their representatives a copy of Form LS-18, Pre-Hearing Statement, (Exhibit 5, PM 10-200). Form Letter LS-21 (Exhibit 9, PM 10-200) is used for this purpose.
3. **Response From Interested Parties**. Each party is required, within twenty-one days after receipt of the form, to complete and return it to the DD and serve copies on all other parties. Extensions of time for good cause may be granted by the DD, but requests for extension must be made within the twenty-one day submission period.
4. **Transfer of Materials**. Upon receipt of the completed forms, the DD checks them for completeness and schedules any conferences deemed warranted. The forms are then forwarded to the OALJ by Form Letter (Exhibit 9, PM 10-300) together with all available evidence which the parties intend to submit at the hearing (exclusive of x-rays, slides, and other materials not suitable for mailing which may be offered into evidence at the time of hearing). The materials transmitted will not include any recommendation of or memoranda prepared by the DD, except in section 8(f) cases where the EC’s application and the DD's denial should be sent (See 20 C.F.R. sections 702(c), 702.317 and 702.319).
5. **Additional Issues**. If the completed pre-hearing statement forms either (1) raise new or additional issues not previously considered by the DD or (2) indicate that material evidence will be submitted that could reasonably have been made available to the DD before the preparation of the last memorandum of conference, the Administration Law Judge (ALJ) may remand the case to the DD for re-evaluation (20 C.F.R. section 702.336). Thus, it is important that the Form LS-18 be completed as accurately as possible.
6. **Failure of a Party to Respond**. If a party fails to complete or return a pre-hearing statement form within the time allowed, the DD may, at his/her discretion, transmit the case without that party's form. However, the transmittal should include a statement from the DD that the party has failed to furnish the form. The party may be given an opportunity to explain the failure to submit

the form in subsequent rulings which may be made in the course of the formal hearing.

7. **Where an LS-18 is received in a case where an 8(f) application is being considered**, the receipt of the LS-18 (18r) should not be keyed into LCMS since the case is not in posture for referral at that point. If 18r is entered in error, it should be deleted. Once a determination has been made on the 8(f) issue, the receipt of the LS-18 should be keyed into the LCMS using the current date.
8. **When a case is referred for a formal hearing**, the 18r or ctoa codes are entered. If additional LS-18s are received after the case has been referred to the OALJ, do not enter the 18r ctoa codes again as this will show a statistically larger number of cases being referred to the OALJ than is actually the case.

4. Referral to OALJ.

1. **Formal hearings are initiated** when the DD transmits to the OALJ copies of available evidence which the parties intend to submit at the formal hearing, and a letter of transmittal. In accordance with 20 C.F.R. section 702.317, each party must furnish all documents or exhibits they wish to be considered at the formal hearing. All exhibits must be listed and identified on the Form LS-18. Generally, the DD will not make copies of the exhibits (from the administrative file), which previously have been furnished by the parties. However, upon written request, copies may be made of documents contained only in the administrative file. These (or the originals), as appropriate, will be furnished to the requesting party.
2. **The letter of transmittal** (Exhibit 9, PM 10-300) is addressed to the Office of the Chief Administrative Law Judge, U.S. Department of Labor, 800 K St., N.W., Suite 400, Washington, D.C. 20001-8002.
3. **The previous practice of sending the Associate Solicitor** of labor for Employee Benefits, Room S4325, U.S. Department of Labor, Washington, DC 20210, and the National Office, DLHWC, a copy of every case referral to the OALJ is discontinued. However, a copy of the transmittal letter and the pre-hearing statements of the parties are sent both to the Associate Solicitor and

to the Director, DLHWC, in the following situations: (1) cases involving issues of OWCP policy, (2) cases involving the interpretation of the Act which have not previously been the subject of formal adjudication and a hearing, (3) cases in which individual corporate officers are named as parties, and (4) other cases which the DD believes should be brought to the attention of the NO.

5. Correspondence Received After Referral.

1. **Inquiries received by the DO** after a case has been referred for a formal hearing to the OALJ, which relate to the formal hearing, should be acknowledged and forwarded to the Chief Judge, OALJ. Requests for modification under section 22 in cases in which either the EC or employee opposes the modification should also be referred to OALJ even if the case is presently on appeal to the BRB. (See LHWCA Circular 86-1, March 3, 1986.) Other correspondence received may be handled in the usual manner.
2. **Congressional inquiries** should be forwarded to the Chief Judge, OALJ, after the appropriate Congressman has been advised of the referral of the particular inquiry.

6. Receipt of Subpoena. Whenever a DD is served with a subpoena, calling for the production of documents and/or directing the DD or a member of his/her staff to appear or testify at a hearing, the DD should notify the Regional Solicitor immediately. Thereafter, the DD will be notified by the Solicitor's Office as to what action shall be taken.

7. Filing and Service of Compensation Orders.

1. **Filing**. The ALJ shall, within twenty days after the official termination of the hearing, deliver by mail, or otherwise, to the DD who has original jurisdiction of the case and is the official custodian of all records with respect to the case, the transcript of the hearing and other documents or pleadings filed with respect to the claim, together with the signed compensation order. Upon receipt thereof, the DD formally dates, signs, and files the original compensation order in the administrative file. The filing must be accomplished by the close of business of the next succeeding business day. On the day the order is filed, the DD sends

by certified mail a copy of the order to each of the parties and to the representatives of the parties.

2. **Form LS-19**. A Certificate of Filing and Service (Exhibit 6, PM 10-200) is appended to each copy of the compensation order. This form contains the certification of the DD that the copies were mailed to all interested parties on the date stated as shown on the form. (Form LS-19a, Certificate of Filing and Service is used for distributing copies of compensation orders issued by the DD. Exhibit 7, PM 10-200.)
3. **Form LS-20**. The Letter Transmitting Decision of ALJ (Exhibit 8, PM 10-200) is used as a letter of transmittal of the compensation order and proof of service. It advises the parties that the transcript, pleadings, and compensation order have been formally dated and filed in the DD's office, and advises them of appeal procedures.
4. **ALJ Orders**.
    a. ALJs will not serve orders that involve any substantial matter, i.e., orders which could be the subject of, or pertain to, appeals to the BRB. Any such order will be sent by the ALJ to the appropriate DO to be served by the DD in the same manner as a decision and order following a hearing, with the proof of service information as usually appended. Opposed requests for modification under section 22 should also be referred to OALJ even if the case is presently on appeal to the BRB
    b. ALJs will issue and serve their own orders which involve what may be characterized as housekeeping matters, e.g., which schedule or reschedule hearings, remand cases to the DD for approval of agreed settlements, etc. ALJ's may also serve notice of deficiency of settlement application. 20 C.F.R. section 702.243(c).
    c. Whenever a DD receives a compensation order from an ALJ which is believed technically incorrect, the DD should nevertheless file and serve the order. However, within forty-eight hours of receipt of the order, the DD should advise the NO, by telephone, of the error, followed by a memorandum to the Director, DLHWC, setting forth the

portions of the order believed to be incorrect. A copy of the memorandum is sent to the Associate Solicitor for Employee Benefits.

8. <u>Procedure Subsequent to Filing of Order</u>.

1. **Effective Date**. A compensation order is effective when filed, at which time any payment required under that order becomes due. (But see, Nealon v. California Stevedore & Ballast Co., 996 F.2d 966, 27 BRBS 31(CRT) (9th Cir. 1993) wherein the court found that a compensation order must be served on the parties before it may be considered filed.)
2. An order becomes final unless proceedings for suspension or having it set aside are instituted within thirty days of such filing. However, unless the BRB or a court issues an order staying payments pending appeal, the compensation continues to be due and payable as of the date the order was filed. Simply filing a motion for reconsideration will not stay payments.
3. **Late Payment**. Under section 14(f), if the award is not received by the claimant within ten days of its filing, there shall be added to the compensation due an amount equal to 20% thereof, to be paid in addition to the compensation due. The DD will have advised the interested parties, at the time copies of the order are sent to them, of the 20% additional compensation payable if compensation is not paid within ten days of the filing of Form Ltr. LS-20. Ten days after the order is filed and served, the DD must determine that the order has been complied with, and if not, take appropriate steps to see that the EC is notified that the additional 20% compensation is due and payable. (See PM 8-203 regarding the section 14(f) penalty in general and PM 8-203.7(b) for application of the ten day rule.)

9. <u>Withdrawal of Controversion</u>. If a party withdraws any controversion of the issues which have been set for a formal hearing, the ALJ may remand the matter to the DD who shall dispose of the case as provided for by issuing a formal compensation order embodying the agreement, to be filed and mailed in the manner described in 20 C.F.R. section 702.349.

10. Retention of Hearing Records. The DO must retain as part of the official file and record in any compensation case referred for formal hearing by an ALJ all original pleadings, motions, briefs, orders and records of formal hearings, or any other documents received from the ALJ handling the case.

Chapter 4-0700, Appeals

Paragraph and Subject	Date	Trans. No.
Table of Contents	09/00	00-01
1. Purpose and Scope	09/00	00-01
2. Authority	09/00	00-01
3. Time Limitations	09/00	00-01
4. Procedures	09/00	00-01
5. Decision of the Board	09/00	00-01
6. Judicial Review	09/00	00-01
7. Action by the DD	09/00	00-01

1. Purpose and Scope. This Chapter describes DLHWC procedures and responsibilities with respect to appeals to the Benefits Review Board (BRB) and to the court of appeals.

2. Authority. The regulations governing appeals to the BRB may be found at 20 C.F.R. sections 802.201 to .411. Section 21(b) of the Act pertains to the establishment and authority of the BRB. Section 21(c) of the Act relates to review of the order of the BRB.

3. Time Limitations. Appeals may be taken directly to the BRB by filing a notice of appeal directly with the BRB and by submitting to the BRB a petition for review of a decision or order. The notice of appeal must be filed with the BRB within thirty days of the filing of the decision or order which has been filed in the office of the DD. (20 C.F.R. section 802.205.) (But see, Nealon v. California Stevedore & Ballast Co., 996 F.2d 966, 27 BRBS 31(CRT) (9th Cir. 1993) wherein the court found that a compensation order must be served on the parties before it may be considered filed.)

4. Procedures.

1. **Notice of Appeal**. Notice of appeal shall be sent by mail or otherwise directly to the Clerk of the Board, Benefits Review Board, U.S. Department of Labor, Washington, DC. A copy of the appeal shall be served on the DD who filed the

decision or order, and upon all other parties in interest. Proof of service of the notice of appeal shall be included with the notice sent to the BRB (20 C.F.R. section 802.204).

2. **Transmittal of Record**. After receipt of the notice of appeal, the DD having custody of the record shall, upon request of the BRB, send it to the Clerk of the Board. Such record shall include the transcript(s) of all formal proceedings with exhibits, and decisions, and orders in the case. (20 C.F.R. section 802.209.)

5. Decision of the Board.

1. **The BRB shall issue a written decision** after the completion of review proceedings before the Board. The transmittal of the decision of the BRB shall indicate the availability of judicial review of such decisions under section 21(c) of the Act.
2. **The original of the decision shall be filed** with the Clerk of the Board. A copy of the Board's decision shall be sent by certified mail or served personally on all parties to the appeal and the Director, OWCP. The record on appeal, together with a transcript of any oral proceedings, any briefs or documents filed with the BRB, and a copy of the decision shall be returned to the appropriate DD for filing.
3. **Proof of service** of Board decisions shall be certified by the Clerk of the Board.
4. **A case may be remanded** by the BRB or by a court to a DD with instructions to take such action as is ordered. (20 C.F.R. section 802.404.)
5. **Reconsideration of the BRB decision** may be initiated by submitting a request in writing in accordance with 20 C.F.R. section 802.406.

6. Judicial Review.

1. **Within sixty days after a final order** has been filed by the BRB pursuant to 20 C.F.R. section 802.403(b), any party adversely affected or aggrieved by

such decision may take an appeal to the appropriate U.S. Court of Appeals pursuant to section 21(c) of the Act.

2. **The Director, OWCP,** as designee of the Secretary of Labor, is responsible for the administration and enforcement of the statutes listed in 20 C.F.R. section 802.101(b), and shall be deemed to be the proper party on behalf of the Secretary of Labor in all review proceedings conducted to section 21(c) of the Act.

7. Action by the DD. Control of referred cases, filing and service of compensation orders, follow-up, and recording shall be in accordance with PM 4-600.7 to .9; inquiries regarding cases pending before the BRB should be acknowledged and forwarded to the Clerk of the BRB for response.

Chapter 5-0100, Introduction

Paragraph and Subject	Date	Trans. No.
Table of Contents	09/00	00-01
1. Purpose and Scope	09/00	00-01
2. Authority	09/00	00-01
3. Policy	09/00	00-01
4. Definitions	09/00	00-01
5. Responsibilities	09/00	00-01

1. Purpose and Scope. This Part of the LHWCA PM establishes the procedures essential for the regulation, administration, and supervision of the medical services, supplies, and care authorized for injured employees under the LHWCA. The several Chapters that follow cover the identification of medical services authorized; the definition of responsibilities for the acquisition and referral of medical services; the screening, interpretation, and application of medical reports; the evaluation of physical impairment; the regulation and administration of medical fees and charges; the procedures to be followed for debarment of medical care providers; and the supervision incident to determining the necessity, character, and sufficiency of medical care for the injured employee under the LHWCA.

2. Authority. The Secretary of Labor is required, under section 7(b) of the LHWCA, to actively supervise medical services provided to injured employees. Designated representatives of the Secretary are delegated the authority to

administer the LHWCA in the National and District Offices to insure proper supervision of that medical care and to manage the reports required for the assessment of case progress. The LHWCA gives the Secretary, and the Secretary has delegated to local District Offices, the power to make determinations as to the necessity, character, and sufficiency of any medical care furnished. It further prescribes that such officials take the initiative to verify that injured employees are receiving proper medical services and, when required, available rehabilitation services (See paragraph 12 in this section).

3. Policy. Medical service and care for an injured employee is defined in paragraph 4, below and shall be as prescribed by section 7 of the Act and 20 C.F.R. sections 702.401 to .422.

1. **It is the duty** of the EC to furnish appropriate medical care for the employee's injury until recovery.
2. **An injured employee** shall have the right to select the attending physician of his/her choice from among those authorized for the occupational injury or illness. In emergencies, where the employee is unable to select a physician, the EC shall make the selection (20 C.F.R. section 702.405). Although the statute is ambiguous on the question, the EC's choice of a physician under such circumstances should not be treated as eliminating the worker's right to choose a different physician once he or she is able to do so. (See PM 5-200.4(b).)
3. **When the employee** has made the initial selection of a physician, any changes in physicians must have the approval of the EC or the DD. However, the employee may take an active part in controlling his/her own medical care. (See Amos v. Director, OWCP, 32 BRBS 144(CRT)(9th Cir., 1998)).
4. **In any case** in which a controversy arises concerning medical questions, the Director, OWCP, through the DDs is empowered to evaluate such questions including appointment of one or more specially qualified physicians to examine the employee or to make such inquiry as required in death cases.
5. **The employee** is required to submit to a special examination necessary to the adjudication of the case, at a designated place which is convenient to the employee. Costs for such examinations or reviews, with the approval of the

Director or designee, are chargeable to the EC or the Special Fund (20 C.F.R. sections 702.410 and 702.412).

4. Definitions.

1. **Physician**.
    a. This term includes doctors of medicine (MDs); surgeons, podiatrists, dentists, clinical psychologists, optometrists, and osteopathic practitioners within the scope of their practice as defined by state law. Physicians defined in this part may interpret their own x-ray. (See 20 C.F.R. section 702.404.)
    b. Although the term “physician” also includes chiropractors, payment for their services is limited, by regulation, to charges for physical examinations, related laboratory tests, x-rays made or required by the chiropractor to diagnose a subluxation of the spinal column, and treatment consisting of manual manipulation of the spine to correct a subluxation which is demonstrated by x-ray. For example, the Board has held that an employer was not liable for biofeedback treatment and physical therapy provided by a chiropractor based upon the plain language of 20 C.F.R. section 702.404 which limits the reimbursable services of a chiropractor. (See Nell Bang v. Ingalls Shipbuilding, Inc., 32 BRBS 183 (1998))
    c. All licensed physicians in the foregoing categories are authorized by the Director, OWCP, to render care under the Act, unless included on the Secretary's list of physicians and health care providers not authorized to render medical care or provide medical services. (See PM 5-600.)
    d. Naturopaths, faith healers, and other practitioners of the healing arts not listed herein are not included within the term "physician" under the LHWCA.
2. **Medical Care**. This term includes medical, surgical, and other attendance or treatment; nursing and hospital services; laboratory, x-ray, and other technical services; prosthetic devices; and any other medical service or supply,

including the reasonable and necessary cost of travel incidental thereto, which is recognized as appropriate by the medical profession for the care and treatment of the injury or disease. (See 20 C.F.R. section 702.401 and PM 5-200.)

a. An employee may rely on treatment by prayer or spiritual means alone, in accordance with the tenets and practice of a recognized church or religious denomination, by an accredited practitioner of such recognized church or religious denomination, and nursing services rendered in accordance with such tenets and practice without loss or diminution of compensation or benefits under the LHWCA.

b. A recognized church or religious denomination shall be any religious organization: (a)that is recognized by the Social Security Administration for purposes of reimbursements for treatment under Medicare or Medicaid or (b)that is recognized by the Internal Revenue Service for purposes of tax exempt status.

c. Acupuncture -- A treatment by means of the insertion of needles, with the purpose of relief of chronic pain, loss of hearing, for anesthesia and other purposes. If recommended by a duly qualified attending physician, it may be covered under the LHWCA. The attending physician should continue to oversee the medical care, including the acupuncture, and submit periodic reports to the district office. The reports should show whether there has been any medical improvement or symptomatic relief. If it appears that the treatment is becoming prolonged, or the results are questionable, the continuation of the treatment should be reviewed with the attending physician and/or other parties as appropriate.

3. **Impairment**. Referring to the *Guides to the Evaluation of Permanent Impairment* of the American Medical Association (AMA), impairment is defined as a permanent anatomical loss or abnormality which interferes with the activities of normal living. Hence, an abnormality becomes an impairment to the degree that it interferes with the activities of normal living for the individual.

4. **Disability**.
    a. This term generally refers to the inability to work due to a functional or anatomical injury, loss, or abnormality. It also includes appraisal of the present and future ability to secure and perform work as affected by age, education, work history, and other economic factors as well as the impairment related to injury. For a more specific definition, see sections 2(10) and 8(h) of the Act.
    b. Partial disability refers to a disabling condition that still allows the employee to perform some work. Some impairments constitute permanent partial disability irrespective of their effect, or lack of effect, on earning capacity. See section 8(c)(1)-(20).
    c. With respect to an occupational disease which becomes manifest after a claimant retires, disability is defined as the permanent impairment of the claimant as determined in accordance with the AMA *Guides to the Evaluation of Permanent Impairment.*
5. **Permanence**. A disability is "permanent" when the underlying medical condition has become stable, i.e., has reached "maximum medical improvement," or when the return of at least some earning capacity is not an expected outcome of a course of treatment or healing period.
6. **Temporary Disability**. A situation in which the individual is temporarily unable to perform regular or other work because of an anatomical or functional abnormality or impairment which is expected to improve. The situation is considered temporary when the final effects of treatment and therapy have not been reached and/or when the return of at least some earning capacity is an expected outcome of a course of treatment or healing period. For other definitions, see PM 0-300.8.

5. <u>Responsibilities</u>.

1. **The Secretary** is required under the LHWCA to actively supervise medical services provided injured employees. The DO: requires periodic medical reports and takes the initiative in contacting injured employees, especially those with serious injuries, to ensure that they are receiving medical care

appropriate to their injuries and that available rehabilitation services are provided.

2. **The Director, OWCP**, through the DDs and their designees, has been delegated the authority to actively supervise the medical care of an injured employee covered by the Act. The degree of supervision is set forth in 20 C.F.R. section 702.407 and examples may be found in the following paragraph.
3. **The District Directors** are responsible for the active supervision of medical care of injured employees in accordance with section 7(b) of the Act and 20 C.F.R. section 702.407. Such supervision shall include:
    a. the requirement for periodic medical reports on cases which are in the office of the DD, the frequency being determined by the DD or sound judgment of the attending physician, as the nature of the injury may dictate;
    b. the determination of the necessity, character, and sufficiency of any medical care furnished or to be furnished the employee;
    c. the determination of whether a change of physicians, hospitals, or other persons or locales providing treatment should be made;
    d. the evaluation of medical questions arising under the Act, with respect to the nature and extent of the covered injury, and the medical care required for it; and
    e. the preliminary determination of disputes concerning whether the charges for such medical care exceed those permitted under the Act.
4. **The Employer/Carrier** is required to furnish appropriate medical care for the employee's injury for such period as the nature of the injury or the process of recovery may require. The liability of an employer for medical treatment shall not be affected by the fact that the employee was injured through the fault or negligence of a third party not in the same employ, or that suit has been brought against such third party. (See section 7 of the Act, 20 C.F.R. section 702.402, PM 2-201.3e and 3-301.3e.) Furthermore, the liability of an employer to furnish medical treatment for a causally related injury is never time barred.

5. **The Employee** shall submit to any special examination as may be requested by the employer at such place as is designated by the DD but at a place reasonably convenient to the employee. (See section 7(d) of the Act and 20 C.F.R. sections 702.403 and 702.410.)
6. **The Claims Examiner (CE)** is responsible for performing such duties as the DD directs in connection with the tasks of subparagraph 5c, above. The CE must determine whether an injured employee is receiving care by an appropriate medical specialist and, if not, should arrange to transfer the case to another physician. CE's should request medical reports at periodic intervals and, if disability is prolonged, insure review by the rehabilitation specialist (RS) for possible medical rehabilitation measures. In cases where surgery is performed, follow-up reports must be obtained and the cases watched for permanent effects. This responsibility is met in conjunction with the CE's continuous monitoring of actions of the EC in distributing compensation benefits and delivering claims services to which an injured worker is entitled. The CE is considered a health care professional -- not a physician providing direct services -- who, along with the EC adjuster, exerts positive influence on the outcome of medical services rendered the injured worker.

   Timely review of extended disability cases insures that injured workers are properly classified, so that "temporary disability" status is not inappropriately extended, preventing him/her from receiving yearly compensation increases under section 10(f). Therefore, all extended disability cases are to be reviewed regularly to insure that there are no delays in making permanency determinations. After the claimant has been receiving temporary total disability for one year the case is to be reviewed carefully. A current medical report which specifically addresses the nature and extent of disability is to be requested. If the report submitted is inadequate, the district office should make arrangements pursuant to Section 7(e) of the Act to have the claimant examined and a satisfactory report submitted. If the claimant has not already been evaluated for rehabilitation services, the district office should make the referral to a rehabilitation specialist. Where a determination cannot be made

regarding extent of disability after one year of temporary total disability payments, the case should be identified for continued regular monitoring.

Chapter 5-0200, Care/Supervision/Rehabilitation

Paragraph and Subject	Date	Trans. No.
Table of Contents	09/00	00-01
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2. Authorized Care/Services	09/00	00-01
3. Identification and Recognition of Need	09/00	00-01
4. Choice of Physicians	09/00	00-01
5. Change of Physician at Claimant's Request	09/00	00-01
6. Change of Physician - Request of Physician	09/00	00-01
7. Change of Physician - Initiated by the DD	09/00	00-01
8. Procedure for Change of Physician	09/00	00-01
9. Conflict in Medical Evidence	09/00	00-01
10. Impartial Medical Examinations	09/00	00-01
11. Cost of Special Examination	09/00	00-01
12. Rehabilitation	09/00	00-01

1. Purpose and Scope. This Chapter establishes procedures for the determination and acquisition of appropriate medical care and qualified physicians for the treatment and/or evaluation of injured employees under the LHWCA. It explains the requirements of effective supervision to insure that timely assessments and determinations are made on the necessity, character, and sufficiency of medical care services, and/or rehabilitation services provided the injured worker. Medical care, services, and supplies for injured workers, as well as the responsibility for the management of the LHWCA program, are defined in Chapter 5-100.

2. Authorized Care/Services.

1. **LHWCA**. Section 7(a) requires the EC to furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require.
2. **Application.**

a. In cases where the DD determines that there is a question as to the necessity, character, or sufficiency of medical care being furnished, or to be furnished the injured employee, the question should be resolved as promptly as possible. The DD should make use of available medical references, seek the advice of the OWCP District Medical Advisor where available, or consult the attending physician.

b. If the injured employee is under the care of a qualified physician authorized or approved to provide medical care and there is any question concerning the attending physician's medical management of the case, e.g., the use of prolonged therapeutic measures of questionable value, it is proper to tactfully request the physician's comments regarding the need to continue the questionable treatment. It is contrary to medical ethics to tell a physician how to treat his patient; however, there should be no hesitation in requesting discussion of the medical problem involved.

c. It is within the scope of the DD's supervisory functions and responsibilities to seek consultation services with other experts in specialized fields of medicine. In such instances, the attending physician must be advised of the action contemplated and informed that the results of any consultations will be made available to the physician.

3. Identification and Recognition of Need.

1. **Employer's Action**. Whenever an employer acquires knowledge of an employee's injury, through receipt of a written notice or otherwise, the employer is required to authorize, in writing, appropriate medical care. The Director has prescribed Form LS-1, Request for Examination and/or Treatment (Exhibit 1, PM 10-200) for this purpose. This is a two-part form. Part A--Authorization, provides a means for the employer to provide medical care under the Act by an authorized physician of the employee's choice. Part A is to be completed in triplicate by the employer and given to the employee to deliver to the authorized physician. The physician is to complete Part B--Attending

Physician's Report, retain one copy, send one copy to the DD (whose address should be shown in Item 12), and send the third copy to the insurance carrier or self-insured employer. Instructions to the employer and the physician are printed on the front and back of the form. The issuance of this authorization for treatment by the employer binds the EC to furnish and pay for such care and services.

2. **Employee's Action on Sustaining Injury.**
    a. An employee will not be entitled to recover any money spent for medical or other treatment or services, unless:
        i. The employee has requested the employer to furnish or authorize such treatment or service by a physician selected by the employee, or
        ii. The employer, having knowledge of an injury requiring treatment or services, has refused or neglected to authorize or provide necessary treatment.
    b. For any special examination required of an employee by the DD, the employee shall submit to such examination at such place as he/she is to report, but the place so selected must be reasonably convenient for the employee. Failure to submit to a lawfully ordered examination can result in the suspension of any claim proceedings, and no compensation otherwise payable shall be paid for any period during which the employee refuses to submit to such examination.
    c. If, at any time, the employee unreasonably refuses to submit to medical or surgical treatment, or to an examination by a physician selected by the employer, the DD (acting for the Secretary) or an ALJ may, by order, suspend the payment of further compensation during such time as the refusal continues. No compensation shall be paid at any time during the period of suspension, unless the circumstances justified the refusal (20 C.F.R. section 702.410 and section 7(d)(4) of the Act).
        i. **Two-prong Test**. The Benefits Review Board has held that application of this provision involves a two-prong test. The

refusal must be both "unreasonable" and not "justified" by the circumstances. The burden of proof is on the employer to show that the refusal was unreasonable; if carried, the burden shifts to the employee to show circumstances justify the refusal.

ii. The board additionally defined reasonableness of refusal as an objective inquiry (i.e., what course would an ordinary person in the claimant's position pursue?), and justification as a subjective inquiry (i.e., focusing on the individual claimant's particular reasons for refusal).

4. Choice of Physicians.

1. **Non-Emergency Situations**. The employee shall have the right to choose an attending physician from among those authorized by the Director, OWCP. The Director has authorized all duly qualified physicians identified in PM 5-100.4 to render medical care under the Act. However, unless authorized by the DD, the employee's choice is limited to those physicians having offices within twenty-five miles of the employee's home or principal place of work. This limitation does not apply, however, when the employee is hospitalized and the physician is on the staff of, or has privileges at, such hospital; nor does it limit subsequent referrals by the attending physician for needed specialized treatment or examination (20 C.F.R. section 702.403).
2. **Emergency Situations**. When the nature of the injury requires immediate medical care and the injured employee is unable to select a physician, the employer shall do so. Such selection by the employer, unless later confirmed by the employee, shall not constitute the employee's initial, free choice of a physician (20 C.F.R. section 702.405).
3. **Special Situations**. “While the Secretary of Labor is authorized under the Act to supervise medical care rendered to injured employees, neither the employer nor the Secretary stands in loco parentis to injured employees. Nothing in the Act requires injured workers to abdicate the right to make their own decisions about their medical care. Although the employer is not required to pay for

unreasonable and inappropriate treatment, when the patient is faced with two or more valid medical alternatives, it is the patient, in consultation with his own doctor, who has the right to chart his own destiny." *Amos v. Director, OWCP*, 32 BRBS 144, 147(CRT)(9th Cir. 1998).

5. Change of Physician at Claimant's Request.

1. **Non-Emergency Situations**. When an employee has made an initial free choice of an attending physician, the employee may not thereafter change attending physicians without obtaining prior written consent from the EC or the DD. Such consent shall be given in cases where an employee's initial choice was not of a specialist whose services are necessary for, or appropriate to, the proper care and treatment of the compensable injury or disease. In all other cases, consent may be given upon a showing of good cause for change. An injured employee who requests a change of physician will be asked to justify the request. Before making a change, the CE should ordinarily write to the attending physician for comment and opinion as to whether the transfer of medical care would interfere with the progress of the case. If the requested transfer is granted, the attending physician must be notified so that he/she may close the file on the case and submit a report. The EC must also be notified in writing.
2. **Emergency Situations**. As indicated above, requests for change of physician will ordinarily be done in writing. However, in an emergency, the request may be made by telephone call either to the DD or the EC. The conversation should be documented by the receiving party and if the request is approved, the entire matter should be confirmed in writing. The DD and EC should arrange for appropriate copies of the documents for each other's files.
3. **Special Situations**. After a claimant has made the initial choice of a physician, the claimant may consult another physician for emergency medical care due to an acute flare-up in condition, if the regular treating physician is unavailable to provide such care. In such situations, the CE should obtain a medical report from the physician who provided the emergency care and

ensure that a copy of this report is furnished to the authorized treating physician and to the EC.

6. Change of Physician - Request of Physician. If the attending physician requests to be relieved from continuing responsibility in a case, the request will be granted. However, the physician will be requested to furnish a report stating reasons for withdrawing from the case, describing the patient's condition at the time and any other recommendation the physician may have.

7. Change of Physician - Initiated by the DD. A change of the treating physician should be ordered by the DD if one or more of the following situations exist:

1. **The physician** will not submit medical reports or does not submit adequate medical reports.
2. **The physician** is not in the appropriate specialty to be treating the injury (e.g., an internist would not be the best choice to treat a back injury).
3. **An independent examination** indicates that the treatment being rendered is prolonged, ineffective, or of questionable medical value.
4. **Where the fees** charged exceed those prevailing within the community for the same or similar services or exceed the provider's customary charges. (See PM 5-500.3.)

8. Procedure for Change of Physician. The primary reasons for changing physicians are to ensure that the best medical treatment possible is obtained and that medical reports are regularly and promptly submitted. The exercise of sound judgment in ordering a change of physicians is of prime importance. Liberal use of special examinations to resolve medical questions is encouraged. Great care should be taken not to interfere with treatment necessary for the well-being of the employee. If the treating physician expresses the opinion that a change of physician is desirable or necessary, the physician may make the referral if he desires and should notify the DD and EC when doing so. The physician may also request the OWCP to designate another physician and make a direct referral. A change in medical management will usually be accomplished by written notification to all parties or by memorandum following an informal conference. However, under authority of section 7(b), the DD may order a change of physician or treatment by issuing a formal order.

9. Conflict in Medical Evidence. In any case in which controversy arises with respect to the degree of an employee's physical impairment, diagnosis, or the extent and effect of treatment, an evaluation of such questions will be made by appointing one or more eminently qualified physicians to examine the employee.

10. Impartial Medical Examinations.

1. **Authority**. Section 7(e) provides that impartial medical examinations may be utilized in any case in which medical questions are in conflict and requires that a report be submitted to the DD estimating the employee's physical impairment and any other information that is deemed appropriate.
2. **Utilization of Impartial Examination.**
    a. The DDs should also utilize the section 7(e) procedures in cases where medical questions arise regarding the necessity for medical treatment, indications for or against medical procedures, the duration of required treatment, or the effectiveness of such treatment as may have been provided.
    b. The procedures in section 7(e) may and should be used when a question arises as to the degree of "the employee's physical impairment". However, questions as to the nature and extent of disability, other than where either section 8(c)(1)-(19) or section 8(c)(23) is the operative provision, are not solely medical questions, but involve both economic and medical concepts. The physician conducting the examination for estimating a claimant's physical impairment cannot and should not be asked to evaluate employee's economic disability.
    c. An impartial medical evaluation should also be utilized to resolve any outstanding medical questions in a case where section 8(f) relief is an issue. The questions may involve: the extent of permanent disability, the date of maximum medical improvement, and the contribution (if any) of the pre-existing condition to the subsequent disability or death.
3. **Selection of Impartial Specialist.**

a. The services of all available and qualified Board certified specialists will be used to the extent practicable to eliminate any possible inference of bias or partiality. However, many general practitioners specializing in industrial medicine are well qualified to treat routine work-related injuries and conduct examinations under section 7(e).
b. Section 7(i) provides that unless the parties agree, no physician shall be employed or selected to conduct examinations and reviews pursuant to section 7(e) who is an employee of an insurance carrier, or who during the period of two years prior to such employment has been employed by or accepted or participated in any fee related to a worker's compensation claim from any insurance carrier. This restriction does not disqualify all doctors who have been paid by insurers for treatment of patients during the preceding two years, but only those who have received fees from carriers or self-insured employers for formulating opinions about cases during that period.
c. Where the parties participate in the selection of a physician, the DD will prepare a list of three or more Board-certified specialists for submission to the parties from which list the parties will be asked to agree on the physician to be selected. In selecting physicians to be submitted to the parties, or where the selection is made by the DD, a rotation system shall be followed.
d. If there is reason to consider a specialist's views or opinions to be reasonably predictable because of the specialist's writings and/or reputation in the specialty, or otherwise, the specialist will not be selected. In making this determination, the OWCP District Medical Advisor, if available, will be consulted.
e. In the following situations, the DD may order impartial examinations under section 14(h). These situations include a case in which payments are being made without an award or:
    i. Where payments of compensation have been stopped or suspended, upon receipt of notice from any person entitled

to compensation, or from the employer, that the right to compensation is controverted;

ii. When no physician qualified under section 7(i), or acceptable to the parties can be identified.

f. Where an impartial evaluation is to be used to clarify medical issues in a case where section 8(f) is an issue, the examination should be arranged by the DD. This is not to be done by the parties. The claimant should be examined by the impartial medical specialist. The DD should frame the questions to be answered by the specialist and the report of the specialist should be sent first to the DD. This procedure should be followed so that the specialist's evaluation will be impartial and not simply reflect the views of the parties.

4. **Pre-judgment by Impartial Specialists**. The special examination should be made in such a manner as to preclude pre-judgment by the impartial examiner. No physician previously connected with the case may be present, nor may any other physician selected by the employer, carrier, or employee be present. An impartial medical examiner should not routinely be provided with copies of all medical reports contained in the case file. If necessary, the impartial physician may be provided with the results of any diagnostic tests performed by other physicians. However, the impartial medical specialist is not to be provided with the opinions, reports, or conclusions of any prior examining physician with respect to the nature and extent of the impairment, its cause, or its effect upon the wage-earning capacity of the injured employee. Even though an impartial medical examiner may be provided with the results of previously performed diagnostic tests, this is to be done only where it is necessary for completion of the examination and not routinely in every case. Furthermore, although section 7(f) of the Act allows the Secretary to provide the impartial physician with the conclusions of other physicians, our policy is that this should be done only in extremely rare and unusual circumstances. The impartiality of specialists, however, is not compromised if the DD apprises the specialist of the undisputed facts pertaining to the nature of the employee's employment, the nature of the injury, the post-injury employment activity, if any, and of any other facts which are not disputed and are considered

pertinent to the type of injury and/or the type of examination being conducted. The DD may also inform the specialist about the claimant's pre-existing condition(s) where the issue involved is section 8(f) relief.

5. **Review or Re-Examination.**
    a. Any party dissatisfied with the report of the impartial examiner may request a review or re-examination of the employee by one or more different physicians employed or selected by the DD, and such review or re-examination must be completed within two weeks from the date ordered unless it is impossible to complete the review and render a report within this time period. Upon receipt of the report of this additional review and re-examination, a recommendation should be made for the consideration of the parties. (Also see PM 5-400.7, 5-400.12, and 3-301.7.)
    b. If the parties are unable to reach an agreement on the medical question(s) after the review or re-examination, the DD or CE shall nevertheless make a recommendation in accordance with PM 4-200. If the recommendation is not accepted, and if requested, the case should then be prepared for referral to the ALJ for a formal hearing on the issue. The DD, howeer, has authority to determine the necessity, character and sufficiency of any medical aid furnished or to be furnished to injured employees. He/she may order a change of physicians or hospitals when, in his/her judgment, such change is desirable or necessary, or where the charges exceed those prevailing within the community or exceed the provider's customary charges (section 7(b) of the Act), and may order the EC to pay for particular medical services.

11. Cost of Special Examination.

1. **The cost** of special examinations requested by a DO under sections 7(e) or 14(h) are to be charged to employers or insurance carriers. Such costs are not to be charged to the Special Fund. If the employer/carrier indicates they will not pay for the examination, the district director may insert language (in the

compensation order directing the special examination) which provides that the employer pay for the examination, and giving the Special Fund authority to pay for the examination if the employer/carrier refuses. However, the order should also indicate that the Special Fund would be entitled to reimbursement and interest. If the employer/carrier then fails to comply with the order, apply for enforcement to the Federal District Court.

2. **The cost** of an examination under section 7(e) will be paid by the Special Fund only where (1) the examination involves a Special Fund beneficiary and (2) the examination was requested directly by the Director, DLHWC. Bills for such examinations are to be sent by the DO directly to the Director, DLHWC, within five days of their receipt.

12. <u>Rehabilitation</u>. Effective supervision of the care and treatment of injured workers includes rehabilitation, both medical and vocational. The OWCP rehabilitation program assists disabled employees who are covered under the LHWCA to minimize their disabilities and return to gainful work. Rehabilitation helps injured workers to become self-supporting and productive, and saves money by elimination or reducing workers' compensation payments.

1. **OWCP Rehabilitation Specialists** (RS) and Claims Examiners carry out the program with the assistance of private and public agency rehabilitation providers, physicians, and employers, making sure that eligible workers receive the rehabilitation services best designed to return them to suitable work, preferably with little or no loss of earnings. The Rehabilitation Specialists are responsible for the following functions:
    a. Provide professional direction to the district office's rehabilitation program;
    b. Oversee the provision of services to individual injured workers, ensuring that quality and timeliness standards are met;
    c. Ensure compliance with OWCP contractual requirements on the part of Rehabilitation counselors (RC's), issuing warnings and termination notices when violations occur and ensuring that changes in OWCP policy are communicated promptly to RC's;

d. In conjunction with Division of Planning, Policy and Standards (DPPS), ensure that as far as possible an adequate number of qualified counselors are certified in the office's area of jurisdiction to provide good quality services to injured workers;
e. Maintain a complete and accurate RTS data base and provide data monthly and quarterly as required to DPPS;
f. Through Claims Examiner referrals or using computer-generated lists, screen and open cases in sufficient numbers to achieve program plan goals;
g. Through personal visits and telephone contact, maintain a fruitful working relationship with employers in the office's jurisdiction to promote the reemployment of injured workers;
h. Provide ongoing direction to counselors on individual rehabilitation cases in the office's jurisdiction, ensuring timely and good quality services.

2. **Longshore Act and Regulation** sections relative to Rehabilitation:
    a. Section 7 (a) of the LHWCA states that the employer shall provide medical care for such periods as the nature of a covered work injury or the process of recovery may require.
    b. Section 39 (c) provides that the Secretary shall direct the vocational rehabilitation of permanently disabled employees, and may use the Special Fund established by section 44 to procure vocational rehabilitation services and appliances necessary for an injured employee to resume work.
    c. Section 8(g) provides for maintenance allowance of up to $25 per week for an employee undergoing rehabilitation, to be paid from the Special Fund.
    d. Section 39(c)(1) requires the Secretary to provide information on vocational rehabilitation services and assist covered employees in obtaining the best such services.

e. The Regulations at 20 DFR 702.501 - 508 govern the rehabilitation process.

f. OWCP Rehabilitation Procedure Manual.

3. **Early Intervention**. Emphasis is on early intervention to prevent long-term disability and improve the chances of successful return to work. CE's must ensure that cases are referred as soon as indicated by medical evidence, and that needed information is conveyed quickly to the RS.

4. **Medical Rehabilitation** refers to those medical services necessary to correct, minimize or modify the impairment caused by a disease or injury with the goal of returning the injured worker to an adequate level of function and employment. Medical rehabilitation may include services such as physical, occupational or speech therapy, orthotics, prosthetics, psychiatric counseling, occupational rehabilitation programs and others.

5. **Vocational Rehabilitation** services can be defined as services which enhance the ability of an injured worker to return to gainful employment. These include testing, evaluation, counseling, guidance, training, placement and follow-up.

6. **Referrals** The CE as well as carriers/employers refer cases to the RS. The claims examiner is responsible for the medical monitoring of cases in a TTD status for early indications of the need for rehabilitation. The claims examiner should refer the case to the Rehabilitation Specialist using Form OWCP-14 where the medical evidence indicates that the claimant cannot return to the job held when injured and is in need of rehabilitation services. If the claimant remains in TTD status for more than 90 days and the medical evidence is not sufficient to make a determination regarding referral, the claims examiner should then release the LS-838 to the employer/carrier to determine whether any rehabilitation effort has been initiated.

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1. Purpose and Scope. This Chapter establishes the requirements and procedures for submitting medical reports to the DDs, and identifies the screening process for obtaining and evaluating reports by the Claims Examiner(CE)/Claims Examiner Clerk(CEC) in the supervision of care and treatment of injured workers under the LHWCA.

2. Obtaining/Screening Medical Reports. The CE/CEC, given the appropriate medical documentation in a case, can efficiently assist the DD in the supervision of LHWCA medical care and treatment. This medical documentation consists of timely initial and supplemental reports as well as a complete final medical report which addresses the extent of permanent impairment when necessary. The remainder of this Chapter discusses these various reports.

3. Initial Reports. Within ten days following the initial examination or treatment, the physician shall furnish a medical report to the DD, with copies to the EC. The "B" side of Form LS-1 (back of the employer's "Authorization" form, Exhibit 1, PM 10-200) has been prescribed for this purpose and it should be used.

1. **Additional Reports**. If the initial medical report is not received within thirty days, a request on Form LS-216 (Exhibit 25, PM 10-200 - Request for Additional Reports) should be sent to the EC. If no response is received within two weeks, a follow-up request shall be made.
2. **Case Closure**. When the required documentation is received in the DO (e.g. Forms LS-1, LS-202, LS-204, and LS-208), the DD may close the case if there is no probability of permanent partial disability or time loss, since no need exists under these circumstances for additional supplementary medical reports (e.g. periodic or progress reports).

4. Supplementary Reports. When an initial medical report is received, Form LS-216 may be released if further treatment is indicated. This form may be used to request the treating physician to provide periodic reports on Form LS-204 or in

narrative reports at approximately thirty day intervals. (See Exhibit 18, PM 10-200, Attending Physician's Supplementary Report; and Exhibit 25, PM 10-200, Request for Additional Reports.) Progress reports should be requested every thirty to sixty days in short-term disability cases. In cases of obvious 2long-term disability, reports at ninety day or longer intervals may be adequate. The frequency with which medical reports are requested should follow the needs of the individual case, as determined by the policy of the DD, or the CE.

5. Final Reports. All extended disability cases must have a final medical report submitted at the time maximum medical improvement is reached. Forms LS-1, LS-204 or a narrative report may be used for this purpose. In providing a report, the examining or treating physician should not be asked to evaluate the employee's disability, but only the employee's physical impairment. In any case where there is potential for permanent partial disability, a medical report should be requested, giving the percentage of permanent partial impairment, in accordance with the AMA Guides to the Evaluation of Permanent Impairment. If a controversy arises as to extent of impairment, section 7(e) or section 14(h) procedures shall be utilized to obtain a medical evaluation of any residual impairment.

6. Failure of Physician to Report Medical Care After Initial Authorization. No claim for medical or surgical treatment shall be valid and enforceable against an EC, unless the treating physician furnishes to the EC and to the DD, within ten days following the first treatment, a narrative report or a report on Form LS-1. The DD may, however, excuse the failure to furnish such report within ten days when he or she determines that it is in the interest of justice to do so. Situations where the delay is excused will vary widely. It may be as simple as a failure on the part of the employer to provide the Form LS-1. Also, case law has held, for example, that in a situation where the employer had not provided any evidence to suggest that the treatment was unnecessary or unrelated to the claimant's work injury, an excusal of delay was in the best interest of justice. These will frequently be instances beyond the control of the claimant in which the physician, for unexplained reasons, is simply tardy in the submission of the report. The DD has wide discretion on this issue. The DD has authority, upon application by a party in interest, to make or deny an award for the reasonable value of such medical or surgical treatment obtained by the employee. (See 20 C.F.R. section 702.422.)

7. CE's Follow-Up of Medical Reports. To ensure the proper implementation of the reporting procedure for medical care, the CE will use the following procedure to guarantee compliance: If a medical report has not been received within sixty days after examination or treatment, send a request to the employer on Form LS-216. If the attending physician fails to comply within a reasonable period or repeatedly fails to submit reports, the CE shall refer the case to the DD, stating

the facts in the case, and making a recommendation for further handling. The DD may wish to write or call the physician for the purpose of securing a current report and explaining the requirements with respect to reporting, or may consider a change in physicians (20 C.F.R. section 702.406).

Chapter 5-0400, Evaluation of Impairment

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13. Determination of Disability	09/00	00-01

1. Purpose and Scope. This Chapter establishes guidance and procedures governing the medical evaluation of physical impairment. It represents the foundation upon which disability evaluation is based. Physical impairment is a medical concept. Disability is generally an economic concept, or, more specifically, the inability of an employee because of an injury and other factors, to earn the wages which the employee was receiving at the time of the injury in the same or other employment. In evaluating the degree of disability in a given case, the physical impairment is but one factor in the overall evaluation. Non-medical factors, such as age, education, availability of suitable work, and work history, also enter into the disability evaluation. Qualified physicians should be requested to furnish an evaluation of physical or anatomical impairment and the limitations imposed by a given injury.

2. Permanent Impairment.

1. **Guidance**. CE's should require any physician selected to evaluate permanent medical impairment to utilize the American Medical Association's (AMA)

Guides to the Evaluation of Permanent Impairment, where applicable, and to report the findings in accordance with those guidelines. Any physician who is unwilling or unable to utilize the AMA Guides should not be employed or selected by CE's to evaluate permanent impairment. Nevertheless, their reports not only may but should address as well the impact of any physical factors, such as pain, that cannot be quantified objectively (and hence are not accounted for in the AMA's ratings) on the practical extent of "loss of use" of the member or faculty in question. The District Director (DD) shall be directly responsible for monitoring and ensuring compliance with this policy.

2. **Additional Factors**.
    a. If the AMA Guides do not evaluate a particular occupational disease impairment, other professionally recognized standards may be utilized (see 20 C.F.R. section 702.601(b)).
    b. Reference to 20 C.F.R. section 410.424 et seq., (Black Lung disability standards) may be useful in evaluating respiratory impairments.
    c. Occasionally injuries occur leaving both objective and subjective residual impairment that cannot be easily measured by the AMA Guides. Some examples are:
        i. Atrophy
        ii. Deformity
        iii. Loss of sensation
        iv. Marked sensitivity to heat or cold
        v. Loss of strength
        vi. Soft tissue damage (scarring, discoloration).

    Where such conditions exist, they should be considered along with the measurable permanent impairment under the Guides, in evaluating permanent disability.
    d. Consideration must be given to the claimant's subjective complaints.

3. <u>Basic Elements Required to Evaluate Anatomical Impairment.</u>

1. **Guidelines for Physician's Report**. Medical examinations are scheduled to obtain information which will enable the CE to evaluate and resolve medical questions regarding the extent of anatomical impairment. Whenever the CE or other party schedules an examination to evaluate anatomical impairment, the CE will request the physician to submit a detailed narrative report containing the following basic information:
    a. An evaluation of impairment in accordance with the AMA Guides, and a percentage rating of the impairment of the injured member, or of impairment of the individual as a whole, as in back or head injuries or retiree occupational disease cases.
    b. A description of any impairment not measured by the AMA Guides (except in retiree claims under section 8(c)(23)).
    c. A description of the physical limitations imposed by the injury with respect to lifting, bending, sitting, walking, standing, stooping, or other activities, and the extent to which such limitations preclude the claimant from performing usual and customary duties. A description of the work limitations would not be necessary in the majority of scheduled injuries, particularly when the claimant has returned to regular full-time work.
    d. Date of maximum medical improvement and/or date employee was able to return to work.
2. **Modifications/Deviations in Evaluations**. Occasionally, special circumstances will require modification of, or deviation from, the above standards. In the absence of special considerations, the CE should request, and expect, a medical report containing the information in subparagraphs 3a(1) through 3a(4) above.

4. <u>Types of Permanent Disability.</u>

1. **Permanent Total Disability (PTD)**. Disability which is permanent in nature and total in quality is referred to as permanent total disability (section 8(a)).
2. **Permanent Partial Disability (PPD)**. Disability permanent in nature but only partial in quality is referred to as a permanent partial disability. Disabilities of

this kind can be subdivided into specific losses (and loss of use of) contained in the section 8(c)(1)-(20) schedule, and the general provisions contained in sections 8(c)(21) and 8(c)(23). Disputes as to the extent of permanent impairment are usually resolved by additional medical evaluations, stipulation of the parties, or by recommendation of the CE following consideration of all of the medical evidence.

a. **PPD Under Section 8(c)(21)**. Permanent partial disabilities falling under section 8(c)(21) do not generally lend themselves to the simple solution of anatomical impairment. In fact, the Act specifically directs that the amount of compensation payable shall be based on the difference between pre-injury wages and post-injury wage-earning capacity. As a practical matter, the CE must rely on the degree of anatomical impairment as a starting point for the application of non-medical criteria in arriving at a disability determination. However, the examining physician(s) must determine the extent to which the degree of anatomical impairment, based on AMA Guides, places physical limitations on the claimant's ability to perform usual and customary duties or other work. Knowledge of the anatomical impairment, plus a sound medical opinion as to the limitations imposed by this impairment, should enable the CE to better evaluate the extent of disability in a given case. However, if the permanent physical effect of the injury is limited to impairment of a member covered by section 8(c)(1)-(20), compensation may not be paid under the provisions of section 8(c)(21); if the scheduled injury does not foreclose the worker from all employment reasonably available to him or her, a schedule award is the only form of periodic compensation available after permanency begins. (See Potomac Electric Power Company v. Director, OWCP[PEPCO], 449 U.S. 268, 14 BRBS 363 (1980).)

b. **PPD Under Section 8(c)(23)**. Awards for permanent partial disability under this section of the Act are made for retired workers afflicted with delayed occupational diseases which did not affect their pre-

retirement earnings. The percent of impairment, as calculated according to the AMA Guides, and expressed in terms of the whole person, is the basis for the award. Compensation shall be 66 2/3 percent of the claimant's "deemed" AWW times the percent impairment. (See 20 C.F.R. section 702.604.)

3. **Permanent Disability Involving Multiple Injuries**. Cases involving severe injuries to a single extremity or multiple injuries to more than one extremity may sometimes be more difficult to evaluate in terms of permanent impairment. Whether such injuries should be treated as schedule losses or general economic disability depends not only on the physician's evaluation of impairment expressed as a percentage, but also on whether the injury involves other than schedule members and whether the claimant is able to perform the duties of his/her employment or other work. For example, the medical evidence must be evaluated by the CE in light of these factors as well as such non-medical factors as age, education, work history, etc., in arriving at a decision as to the nature of the disability. However, if the injury is limited to a member covered by the schedule contained in section 8(c)(1)-(20), and the claimant is only partially disabled, recovery is limited to the number of weeks provided for in the schedule, as noted in 4b(1), above.

   In **Frye v. Potomac Electric Power Co**, 21 BRBS 194 (1988) the Board noted that, subsequent to PEPCO, it had held that a Claimant, who sustained two injuries, was entitled to a schedule award and a section 8(c)(21) award but that any LWEC due to the impaired schedule member must be factored out of the section 8(c)(21) award. (See Turney v. Bethlehem Steel Corp., 17 BRBS 232 (1985). The Board concluded that there is no reason to limit the holding in Turney to those cases where two or more work accidents occur. Accordingly, we hold that where the Claimant suffers two distinct injuries, a scheduled injury and a non-scheduled injury arising either from a single accident or multiple accidents, he may be entitled to received compensation under both the schedule and section 8(c)(21). Since the scheduled injury is being compensated separately, any loss in wage-earning capacity due to the scheduled injury must be factored out of the section 8(c)(21) award. Frye at

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The Board has never given any concrete guidance on how the factoring out should be done. Please contact the NO for guidance on specific cases.

5. Physician's Use of AMA Guides.

1. **Application**. Generally, the physicians who treat job-related injuries arising under the LHWCA are familiar with the features of section 8(c). It is imperative, however, that the CE requesting a final evaluation of permanent impairment, makes certain that the evaluating physician's report expresses the percentage of impairment in accordance with the AMA Guides.
2. **Degree of Permanent Impairment**. It is generally easier for a physician to evaluate the degree of permanent impairment in injuries involving the extremities. Limitation in flexion, extension, etc., can be measured with reasonable accuracy in accordance with the Guides. However, in evaluating permanent impairment in back injuries, other factors may influence the physician's final evaluation.

6. Evaluation When No Conflict Exists in Medical Evidence.

1. **Request for Medical Evaluation**. As soon as practicable following the date the CE learns that a claimant has reached maximum medical improvement, or is no longer temporarily totally disabled, and suspects some permanent partial disability is present, the CE will request a medical evaluation of permanent impairment. The report of this evaluation should contain the information outlined in paragraph 10, below.
2. **Channels of Request**. The CE may either write directly to the physician and ask for the evaluation and report, or direct the EC to make the arrangements. In cases where section 8(f) relief is at issue, the referral must be made by the DO. The physician should be asked to submit a report as soon as possible after the claimant is examined.
3. **Use of Report**. When the medical report is received, the CE should review it carefully (along with the other factors considered in determining disability),

decide the extent of disability, and make a recommendation for the consideration of the parties.

7. <u>Evaluation When There is Conflicting Medical Evidence and/or Disagreement</u>. Whenever the CE determines that a medical evaluation is needed to resolve disputes as to the degree of permanent impairment, the CE should immediately arrange for an evaluation. Selection of a physician and scheduling of the evaluation can be handled by phone, letter, or at a conference by any of the parties in interest. Where section 8(f) relief is an issue, all arrangements must be made by the DO

8. <u>Selection of Physician to Conduct Evaluation</u>. The selection of a physician to conduct the evaluation of impairment can be made in several ways. While any of these methods may be used, it is generally preferable to have the parties participate in the selection of the physician. Please refer to PM 5-200.10 for further guidance on the selection of impartial specialist.

1. **Selection by CE**. The CE can select a physician for an impartial evaluation pursuant to section 7(e) or section 14(h) of the Act.
2. **Selection by Parties**. The CE can provide the names of three or more Board-certified specialists in the needed specialty and have the parties select a physician from those named.
3. **Mutual Agreement of Parties**. The parties can mutually agree on a physician of the appropriate specialty. This method for choosing a physician should not be used in cases where section 8(f) relief is an issue.

9. <u>Selection of Physician by Claims Examiner.</u>

1. **Rotation System**. Whenever the CE presents names of physicians for selection by the parties, or selects a physician without the participation of the parties, a rotation system of selection will be followed.
2. **Suitability of Physician**. There will be physicians who are unable or unwilling to conduct evaluations. Other physicians may have become known as being unduly biased in favor of either claimants or employers. Such physicians should be omitted from the rotation system.

3. **Section 7(i) Restriction**. If the restrictions of section 7(i) and a party's unwillingness to waive them make the use of that provision impractical, the CE then proceeds with the evaluation under the authority of section 14(h), which is an alternative to section 7(e) for evaluating permanent impairment.
4. **Examination Under Section 14(h)**. Examinations under section 14(h) shall generally be arranged to preclude pre-judgment by the impartial specialist. No physician previously connected with the case should be present, nor may any other physician selected by either party be present.
5. **Impartiality of Examinations**. The examining physician should not routinely be apprised of the opinions, reports, or conclusions of any prior examining physician with regard to the nature and extent of the employee's impairment and its cause or effect on the employee's wage-earning capacity. (See 20 C.F.R. section 702.411(a) and (b) and PM 5-200.10.)

10. Referral Arrangements.

1. **Requirements for Physician's Report**. Once the impartial specialist has been selected, either under section 7(e) or section 14(h), the CE will contact the physician's office, preferably by telephone, to determine if the physician is willing to conduct such an evaluation. If so, the arrangements will be formalized by use of a narrative letter which sets forth the essential background data and requests that the report include all or as much of the following information as may be appropriate:
    a. Date of examination.
    b. History given by employee.
    c. Detailed description of findings.
    d. Results of any x-ray or laboratory tests.
    e. Diagnosis.
    f. An estimate of the percentage of impairment remaining due to the injury in accordance with the AMA Guides, where applicable.
    g. Date of maximum improvement, if reached.
    h. Prognosis.

i. Advice as to the work limitations imposed by reason of injury-related impairment with respect to lifting, bending, stooping, walking, reaching, standing, etc.

j. Recommendations for further medical treatment, if indicated.

k. An indication whether the physician would be available to testify at a formal hearing, either in person or by deposition.

2. **Arrangements by Party in Interest**. If there is mutual agreement by the parties as to the examining physician, one of the parties may arrange the examination, contact the physician's office, make the referral, and request that the medical report contain information which is outlined in subparagraph 10a. As previously noted, this method should not be utilized in cases where section 8(f) relief is an issue.

3. **Referrals in Section 8(f) Cases**. Where an impartial evaluation is to be used to clarify medical issues in a case where section 8(f) is an issue, the examination should be arranged by the DD. This is not to be done by the private parties. The claimant should be examined by the impartial medical specialist. The DD should frame the questions to be answered by the specialist and the report of the specialist should be sent first to the DD. This procedure should be followed so that the specialist's evaluation will be impartial and not simply reflect the views of the private parties.

11. Receipt of Medical Report of Evaluation. On receipt of the medical report, the CE should make a copy of the report available to the parties, if they have not already been furnished one. The CE will then review the report carefully and, along with other factors necessary in evaluating disability, determine the extent of disability, and make a recommendation for the consideration of the parties.

12. Evaluation Disputed.

1. **Request for Reexamination**. A party who is dissatisfied with the findings of the evaluating physician may request a review or reexamination of the claimant. The CE should grant the request unless considered unwarranted. When the request is granted, the physician should be chosen using the same procedure as when the initial selection was made.

2. **Conduct of Reexamination**. The reexamination shall be completed within two weeks from the date ordered, unless it is impossible to complete the reexamination and render a report within such time period.

13. Determination of Disability. Following receipt of medical reports of reexaminations or reviews, the CE should not usually authorize any further evaluations, reexaminations, or reviews, but will carefully evaluate all the medical evidence and non-medical factors necessary in evaluating disability, determine the extent of disability, and make a recommendation for the consideration of the parties.

Chapter 5-0500, Fees/Charges

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1. Purpose and Scope. This Chapter establishes the policy and procedures for the determination, evaluation, and/or payment (recovery) of fees or charges incurred by the OWCP (Special Fund), EC, or employee for medical treatment, services, or supplies under the LHWCA. The procedure for handling disputes on prevailing charges for medical services is also described. (See 20 C.F.R. sections 702.414 to .417.)

2. Policy.

1. **Chargeable Costs**. The Director, OWCP or designee, ordering a special examination, shall charge the cost of the examination or review to the employer/carrier, or to the Special Fund established by section 44 of the Act (20 C.F.R. section 702.412). Examination costs shall be charged to the Special Fund only in cases involving Special Fund beneficiaries where the Director, DLHWC, has directly requested the examination (see PM 5-200.11).
2. **Fee/Charge Standards.**

a. Prevailing Community Charge. All fees charged by physicians for the care of injured employees under the LHWCA, or any other charges for medical treatment or supplies within the purview of the Act, shall be limited to such charges as prevail for similar treatment, services, or supplies in the community in which the physician, medical facility, or supplier is located.

b. Provider's Customary Charge. Section 7(b) of the Act authorizes a change in treating physician or hospital where the medical charges "exceed the provider's customary charges. When the Act was amended in 1984 to include this authority, the legislative materials stated "the doctor cannot charge more for Longshore clients than for other patients." See, H. Rep. No. 1027, 98th Cong., 2d Sess., 130 Cong. Rec. 25,493, 25,500 (1984). Therefore, section 702.413 of the regulations limits the fee for medical services to the lower of the prevailing community rate or the provider's customary charges for the same or similar services.

3. Fees for Medical Charges. It is DLHWC'S practice, in accordance with sections 7(b) and 7(g), to authorize the prevailing rates for similar services to the general public in the community in which the medical care provider is located. Medical fees are also limited to the provider's customary charge. See 20 C.F.R. section 702.413. On October 2, 1995, final rules were published in the Federal Register establishing that the OWCP fee schedule (as described in 20 C.F.R. section 10.411) is to be used to determine the reasonable and customary amount of a medical fee where there is a dispute (Federal Register, Vol. 60, No. 190 at 51,346). If charges for the services appear unreasonable or the frequency and nature of services provided appear excessive, the case may be referred to the DD for action in accordance with paragraph 4 below.

4. Dispute Over Fees for Medical Services. Attempts should be made to informally resolve medical fee disputes whenever possible (see subparagraph b below). However, where resolution cannot be reached through informal means, the course of action to be followed should be determined by whether or not there is already a compensation order awarding medical benefits in effect in the case.

In a case where a compensation order has already been issued requiring the employer to pay the reasonable charges for medical services reasonably required by the injury and the disputed medical fee cannot be resolved informally,

the procedures described in 20 C.F.R. 702.413-702.41 and in subparagraph c below should be used. If necessary, enforcement can be obtained through sections 18(a) or 21(d) of the Act.

If a compensation order awarding medical benefits has not been issued and (1) there is an underlying dispute concerning the compensability of the condition for which the treatment was provided, or (2) compensability is uncontested (e.g., the employer has instituted compensation payment for TTD and has disputed only the reasonableness of the medical provider's fee), the case should be referred to the OALJ for hearing and adjudication of the claim. Without a compensation order awarding medical benefits, neither section 18(a) nor section 21(d) of the Act can be used for enforcement.

When DLHWC published the Longshore Act regulations, to implement the 1984 amendments, it provided the following guidance: "[t]he Department cautions that such actions as medical fee determinations cannot be taken unilaterally by any party, but must follow the process established by law and structured in the regulations." 51 Fed. Reg. 4320, 4280 (1986)

In an All Assistant Deputy Commissioners memorandum dated August 28, 1987, the NO provided the following guidance:

Section 7(g) of the Act limits the charges for medical treatment or services to the prevailing community charge for such treatment or service. The authority to make initial medical fee determinations is under the jurisdiction of the deputy commissioner (20 CFR 702.407). Such determinations should not be made unilaterally by any party. If a dispute arises concerning whether a medical fee conforms to the prevailing community rate it should be brought to the attention of the deputy commissioner for resolution.

When such a dispute arises, the deputy commissioner should ask the parties to submit their position in writing. These submissions should be as specific as possible and should be accompanied by supporting evidence. The burden of proof is on the party who is raising the issue. If either party does not submit supporting evidence the deputy commissioner may issue a recommendation based upon the evidence submitted.

The memorandum further stated

Should an informal resolution of the fee dispute prove unsuccessful, the deputy commissioner should initiate the formal proceedings provided for in Section 702.414. The deputy commissioner should collect whatever additional evidence is necessary. An informal conference may be held with the parties. At the conclusion of these formal proceedings the deputy commissioner is to issue

specific findings of fact on the fee in dispute. If the fee is found to be in conformance with the prevailing community rate the employer/carrier is to be advised that it is a reimbursable expense under Section 7 of the Act. If the fee is found to exceed the prevailing community rate or the provider's customary rate, the findings of fact should indicate that the portion of the fee found to be excessive is not a reimbursable charge under Section 7 of the Act

1. **Burden of Proof**. In Newport News Shipbuilding and Dry Dock Co. v. Dr. Sidney S. Loxley, et al., 934 F.2d 511, 24 BRBS 175(CRT)(4th Cir. 1991), cert. denied 112 S.Ct. 1941 (1992).the Fourth Circuit concluded "that a physician who seeks an order compelling full payment of his charges carries the burden of proof at the administrative hearing." 24 BRBS @ 184(CRT)

   The Court of Appeals rested its conclusion on the fact the formal hearings under the Act are conducted in accordance with section 556 of the Administrative Procedure Act (APA). The APA notes that "the proponent of a rule or order has the burden of proof." This approach to assigning the burden of proof has been endorsed by the Supreme Court, in Director, OWCP v. Greenwich Collieries, 512 U.S. 267, 28 BRBS 43(CRT)(1994). Therefore, the party initiating a fee dispute has the burden of proof.

2. **Initial Proceedings.**
   a. The DD may, upon written complaint of an interested party, or upon the DDs own initiative, investigate any medical care provider or any fee for medical treatment, services, or supplies or the provider's customary charges.
   b. Where a dispute arises concerning the amount of a medical bill, the DD shall determine the prevailing community rate using OWCP Medical Fee Schedule to the extent appropriate, and where not appropriate, may use other state or federal fee schedules. The DD should also determine the provider's customary charge (see subparagraph 2b(2). When necessary, the DD's investigation may include contacting the medical care provider on his/her own or through the District Medical Advisor (DMA) to clarify type of treatment and charges and the provider's customary charge.

c. If the DD determines that the fee is excessive, the DD or DMA may contact the medical care provider to advise that a particular fee has been found to be excessive. The medical care provider should be given the opportunity to voluntarily adjust the fee without further proceedings. If the medical care provider declines to adjust the fee, further proceedings described below in subparagraph c should be initiated.

d. If the fee is found to conform to the prevailing community rate, the EC should be advised that the fee is a proper charge under section 7 of the Act. If the EC declines to pay the fee, or any portion of the fee, on the ground that the charge is excessive, further proceedings described below in subparagraph c should be initiated.

3. **Further Proceedings.**

a. If the initial investigation is unsuccessful in resolving the dispute further proceedings may be undertaken by the DD to collect any additional evidence needed to make specific findings of fact. These proceedings may include, but not be limited to: an informal conference involving all interested parties; agency interrogations to the pertinent medical care provider; and issuances of subpoenas duces tecum for documents having a bearing on the dispute. A claim by the provider that the OWCP fee schedule does not represent the prevailing community rate will be considered only where the following circumstances are presented:

i. where the actual procedure performed was incorrectly identified by medical procedure code;

ii. that the presence of a severe or concomitant medical condition made treatment especially difficult;

iii. the provider possessed unusual qualifications (board certification in specialty is not sufficient evidence in itself of unusual qualifications); or

iv. the provider or service is not one covered by 20 C.F.R. section 10.411(d)(1).

The above circumstances are the only ones which will justify reevaluation of the amount calculated under the OWCP fee schedule.

b. The failure of any medical care provider to present any evidence required by the DD in these proceedings without good cause shall not prevent the DD from making findings of fact.

c. At the conclusion of these proceedings, the DD is to issue findings of fact regarding the disputed fee. These findings of fact are to be issued over the signature of the DD and are to be mailed to all interested parties.

d. If the DD finds the fee to be proper the findings of fact should state that it is a reimbursable expense under section 7 of the Act. If the fee is found to be excessive, the findings of fact should indicate that the portion of the fee found to be excessive is not a reimbursable charge under section 7.

   Where a health care provider is successful in obtaining its full fee, the DD may include interest on the unpaid fee and award an attorney fee for work performed in obtaining the fee. Hunt v. Director, OWCP, 999 F.2d 419, 27 BRBS 84(CRT) (9th Cir. 1993).

e. If any interested party is not satisfied with the findings of fact, a formal hearing may be required. If a formal hearing is not requested within thirty days of the mailing of the findings of fact, they become final (see 20 C.F.R. section 702.415) and are not appealable to the Benefits Review Board. Assuming there is a compensation order awarding medical benefits in effect in the case, the DD's findings of fact that the fees are reasonable bring those fees within what is payable under the existing compensation order. Should the EC refuse to pay (or to pay in full), the claimant or medical provider can seek enforcement by requesting issuance of a supplementary order under section 18(a) of the Act declaring the amount of the unpaid fees plus interest to be in default. (See Lazarus v. Chevron USA,

Inc., 958 F.2d 1297, 25 BRBS 145 (CRT) (5th Cir. 1992), concerning medical fees being within the meaning of “compensation” for the purposes of section 18(a).)

5. Formal Hearings. If a formal hearing is requested, the case is to be referred to the OALJ in accordance with current procedures. The DO should notify the Solicitor's Office and the NO by separate memorandum at the time of referral.

6. Effect of Adverse Decisions in Medical Fee Disputes.

1. **If a final decision** of the DD or an ALJ finds a fee excessive, the provider shall be given thirty days to make the necessary adjustment in the fee. If a final decision of a DD or an ALJ finds a fee reasonable the EC should pay promptly. Within thirty days after issuance of the DD's findings of fact any affected provider, employer or other interested party may request a formal hearing before an ALJ. If no request for a hearing is filed with the DD within thirty days the findings shall be final.
2. **If the medical** care provider still refuses to make the required readjustment, the provider shall not be authorized to provide further medical services or treatment (20 C.F.R. section 702.417). This removal of authorization only applies to the case in which the dispute arose. However, the DD may initiate debarment proceedings as indicated in PM 5-600 if such proceedings are warranted.
3. **In cases** where part of a fee has been disallowed, the DD will inform the claimant that he or she is not personally liable for payment of the disallowed charge. The medical care provider should be provided with a copy of the letter to the claimant.

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1. Purpose and Scope. This Chapter establishes the procedures to be followed for debarment of medical care providers under section 7 of the Act, and 20 C.F.R. sections 702.431 to .436. These procedures also apply, where specified, to the debarment of claims representatives under section 31 of the Act, and 20 C.F.R. section 702.131.

The debarment process consists of three distinct steps: (a) investigation and collection of evidence, 20 C.F.R. section 702.414; (b) a notice of initiation of debarment proceedings, 20 C.F.R. section 702.432(b); and (c) a notice of intent to debar, 20 C.F.R. section 702.432(e).

2. Policy.

1. **Physicians or Health Care Providers**. According to section 7(c) of the Act, the Secretary shall annually publish a list of physicians and health care providers not authorized to render medical care or provide medical services under the Act. Such physicians or health care providers shall be debarred if it is found, after appropriate investigation and a formal hearing (if requested), that such physician or health care provider has:
    a. knowingly and willfully made, or caused to be made, any false statement or misrepresentation of a material fact for use in a claim for compensation or claim for reimbursement of medical expenses under the Act;
    b. knowingly and willfully submitted, or caused to be submitted, a bill or request for payment under the Act containing a charge which the Director, OWCP finds to be substantially in excess of the charge for the service, appliance, or supply prevailing within the community or

in excess of the provider's customary charges, unless the Director, OWCP finds there is good cause for the bill or request containing the charge;

c. knowingly and willfully furnished a service, appliance, or supply which is determined by the Director, OWCP to be substantially in excess of the need of the recipient thereof or to be of a quality which substantially fails to meet professionally recognized standards; or

d. been convicted under any criminal statute, without regard to any pending appeal thereof, for fraudulent activities in connection with federal or state programs for which payments are made to physicians or providers of similar services, appliances, or suppliers; or has otherwise been excluded from participation in such programs.

2. **Claims Representatives**. The Secretary will also annually publish a list of individuals who are disqualified from representing claimants under the Act. Individuals on this list are not authorized to represent claimants under the Act subject to the provisions of section 31(b)(2)(C), and they shall not have their representation fee approved as provided in section 28(e). Individuals shall be included on the list if the Secretary determines, after proceedings under 20 C.F.R. section 702.432(b) to .434, that such individual:

    a. has been convicted (without regard to any pending appeal) of any crime in connection with the representation of a claimant under the Act or any workers' compensation statute;

    b. has engaged in fraud in connection with the presentation of a claim under this or any workers' compensation statute, including but not limited to knowingly making false representations, concealing or attempting to conceal material facts with respect to a claim, or soliciting or otherwise procuring false testimony;

    c. has been prohibited from representing claimants before any other workers' compensation agency for reasons of professional misconduct which are similar in nature to those which would be grounds for disqualification under this Act; or

d. has accepted fees for representing claimants under the Act which were not approved, or which were in excess of the amount approved pursuant to section 28 of the Act.

3. Receipt of Complaint or Other Information. When information concerning any activity or action described in subparagraphs 2a and 2b is received it is to be recorded by the DD. This information may be in the form of a written complaint, a memorandum from a CE or may originate from a review of the case file by the DD. The information is to be recorded in a chronological log which is to be permanently maintained. The log is to include the following items: the name and address of the health care provider or claims representative; the source of the information; and a description of the complaint or information. A separate folder is to be maintained for each health care provider or claims representative, separate from the administrative files.

4. Investigation and Collection of Evidence. All complaints must contain sufficient documentation. Please refer to PM 5-500.4a for a discussion of the burden of proof. The DD will evaluate the complaint and the supporting evidence to determine whether further proceedings will be undertaken.

1. **Guidance**. In evaluating information throughout the debarment process the DD should consult with the OWCP District Medical Advisor and the Regional Solicitor's Office.
2. **Insufficient Evidence**. If the DD determines that the evidence submitted is insufficient or that the complaint is not an appropriate basis for debarment, the complainant is to be so advised by a letter over the signature of the DD. The letter should indicate: (1) that, for future reference, a file has been created concerning the complaint; (2) that the evidence submitted is not sufficient to initiate debarment proceedings; and (3) that additional evidence may be submitted.
3. **Sufficient Evidence**. If the DD determines that the documented complaint is sufficient, or that the additional evidence submitted is adequate, to show a violation prima facie, a copy of the complaint, together with the supporting evidence, is sent to the respondent (the health care provider or claims representative) for comment. When a reply is received from the respondent,

the DD reevaluates the complaint and makes a determination on whether or not to proceed further.

a. **Meeting**. The DD may provide for a meeting with the complainant and the respondent if, in the opinion of the DD, such a meeting might resolve the issue.

b. **No Further Proceedings**. If the DD determines that further proceedings are not indicated, the complainant is to be advised by letter over the signature of the DD with a copy sent to the respondent. This letter should include a copy of the reply from the respondent. The decision of the DD, that debarment proceedings will not be initiated, is final and not subject to appeal or formal hearing.

c. **Further Proceedings**. If the DD determines that further proceedings are indicated, the Regional Solicitor's Office should be consulted for an analysis of the merits of the case and advice on what additional evidence may be necessary. The DD is to send a notice of initiation of debarment proceedings to the respondent.

5. Notice of Initiation of Debarment Proceedings. This notice is to include the following items (see Draft Notice to Initiate Proceedings, Exhibit 10, PM 10-300):

1. **A concise statement** of the grounds upon which debarment may be based;
2. **A summary** of the information upon which the DD has relied in reaching an initial decision that debarment proceedings should be initiated;
3. **An invitation** to the physician, health care provider, or claims representative to:
    a. resign voluntarily from participating in the program without admitting or denying the allegations presented in the written notice; or
    b. request a decision on debarment to be based upon the existing agency record and any other information the physician, health care provider, or claims representative may wish to provide;
4. **A notice** of the physician's, health care provider's, or claims representative's right, in the event of an adverse ruling by the DD, to request a formal hearing before an administrative law judge;

5. **A notice** that, should the physician, health care provider, or claims representative fail to provide written answer to the written notice of initiation of debarment proceedings within thirty days of receipt, the DD will deem the allegations to be true and will order exclusion of the physician, health care provider, or claims representative without conducting further proceedings; and
6. **The name** and address of the DD who shall be responsible for receiving the answer from the physician, health care provider, or claims representative. Among other things, this notice provides for the submission of additional information which should allow the respondent an opportunity to present his or her position fully. The DD is to evaluate the evidence already collected together with any additional information submitted by the respondent. The DD should then make written findings of fact and a decision on whether or not to proceed with the debarment.

   If the respondent does not make a reply to the Notice of Initiation of Debarment Proceedings, the DD may use the information described in subparagraph 5b as the findings of fact. The fact that a physician, health care provider, or claims representative has been convicted of a crime described in subparagraphs 2a and 2b above, or excluded or suspended or has resigned in lieu of exclusion or suspension, from participating in any workers' compensation program, shall be a prima facie basis for a finding of fact.

6. <u>No Debarment</u>. If the DD determines that debarment is not warranted, a letter is sent to the respondent and the complainant. A copy of the findings of fact is to be attached. The decision of the DD not to debar a health care provider or claims representative is not subject to appeal or formal hearing.

7. <u>Debarment</u>. If the DD determines that debarment is indicated, a written decision is issued which incorporates the findings of fact (see 20 C.F.R. section 702.432(e) and Exhibit 11, PM 10-300, Draft Decision To Debar). Such decisions should be served by certified mail return receipt requested, in order to document the date of receipt (critical with these decisions only). If the respondent does not file a request for a formal hearing within thirty days after receipt, the respondent is entered on the Secretary's list of those not authorized to provide medical care or services or to represent claimants. Debarment will not occur until the health

care provider or claims representative is placed on the Secretary's list. The district office should notify the NO when an individual or supplier is ready to be placed on the Secretary's list. Individuals or suppliers will not be placed on this list until after a formal hearing, if requested, 20 C.F.R. section 702.432(e).

8. Formal Hearings. 20 C.F.R. Section 702.433.

1. **A request** for hearing is sent to the DD who issued the decision. The request may be on Form LS-18, Pre-Hearing Statement (Exhibit 5, PM 10-200) or may be in letter form but it should contain a notice of the issues on which the physician, health care provider, or claims representative desires to give evidence at the hearing with identification of witnesses and documents to be submitted at the hearing.
2. **A request** for hearing must be received within thirty days after the Decision to Debar is received by the health care provider or claims representative (see section 7(j)(2) of the Act). If a request for hearing is received by the DD within that time, the matter shall be referred to the Chief Administrative Law Judge.
3. **A formal hearing** will be held, and at the conclusion of the hearing, the administrative law judge will issue a recommended decision. This decision will contain appropriate findings, conclusions and a recommended order. The administrative law judge should forward the recommended decision and order, together with the record of the hearing, to the Department of Labor’s Administrative Review Board for a final decisions. The recommended decision and order shall be served on all parties to the proceeding (see 20 C.F.R. section 702.433(e)).
4. **Based upon** a review of the record and the recommended decision and order, the Administrative Review Board will issue a final decision. This decision will be mailed to all parties to the proceeding.

9. Appeal. 20 C.F.R. Section 702.434.

1. **Any physician**, health care provider, or claims representative may obtain review of the Assistant Secretary's decision by a civil action commenced within sixty days after the mailing of the decision. However, this civil action will

not act as a stay of the effect of the Assistant Secretary's decision to debar the physician, health care provider, or claims representative.

2. **The civil action** shall be brought in the Court of Appeals of the United States for the judicial circuit in which the plaintiff resides or has his or her principal place of business.

10. Effects of Debarment.

1. **Physicians** and health care providers included on the Secretary's list are not authorized to render medical care or provide medical services under the Act. However, a claimant may be reimbursed for any otherwise reimbursable medical treatment, service, or supply received from a debarred provider in an emergency situation. In such a situation, the DD should advise the claimant to select a duly qualified health care provider at the earliest medically appropriate opportunity.
2. **Claims representatives** included on the Secretary's list may not have their fee approved pursuant to section 28 of the Act and an employer is not liable to pay a representation fee to such individual. However, the fact that a claims representative is included on the Secretary's list will not prevent that individual from presenting his/her own claim or from representing, without a fee, a claimant who is his/her spouse, mother, father, sister, brother, or child.
3. **Debarment** shall be for a period of not less than three years and until the DD finds and gives notice to the public that there is reasonable assurance that the basis for the debarment will not reoccur.

11. The List.

1. **The Secretary's** list of physicians and health care providers not authorized to render medical care or provide medical services under the Act shall be sent to:
    a. All Longshore DO's;
    b. The Health Care Financing Administration;
    c. The State or Local authority responsible for licensing or certifying the debarred party;

d. All ECs and other interested parties; and

e. The general public by posting in the DO in the jurisdiction where the debarred party maintains a place of business.

2. **If a claims representative** is placed on the Secretary's list of individuals not authorized to represent claimants under the Act notice shall be sent to those groups listed in subparagraph a, numbers 1, 3, 4 and 5 above.

12. Reinstatement.

1. **If a physician** or health care provider has been debarred for the reason set forth in subparagraph 2a(4) above or if a claims representative has been debarred for the reasons set forth in subparagraphs 2b(1) and (3) above, the individual debarred will be reinstated upon notice to the DD that the conviction or exclusion has been reversed or withdrawn. When such a notice is received by the DD it should be sent to the NO by separate memorandum. The NO may also determine that debarment proceedings should be reinstituted based upon the subject matter involved.
2. **A debarred individual** may apply for reinstatement to practice under the Act after three years from the date of entry of the order of debarment. Such application should be addressed to the Director, DLHWC and should be submitted through the DD. The application must contain a statement of the basis for reinstatement along with any supporting documentation. The applicant should also promise that the basis for the debarment will not be repeated. The DD should review this application and submit it to the NO together with a recommendation either for or against the reinstatement.
3. **As part** of the reinstatement process, the Director, DLHWC may require special reporting procedures for the applicant for a probationary period not to exceed six months. During this period, the DD shall monitor the activities of the applicant in connection with providing any service under the Act.
4. **At the conclusion** of the six-month probationary period the DD shall prepare a memorandum covering the activities of the previously debarred individual during that period and make a recommendation either for or against reinstatement. If the DD determines that continued debarment is indicated the

DD shall issue a written decision which incorporates his/her findings of fact concerning the investigation of the merits of the reinstatement application and results of the probationary period, and repeat the procedures as provided in paragraph 5-600.7, above

5. **The physician**, health care provider, or claims representative will be reinstated if it is determined that such reinstatement is consistent with the goal of preventing further fraud and abuse.

Chapter 6-0100, Introduction

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1. Purpose and Scope	09/00	00-01
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1. Purpose and Scope. This Part of the LHWCA PM discusses the Special Fund created under the provisions of section 44 of the Act. By establishment of the Special Fund, Congress intended to provide non-government money for a variety of uses, to be administered under the direction of the Secretary of Labor and, by delegation, the DLHWC. Chapter 6-200 provides an overview of the uses of the Special Fund. Chapter 6-201 contains specific procedures for processing section 8(f) application for relief from the Special Fund. Chapter 6-202 contains procedures for processing cases for payment under section 18(b) of the Act where the employer and carrier are defunct. Chapter 6-203 contains procedures for processing payments from the Special Fund in cases where section 8(f) relief has been awarded by compensation order.

2. Authority and Purpose.

1. **Legislative Authority for the Special Fund**. The Special Fund was established in the U.S. Treasury by section 44 of the Act, to be administered by the Secretary of Labor. The Treasurer of the United States is the custodian of the Fund, and the monies and securities in the Fund are held in trust and are not the money or property of the United States. Disbursements are made from the Fund on the order of the Director, OWCP, acting for the Secretary. There is a separate Fund maintained under the District of Columbia

Workmen's Compensation Act and administrated in the same way as the LHWCA Special Fund.

2. **Purpose of the Special Fund**. In establishing the Special Fund, Congress intended to relieve an individual EC of the burden of paying for the full compensation benefits due the employee who was previously partially disabled but was hired or retained by the EC, to share the burden of paying compensation in the event of an insolvency of an EC and to pay for certain rehabilitation services which are otherwise not available.

3. Sources.

1. **The Act** provides the following sources of money for the Special Fund:
    a. For the death of a covered employee having no eligible beneficiary, the EC is required to pay $5,000 (see section 44(c)(1)).
    b. Since an award for disability may be made after the death of an injured employee, if there are no statutory survivors, the balance of the award unaccrued and unpaid at the time of death shall be paid into the Fund (see section 8(d)(3) and Wilhilmina Wood v. Ingalls Shipbuilding, Incorporated, 28 BRBS 27 (1994)).
    c. An annual assessment against ECs (see section 44(c)(2)).
    d. All amounts collected as fines and penalties under the Act (e.g., for failure or delay in filing a report of injury, and failure or refusal to comply with safety rules and regulations).
2. **Any payments** made by the Special Fund are a lien upon the proceeds of any settlement obtained from or judgment rendered against a third person (see section 33(g)(3)).
3. **All monies** collected are made payable to the U.S. Department of Labor, Longshore Division and mailed to the National Office, DLHWC, for deposit in the Special Fund.

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1. Purpose and Scope. This Chapter describes the uses of the Special Fund, procedures for authorizing use of the Fund and provides references to other Procedure Manual Chapters which contain specific procedures pertaining to use of the Fund.

2. Uses of the Special Fund. The Fund is used for payment of individual amounts as specified under various sections of the Act. The sections providing for benefits or other payments from the Special Fund are:

1. **Medical Examination under Section 7(e)**. The cost of medical examinations ordered by the DD may be charged to the EC or, in certain specific instances, to the Special Fund. (See PM 5-200.11.)
2. **Payment under Section 8(f)**. The liability for payment by an EC may be limited if certain requirements have been met. (See PM 6-201.)
3. **Payment under Section 10(h)**. Adjustments for pre-1972 PTD and death cases to bring benefits to post-1972 levels are paid from the Special Fund. (See PM 3-203.)
4. **Payments under Section 18(b)**. This section of the Act provides for payments where the insolvency of the EC or other circumstances would otherwise preclude payment of benefits. (See PM 6-202.)
5. **Maintenance Payments under Section 8(g)**. This section of the Act provides for payment of those extra expenses that a disabled claimant incurs as a result of participation in an approved vocational rehabilitation program. These payments may not exceed $25 per week and are authorized by a rehabilitation specialist. Questions regarding such payments should be directed to the DO Rehabilitation Specialist. (See Chapter 3-500 of the OWCP Rehabilitation Procedure Manual.)
6. **Rehabilitation Services under Section 39(c)**. The Special Fund may be utilized to provide rehabilitation services for permanently disabled workers where such services are not otherwise available. Present practice is to pay for

most such services, other than for medical rehabilitation, from the Special Fund. The development and implementation of rehabilitation plans are the responsibility of the Rehabilitation Specialist. (See PM 3-301.3g and OWCP Rehabilitation Procedure Manual Chapters 3-200 and 3-300.)

7. **Prosthetic Appliances under Section 39(c)(2).**
    a. Purchase or repair of prosthetic devices under section 39(c)(2) at the expense of the Special Fund may be provided in the following situations: if the file shows that OWCP (or its predecessor) had previously purchased or repaired the prosthesis under authority of this subsection (See LHWCA MEMO No. 9, March 4. 1965, a copy of which may be obtained from the National Office, if needed); and if, because of unusual circumstances such as the EC being out of business or bankrupt, the service cannot be provided otherwise. In a case coming under section 8(f) requiring a prosthetic appliance, if the EC obtains the initial device, replacements may be authorized by the DD at the expense of the Special Fund, after obtaining approval of the NO.
    b. The following procedures for authorizing the purchase or repair of prosthetic appliances must be used:
        i. Obtain a written statement from the injured employee requesting repair or replacement of the prosthesis.
        ii. On receipt of the request, refer the claimant for examination, if indicated, to an appropriate physician for advice as to the need for replacement or repair of the prosthesis. An estimate of the cost should be obtained and submitted for the DD's approval.
        iii. The DD will notify the parties to proceed with the repair or replacement of the prosthesis.
        iv. After completion of the authorized services, the employee should furnish a statement of satisfaction. The vendor should submit a bill on its regular billing form or government voucher.

v. The DD refers copies of the request, authorization, certification of satisfaction, and bill for payment to the Director, DLHWC.

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1. Purpose and Scope. This Chapter contains the procedures associated with requests for relief under section 8(f) of the Act. These procedures cover: the request for relief, section 8(f)(3) and 20 C.F.R. section 702.321(b); the application, 20 C.F.R. section 702.321(a); and the consideration of the application by the DO.

2. Policy.

1. **Absolute Defense**. Public Law No. 98-426, the Longshore and Harbor Workers' Compensation Act Amendments of 1984, made a significant change in how the issue of section 8(f) relief is handled. Section 8(f)(3) of the Act now reads:

   Any request . . . for apportionment of liability to the special fund established under section 44 of this Act for the payment of compensation benefits, and a statement of the grounds therefore, shall be presented to the deputy commissioner prior to the consideration of the claim . . . .

Failure to comply with this requirement will be an absolute defense to the liability of the Special Fund.

When section 8(f) of the Act was amended Congress intended:

to encourage employers to raise the special fund issue early in the claims adjudication process, in order to assure the deputy commissioner and the Director of OWCP the opportunity to examine the validity of the employer's basis for seeking special fund relief. H. R. Rep. No. 1027, 98th Cong. 2d Sess. 31 (1984).

The regulations developed by the Department to implement this section of the Act, 20 C.F.R. section 702.321, are meant to insure that the accompanying statement of the grounds is complete enough so that the DD, and the Director, OWCP have sufficient evidence to examine the validity of the request for relief. In formulating these regulations the Department wanted to balance the needs of the claimant for a speedy formal hearing where benefits are not being paid and the needs of the EC for adequate time to develop their section 8(f) application. When reviewing cases where section 8(f) relief is an issue the DO is to apply the regulations and these procedures in a manner consistent with the Congressional intent noted above and consistent with the Department's desire to mediate the apparently conflicting needs of the claimant and the EC.

2. **Combining Section 8(f) Relief with Settlement Under Section 8(i)**. Section 8(f) relief is not appropriate where the parties have entered into a section 8(i) settlement (see section 8(i)(4)). However, some district offices have been presented with applications for section 8(f) relief for hearing loss combined with section 8(i) settlement for the employer/carrier for their portion of the hearing loss. This situation has been reviewed and it has been determined that approval of such applications conflicts with the statute. Section 8(i)(4) precludes an employer or carrier from seeking relief from the Special Fund after reaching settlement with a claimant in a case that would ultimately be assigned to the Fund.

In enacting section 8(i) Congress expressed its specific intent to overturn the decision in Brady v. J. Young & Co., 16 BRBS 31 (ALJ) 1983 (See also 17 BRBS 46). This decision ordered the Fund to reimburse the employer for all sums paid to the claimant under the approved settlement, minus 104 weeks of compensation, finding the employer otherwise entitled to such relief. Congress added section 8(i)(4) to the statute to prohibit Special Fund contributions to section 8(i) settlements and thereby reduce the possibility of collusion or fraud between the settling parties and to ensure that the employer acknowledges its actual liability to the claimant before it requests section 8(f) relief.

Of course, an employer is always free to settle a claim. However, a section 8(i) settlement, which discharges the employer's potential liability, also discharges the potential liability of the Special Fund, which is only derivative.

The objection that may be raised when we deny these applications is that we may prevent a claimant from receiving any compensation at all, since an employer may be willing to pay a reduced amount in order to avoid litigation, but unwilling either to pay the full amount of compensation or to give up relief under section 8(f). But whether or not litigation might be avoided in a particular case, it is our role to ensure that the statutory prohibition against fund contributions to settlements be followed. It is also our role to administer the Act in as even-handed a manner as possible, and thus to ensure both that claimants receive the benefits they are entitled to, and to ensure that claims not be improperly placed in the fund, where costs are spread over the industry rather than borne by an individual employer without the findings required by section 8(f).

a. **Contingent Relief**. Thus, if an employer applies for section 8(f) relief but is unwilling to agree to the entry of a compensation order, or to pay the full amount of benefits claimed without such an order, and it is otherwise appropriate to grant such relief, section 8(f) relief may be granted CONTINGENT ON THE ENTRY OF A COMPENSATION AWARD FOR PERMANENT DISABILITY. The following language is

suggested to be used in referral letters when contingent relief is appropriate if the case is appealed to the OALJ:

Section 8(f) has been considered and in the event the Administrative Law Judge assigned the case determines that a compensation order, awarding benefits for permanent disability (excluding a nominal award), is appropriate, the Director agrees to the application of section 8(f) relief and payment by the Special Fund. See Todd Shipyards Corp. v. Director, OWCP (Poras), 792F.2d 1489 (9th Cir. 1986) (an employer is not entitled to section 8(f) relief from a nominal award because, as a matter of law, any pre-existing permanent partial disability can not materially contribute to the current disability.) In such event, payment by the Special Fund should commence 104 weeks(or the appropriate period if a scheduled award) after the date the evidence establishes that the claimant reached maximum medical improvement. In no event does the Director agree to the application of section 8(f), or payment by the Special Fund, in any settlement of the claim. 33 U.S.C. 908(i)(4).

While it may be appropriate to determine that the requirements for such relief have been established, it is nevertheless also always necessary to defer actual approval until compensability has been determined and embodied in a compensation award, or until the employer has agreed to pay the full amount of benefits claimed. If the parties, in good faith, want to compromise on any of the findings underlying section 8(f) relief, including the nature and extent of the claimant's disability, and the settlement is approved under section 8(i), the employer has no entitlement to section 8(f) relief.

If the parties cannot agree to the entry of a section 8(i) award, because the claimant believes he is entitled to the full-uncompromised award, the case must be referred to formal

hearing. If section 8(f) would be otherwise appropriate in the absence of a section 8(i) settlement of the claim, the Solicitor's office should be alerted to inform the ALJ that the Director agrees to section 8(f) relief contingent upon an award of permanent disability.

b. **Hearing Loss Cases**. In hearing loss cases, you may enter a compensation award that grants section 8(f) relief, based upon a stipulation of facts that you approve. The award, however, should not be based on a compromised disability rating for less that the record reflects simply because one side theorizes that it can seek another audiogram which will show the compromised rating. Instead, the district office should make a factual determination, based on the evidence, regarding the appropriate level of compensation. For example, if audiogram X establishes the preexisting hearing loss; audiogram Y establishes an increased disability rating; but audiogram Z indicates a lesser amount of disability than audiogram Y, it is up to you as the fact finder to determine which of these audiograms is reflective of the degree of hearing loss or whether an amount in between may be the appropriate amount. If the parties agree with your assessment of the appropriate amount, you may then issue a compensation order which also grants section 8(f) relief, allocating the amount payable by the employer and the Special Fund. In such instance, because you have resolved the issue by findings of fact and not by approving a compromise of liability, this is not a settlement and should not be characterized as a section 8(i) order, or an approval of a section 8(i) agreement.

   When the parties request approval of a settlement agreement order based upon a preexisting audiogram and a subsequent audiogram, if you determine that the stipulated amount is not adequate, deny the request for approval. Your referral to the OALJ should, of course, explain why the stipulated amount is inadequate. The referral to the OALJ should also state that although section 8(f) relief is not appropriate unless the ALJ first

finds that the claimant has a compensable permanent disability, the employer met the requirements for such relief in all other respects. Further explain, explicitly, that if a section 8(i) agreement is approved, the Fund cannot be liable and that section 8(f) relief must be denied if a section 8(i) agreement is approved. Again, the Solicitor's office should be alerted to set forth this position to the ALJ.

The Associate Solicitor has notified the Regional Solicitors of this policy. The Associate Solicitor has also advised the Regional Solicitors that a case should be referred to the Employee Benefits Division in SOL's National Office for consideration of appeal upon your request if an ALJ grants an employer's application for section 8(f) relief in conjunction with the entry of a section 8(i) order.

c. **Section 10 (h)**. For similar reasons, a section 8(i) settlement agreement that provides for continuing payments by the Special Fund of annual increases pursuant to section 10(h) should not be approved. Since a section 8(i) settlement discharges the employer's liability, it also discharges the Fund's derivative liability and continuing payments are not consistent with that discharge of liability. Section 8(i)(4) precludes the Fund from liability for "any sums paid or payable" under a section 8(i) settlement, whether the amounts agreed to are based on section 8(f) or section 10(h) of the statute.

3. <u>Request for Section 8(f) Relief</u>. Consideration of the section 8(f) issue begins with a request for section 8(f) relief.

1. **Time for Submission of the Request**. The request should be made as soon as the permanency of the claimant's condition becomes known or is an issue in dispute. Where the claim is for death benefits, the request should be made as soon as possible after the date of death. This is intended to have ECs raise this issue early in the claims adjudication process, in order to assure that the

DD, the DC and the Director, DLHWC have the opportunity to examine the validity of the request for section 8(f) relief. Events that give rise to the EC's obligation to raise section 8(f) are:

a. The issue of permanency is raised at the informal conference;
b. The EC is voluntarily paying permanent disability benefits; or
c. The EC has knowledge that the claimant's condition is permanent (see Cajun Tubing Testors v. Hargrave, 25 BRBS 109 (CRT), 951 F.2d 72, 25 BRBS 109(CRT)(5th Cir. 1992)).

Where permanency is in dispute, this fact should not be used as a basis for denying section 8(f) relief. Rather, a determination as to appropriateness of section 8(f) relief should be made using the assumption that permanency has been established.

2. **Permanency or Death Not An Issue**. If permanency is not an issue, or if benefits are being paid for temporary disability, as opposed to permanent disability or death, the request need not be made until permanency or death becomes an issue. In all other cases, a request for section 8(f) relief, together with a complete application (described below) must be presented to the DD before the case is referred to the OALJ for a formal hearing.

4. Statement of the Grounds for Section 8(f) Relief.

1. **The Application**. Section 8(f)(3) of the Act requires that a statement of the grounds accompany any request for relief of liability. For purposes of these procedures this statement of the grounds is referred to as an application.
2. **A Complete Application**. An application must contain the following information:
    a. A specific description of the pre-existing condition relied upon as constituting an existing permanent partial disability including evidence that the condition was permanent prior to the second injury.
    b. The reasons for believing that the claimant's permanent disability after the injury would be less were it not for the pre-existing permanent partial disability or that the death would not have

occurred but for that disability. These reasons must be supported by medical or vocational evidence as specified in (4) below.

c. Evidence to show that the pre-existing permanent partial disability was manifest to the EC prior to the second injury, either actually or constructively. However, see Newport News Shipbuilding and Dry Dock Company v. Harris, 24 BRBS 190(CRT), 934 F.2d 548 (4th Cir. 1991), wherein the Fourth Circuit Court of Appeals limited the manifest requirement in post-retirement occupational disease cases.

d. Documentary medical evidence to support the request for section 8(f) relief which should include impairments and the date of maximum medical improvement.

    i. If the current disability is total, the medical evidence must demonstrate that the disability is not due solely to the second injury (see Director, OWCP v. Luccitelli et al., 964 F.2d 1303 (2d Cir. May 1992); and LHWCA Circular No. 92-02.); and, that, in the absence of the pre-existing disability, the worker would otherwise be employable (see Director, OWCP v. Jaffe N.Y. Decorating, 25 F.3d 1080 (DC Cir. 1994).

    ii. If the current disability is partial, the medical evidence must explain why the disability is not due solely to the second injury and why the resulting disability is materially and substantially greater than that which would have resulted from the subsequent injury alone. (See Newport News Shipbuilding and Dry Dock v. Director, [Harcum II] ___ F.3d ___, 31 BRBS 164(CRT)(4th Cir. 1997)

    iii. If the injury is loss of hearing, the pre-existing hearing loss must be documented by an audiogram which complies with the requirements of 20 C.F.R. section 702.441 (see PM 3-401). It should be noted that the two most recent audiograms available can be utilized by the EC for asserting a claim for Section 8(f) relief. While the use of

recent audiograms may place greater liability on the Special Fund than would otherwise be the case, the EC cannot be required to base its request for relief using only the oldest certified audiogram versus the most recent audiogram of record. Similarly, the employer cannot be required to base its request for relief using a pre-employment audiogram (see Risch v. General Dynamics, 22 BRBS 251). Also relief cannot be denied where the employer administers audiograms to an employee and allegedly does not inform him of the results or file an injury report, but then uses those audiograms in connection with the request for Section 8(f) relief (see Skelton v. Bath Iron Works, 27 BRBS 28).

iv. If the claim is for survivor's benefits, the medical report must establish that the death was not due solely to the second injury. The District Office should obtain the death certificate and a copy of the autopsy report where available.

v. If the EC claims entitlement to section 8(f) relief for both a disability and death claim, its application must satisfy the statutory requirements for both claims.

3. **An Application Must Be Submitted In Duplicate**. This is to insure that a copy can be used by the Solicitor's Office, in preparation for a hearing, while the original remains in the case file. If an application is not submitted in duplicate, DOs may need to reproduce the application which is an added unnecessary expense. The application is the burden of the EC who directly benefits from section 8(f) relief, and should therefore be submitted in duplicate. Where an application is determined to be deficient, a copy of the application should be kept in the administrative file and not returned to the EC. Should the case be referred for formal hearing, the copy may be needed for possible absolute defense purposes.

4. **The DO Should Closely Monitor Section 8(f) Cases**. It is important to insure that all applications are submitted in duplicate and contain all the information described above. Failure to monitor cases at the DO level will result in cases being returned by the NO for additional information.

5. Submission of the Application.

1. **General Guidelines**. The DD sets the date for the submission of the fully documented application. In setting this date the DD should allow sufficient time for the EC to gather the necessary information while insuring that the claimant's right to a timely hearing is preserved. The DD should also try to have the application submitted prior to the expiration of the 104 week period. This is desirable because the Special Fund has been found liable for interest on reimbursements to ECs for payments made in excess of the 104 week period and we want to minimize this liability. Particular attention should be given to cases where the EC continues to pay benefits voluntarily and the natural tendency would be to allow the application process to be prolonged. These are general criteria which the DD should apply to the facts of each case. More specific guidance on the selection of the date for submission of the application follows. Also see 20 C.F.R. section 702.321(b).
2. **Notice of the Informal Conference**. Both 20 C.F.R. section 702.321(b) and section 702.313 require that the notice of the conference specify the matters to be discussed. Therefore, form LS-141, Notice of Informal Conference (See Exhibit 13, PM 10-200), is to include all the issues to be discussed at the conference. All parties are required to list issues reasonably anticipated to be discussed at the conference when the initial request for a conference is made and to notify all parties of additional issues which arise during the period before the conference is actually held.
3. **Permanency Or Death An Issue Before Informal Conference**. Where notice is given to all parties that permanency or death is to be an issue at an informal conference, the fully documented application shall be submitted at or before the conference. Therefore, if permanency or death is an issue, care should be taken in scheduling the conference since the complete application must be

submitted at that time. In such cases the EC should be allowed sufficient time to gather the information necessary for a complete application.

4. **Issue of Permanency Or Death First Raised At An Informal Conference**. Where the issue of permanency or death is first raised at the informal conference and could not have reasonably been anticipated by the parties prior to the conference, the DD or CE shall interrupt the conference and set the date by which the fully documented application must be submitted and so notify the EC. With the concurrence of the parties the conference may be resumed. The date shall be set after reviewing the circumstances of the case and considering the factors listed in subparagraph 5f, below. In setting the date, the DD should attempt to balance the needs of the claimant for a speedy trial and the needs of the EC for sufficient time to develop its application.
5. **Cases Where the EC Denies Any Disability**. In cases where a claim is made for permanency but the EC maintains that there is no disability or that maximum medical improvement has not been reached, the DO should make a determination based upon the evidence of record. If additional medical evidence is needed an impartial medical evaluation should be scheduled. Based upon the evidence in the case file the DO should either set the date for submission of the application or indicate that the claimant has not reached maximum medical improvement.
6. **Other Factors and Extensions.**
    a. In fixing the date for submission of the application under circumstances other than those described above, or in considering any request for an extension of the date selected, the DD shall review all the facts of the case, including, but not limited to:
        i. Whether the claimant is being paid compensation and the hardship to the claimant of delaying referral of the case to the OALJ;
        ii. The complexity of the issues and the availability of medical and other evidence to the employer;
        iii. The length of time the employer was or should have been aware that permanency or death is an issue; and

iv. The reasons listed in support of a request, where the EC has requested an extension or a specific date.

b. Extensions should only be granted for good cause and in such a way that the timely adjudication of the claim is not adversely affected. However, neither the date selected for submission of the fully documented application nor any extension therefrom can go beyond the date the case is referred to the OALJ for formal hearing.

7. **Where Permanency Or Death Is Not An Issue**. Where the claimant's condition has not reached maximum medical improvement or no claim for permanency or death is made by the date the case is referred to the OALJ, an application need not be submitted to the DD to preserve the EC's right to later seek relief under section 8(f).

8. **Absolute Defense**. It is important to set a firm date for the submission of the application. Once the date for submission of the application has passed, the EC should be advised in writing: that the claim for section 8(f) relief is denied due to its failure to file a timely application; that the absolute defense will be asserted; and, that the case will be referred for formal hearing. The Solicitor's Office should be notified and requested to assert the absolute defense. (See paragraph 9 below, and the case of Quinlan v. Dravo Corporation, 20 BRBS 802). Also, where a case involving potential 8(f) relief is referred for formal hearing, the transmittal memorandum to the OALJ should contain a specific statement as to whether section 8(f) relief has been raised by the EC. (see the case of Hawthorne v. Ingalls Shipbuilding, 29 BRBS 103).

6. <u>Review of the Application.</u>

1. **General.**

a. Although we do not condone nor encourage the filing of premature applications, there is no prohibition in either the statute or the regulations against an EC submitting an application before the issue is ripe for adjudication. If an EC submits an application for relief and the DO concludes that it is premature, i.e. permanency is not an issue, the application should not be returned to the EC. It should be

placed in the case file and the EC so notified. Any evidence submitted with the application may be used in evaluating the claim for compensation.

b. Upon receipt of the application the DD should review it to insure that all the required evidence was submitted. If any required evidence is missing or if the DD determines that additional evidence is necessary the EC should be notified and given the opportunity to submit the evidence. If the EC does not submit the evidence, or if the evidence submitted is found to be unsatisfactory, the DD is to deny the application.

c. When the application is received, the DD or CE must enter the date of receipt and the code '8far' on the LCMS Diary Tab. This code, and the corresponding date, are also to be entered upon receipt of any additional evidence requested from the EC.

d. If the application for relief does not specify whether it is for partial or total disability, the entire case file, including evidence submitted by the claimant, is to be evaluated in making this determination. Only by a reviewing all the evidence of record can the DO make a reasoned judgment concerning the nature and extent of the claimant's disability and the claimant's possible entitlement to benefits. This will also establish the basis for the request for section 8(f) relief which is contingent on the injured employee's claim for compensation.

e. The DD should use the initial review of the application as an opportunity to provide technical assistance to the EC so that full compliance with the regulations and these procedures can be achieved. This is particularly important where the EC does not have much experience with the section 8(f) issue. Any deficiency in the application should be noted and the EC should be given the opportunity to correct the deficiency. This process is to be followed initially with all ECs. However, if an employer continues to submit deficient applications, the DD may act on the application as submitted.

f. In reviewing these applications, the DD is acting on behalf of the Director, OWCP, who is the administrator of the Special Fund. Therefore, the DD is to consider how issues will impact on the position of the Special Fund.

g. The DD should attempt to resolve all outstanding issues to the extent possible. Conflicts in medical evidence concerning the nature and extent of the claimant's disability or the pre-existing disability are to be resolved. Impartial medical evaluations are to be used in cases where the evidence does not conflict but, in the opinion of the DD, the evidence submitted by the parties is non-determinative. In arranging for an impartial medical evaluation, the DD should follow the procedures outlined in PM 5-200.10 and PM 5-400.10.

h. The DD should make a determination, in occupational disease cases, whether the disease became manifest (i.e., significant symptoms) before or after retirement. This is important for consideration of the section 8(f) issue since it determines the level of benefits (i.e., partial or total) to which the employee is entitled and the corresponding medical evidence required in the EC's application (see subparagraph 4b(4)(a) or (b), above). Where the claimant's disability is first manifest after retirement, the claimant is entitled to benefits only for permanent partial disability based on a percentage of permanent impairment (see section 8(c)(23) and 20 C.F.R. section 702.601).

2. **Time To Review The Application.**

a. The DD shall review the application (or have it reviewed by a CE) within forty-five days of receipt and take one of the following actions:

i. Identify any deficiencies in the application or any other necessary evidence and return it to the EC for the submission of additional information (However, a copy of the application should be kept in the file.), or

ii. Make a recommendation for approval and transmit the case to the National Office for consideration, or

iii. Deny the application.

b. When the EC submits additional evidence, the DD (or CE) shall review the application and either transmit the case to the National Office with a recommendation for approval or deny the application within forty-five days.

c. Timely follow-ups on requests for additional information should be used so that the adjudication process does not lag. This is especially important in cases where the claimant is not being compensated. As noted above (subparagraph 5a) timely follow-up on deficient applications could lessen the amount of interest payable on reimbursements to ECs.

d. It is important to set a firm date for submission of the additional information and to follow through if the information is not submitted by this date. This will enable us to assert the absolute defense in those cases where it is appropriate.

e. Any special circumstances which caused the completed application to be submitted to the National Office later than forty-five days from receipt should be identified by the DD in the accompanying transmittal memorandum.

f. When the case is reviewed, or when the DO requests the EC to submit additional information, this date and the code '8fds' are to be entered in the LCMS on the Diary Tab. This code, and the corresponding date, are also to be used when the DO reviews any additional information submitted by the EC.

g. When an application is premature; that is, maximum medical improvement has not been reached, it is not in posture for review. The DD shall advise the EC by written correspondence that the application is premature, and the reason for which it is premature. The EC should be instructed to resubmit the application when permanency becomes an issue.

3. **Approval.**

a. Where EC has established the statutory requirements, the DD has the authority to approve section 8(f) relief in those cases which involve a loss of hearing both as the pre-existing condition and as the second injury.

b. All other cases must have the concurrence of the Director, DLHWC before a compensation order can be issued awarding section 8(f) relief. In order to secure the concurrence of the Director, the case must be referred to the National Office for review in accordance with paragraph 7 below.

c. When a claimant, who was receiving disability benefits from the Special Fund, dies, payment for any death claim will not be made from the Fund without the concurrence of the EC. In such cases, the DO should request a death certificate and determine whether the death was related to the accepted condition. The DO should make a recommendation on the payment of the death claim from the Special Fund and request the concurrence of the EC. When this concurrence is received, the matter should be referred to the National Office for review. (See PM 6-203, and paragraph 4b above.)

4. **Denial.**

a. Section 702.321(c) of the regulations allows for the delegation of the authority to deny the application for section 8(f) relief. This authority was delegated to the DDs effective April 17, 1987. (See Longshore Memorandum No. 17, April 17, 1987, a copy of which can be obtained from the National Office if needed.)

b. Our present policy is that the EC must be informed in writing of the deficiencies in the application before it can be denied. The EC must be given a reasonable amount of time to submit additional evidence to correct the deficiencies in the application. This must be done in every case, and can be an opportunity for the DO to provide technical assistance to the EC so that full compliance with the regulations and procedures can be achieved. This will also give us a firm basis to assert the absolute defense. If an EC repeatedly

submits deficient applications and previous letters have been unsuccessful in obtaining compliance with the regulations and procedures, the DD may deny the deficient application without further correspondence. However, the letter of denial must clearly list the reason(s) for the denial. The DD should recommend the absolute defense against these applications. When requesting Solicitor participation in these cases, a history of the EC's previous noncompliance should be included. (See subparagraph 9b, below.)

c. If an EC has been informed in writing of the deficiencies in the application for relief, and the EC has not corrected those deficiencies, the application may be denied. The application may also be denied where the EC has made a good faith effort to correct the deficiencies but the facts of the case do not warrant section 8(f) relief. For these purposes, a deficient application may be considered as one where the evidence submitted by the EC fails to relate to or discuss one of the three criteria for relief. The fact that the DO is not convinced by the EC's evidence does not necessarily render the application incomplete or deficient. In cases where the application meets the minimum requirements of the regulations but the DO determines that it does not support the administrative approval of section 8(f) relief, the application should be denied, but the absolute defense should not be asserted. In addition, where the EC makes a good faith effort to submit a complete application but the DO determines that the evidence does not support section 8(f) relief, the absolute defense should not be asserted. Instead, the application should simply be denied.

d. The denial of the application is to be issued as a letter over the signature of the DD.

e. The fact that the issue of nature and extent of the claimant's disability is in dispute is not an appropriate basis to deny the application. Furthermore, it is not our policy to deny the application merely because the parties have failed to agree on the nature and extent of

the claimant's condition. In cases where this issue is in dispute, the DO should assist the parties in the resolution of the dispute. This should be done, where possible, by means of informal conferences, impartial medical evaluations and rehabilitation evaluations.

f. If the DO denies the application and requests Solicitor participation at the hearing, evidence must be provided to support the denial. It is responsibility of the DO to see that this evidence is developed. Where an independent medical opinion is solicited, the DO should identify in the file the specific medical records that are sent to the physician, which form the basis for the doctor's opinion.

7. Referral to the National Office.

1. **Transmittal Memorandum.**

   a. All cases referred to the National Office for review must be accompanied by a memorandum over the signature of the DD which fully discusses the facts of the case. A form has been developed for this purpose. (See Exhibit 12, PM 10-300.) If this form is not used, or if it is not fully completed, the case will be returned to the DO.

   b. It is important for the transmittal memorandum to contain a narrative discussion in Items 13 through 16 in addition to referencing medical reports and EC exhibits. It is also important that a comprehensive discussion of any contested issues which impact on the section 8(f) issue, such as jurisdiction or nature and extent of disability, be included under Item 17. A discussion of the grounds for approval should also be included in Item 17.

   c. If the parties have stipulated to contested issues, the DO should fully explain how the stipulations were arrived at.

   d. Under Item 18, the DO should provide the basis for computing the compensation rate in PPD cases based upon a loss of wage earning capacity (LWEC). The claimant's pre-injury wage should be included as well as the actual or projected post-injury wage which forms the

basis for the LWEC determination. If an estimated wage is used, the DO should explain how it was established.

e. If all outstanding issues have been addressed in a recent conference memorandum, that memorandum may be attached and referenced.

f. The transmittal form is an internal form and it is to be completed only by DO personnel. Under no circumstances is it to be released to ECs for completion by them.

2. **The Case File Must Accompany the Transmittal Memorandum**. In addition, if the application concerns several injuries which were covered by the Act and the DO has case files on the injuries, these case files should also accompany the transmittal memorandum.

3. **Duplicate Applications**. Since the application may be voluminous it will not be necessary to send the duplicate copy to the National Office. The case file should be marked to indicate that a duplicate application was received and retained in the DO.

4. **All Issues Should Be Resolved**. If the DO recommends approval of the application, the case should not be referred to the National Office with unresolved issues. As with other cases, we expect the DO to informally assist in the resolution of all disputed issues. This should be done, where appropriate, by means of informal conferences, impartial medical evaluations, and rehabilitation evaluations. The DO should attempt to get the agreement of the parties on all issues, including the amount of the claimant's earning capacity, before the case is referred to the National Office. If the parties are unable to agree on any issue, the DO should still make a recommendation.

8. Action by the National Office.

1. **The Initial Review**. At the time of receipt in the National Office, the case file and transmittal memorandum will be reviewed to insure that all applicable procedures have been followed. If it is found that these procedures have not been followed, the case file and section 8(f) application will be returned to the DO for further action.

2. **The Review of the Issues**. The Director, OWCP is a party in interest to all claims. This authority, as well as the authority to review section 8(f) applications, has been delegated to the Director, DLHWC. The National Office may also determine that further development of some issues may be necessary before the application can be fully considered.
3. **Additional Development**. If the case file contains unresolved issues or if it appears that the evidence of record does not support or explain the stipulations of the parties, the case will be returned to the DO. The case may also be returned if the National Office determines that additional evidence is necessary. The DO should attempt to obtain the additional evidence as quickly as practicable so that any delay in the adjudication of the case can be minimized. The time frames listed above, in subparagraph 6b, should be observed.
4. **Approval of the Application.**
    a. If the evidence in the case file and the application support section 8(f) relief, the Director will advise the DD to issue a compensation order embodying the agreement of all the parties. Once this compensation order is issued, the DO should initiate the payment of benefits by following the procedures outlined in PM 6-203. If section 8(f) is an issue in a case, a compensation order should not be issued until all issues, including section 8(f), have been resolved.
    b. The "Fund First" rule provides that the Special Fund should receive credit for prior payments on an injury rather than giving it to the employer as the credit would result in a payment for less than the statutory obligation for the second injury. In the case of Director, OWCP v. Bethlehem Steel Corp., 868 F.2d 759, 22 BRBS 47 (CRT)(5th Cir. 1989), aff'g in part and rev'g in part Brown v. Bethlehem Steel Corp., 19 BRBS 200 and 20 BRBS 26 (1987), the court held that when a second scheduled injury (i.e., an injury which falls with section 8(c)(1) to 8(c)(20)) increases a claimant's pre-existing permanent partial disability and where this second injury alone results in over 104 weeks of compensation, then whenever a

credit for previous compensation paid as a result of the initial injury is available to offset the present amount due claimant, that credit shall first reduce the total award before there is any allocation of liability under Section 8(f). This reduction in the total award due as a result of the second injury will effectively apply the credit to the Special Fund's liability first, with any credit remaining to be applied against the employer's liability. The court further held that the amount of the credit to be allowed against the total award shall be the actual dollar amount of payment that was previously made to claimant as a result of the initial injury.

5. **Denial of the Application**. If the evidence does not support the application, section 8(f) relief will be denied by the Director. The Director is not bound by the stipulations of the other parties, and will not accept these stipulations if they are unreasonable or not supported by the evidence of record. If the application is denied, the DD will be informed by memorandum from the National Office. This memorandum is not to be released to the parties. The DD may use information from this memorandum when advising the parties of the reason(s) for the denial. The EC may then request a formal hearing. When the case is referred- to the OALJ, the DO is to notify the Solicitor's Office as outlined in paragraph 9 below.

9. Referral to the Solicitor's Office.

1. **Solicitor Defends the Denial**. If the application is denied, either by the DD or the Director, and the case is referred for a formal hearing, the DD should request Solicitor participation at the hearing to defend the denial. The Solicitor's Office has decentralized this responsibility to the Office of the Regional Solicitor. However, District Office 40 should continue to send their requests for representation to the Associate Solicitor for Employee Benefits in Washington, D.C.
2. **Memorandum to the Solicitor's Office**. A request for Solicitor participation at a formal hearing should be in the form of memorandum to the appropriate Solicitor's Office. This memorandum should include:

a. A copy of the application for section 8(f) relief together with the evidence submitted in support of the application,
b. A copy of the DD's denial memorandum, or a copy of the DD's approval memorandum and a copy of the Director's denial,
c. A copy of the DD's request for an impartial medical evaluation and a copy of the physician's response, and
d. Any additional information considered necessary to defend the denial of relief. Since the Solicitor's Office may depend on the DD's memorandum of denial or approval for an analysis of the case, this memorandum should be as complete as possible. The DD should also include copies of pertinent evidence from the case file which will assist the Solicitor's Office. As noted in subparagraph 6d(6) above, it is the responsibility of the DO to insure that there is sufficient evidence for the Solicitor to use to support the denial of section 8(f) relief. If necessary, the DO must develop this evidence. A copy of the memorandum requesting Solicitor participation, without the attachments, should be sent to the Director, DLHWC, at the time of referral.

3. **Time of Referral**. The memorandum requesting participation at the formal hearing should be sent when the case is referred to the OALJ. It is not necessary to refer cases to the Solicitor's Office before a denial is issued or before the case is terminated. However, the DD may discuss the facts of the case with the Solicitor's Office and attorneys in that office may review the file. The DD should not permit this consultation period to delay the referral of the case.
4. **Action by the Solicitor's Office**. Since the DO will be dealing directly with the Regional Solicitor's Office it is important to develop a good working relationship. The DD (or CE) should be prepared to discuss the denial, and any additional development needed to prepare the case for formal hearing. Any necessary development is to be done by the DO. The Solicitor's Office may determine that the testimony of an expert witness, or additional evidence, is necessary to defend the Special Fund. In such cases, the DO should, upon

request, cooperate in identifying potential witnesses. The cost of the expert testimony will be charged to the Longshore Program's budget. Questions concerning the form for submitting this type of bill should be referred to the National Office. At the time of referral for an impartial medical evaluation, the DD should advise the physician that he or she may be called on to be a witness at a formal hearing.

If in the course of discovery and preparation for trial, the employer/carrier develops additional factual, medical, or vocational evidence sufficient to overcome the deficiencies of the original application for Special Fund relief, the District Director, in consultation with the RSOL staff, may accept the claim for relief upon consideration of such evidence. It is not necessary to submit the case file or the new evidence to the National Office for reconsideration of the application for section 8(f) relief, although the National Office staff is always available for consultation and guidance. (See PM 6-201.10(c) below.)

10. <u>8(f) First Raised While Case Pending at OALJ.</u>

1. If the issue of Section 8(f) relief is raised for the first time while the case is pending at the OALJ, e.g., permanency is reached after referral, the ALJ, not the DD, has authority to decide the issue. The case need not be remanded by the ALJ to the DO, however, the EC must notify both the DD and the RSOL that it intends to seek Section 8(f) relief, and submit a copy of the 8(f) application to both.
2. If an 8(f) application is submitted to the DO while the case is pending before the ALJ, it should be treated as a request for relief from the ALJ to which the Director, as a party to the ALJ proceeding, must respond. Upon receipt of the application, the DO must review it on the merits in accordance with the regulations at 20 CFR § 702.321 and with PM 6.201.4. As soon as practicable, the DD must inform the RSOL of the Director's position as to whether 8(f) relief is appropriate. RSOL will notify the ALJ of the Director's position, and will represent the interest of the Special Fund in the ALJ proceeding.

3. If the DD determines that 8(f) relief should be granted, concurrence of the Director, DLHWC is not required. The DO need not refer the case to the National Office for approval, although the NO is available for consultation. If the DD determines that Special Fund relief is not warranted, either because the application is untimely or that one or more of the criteria for relief has not been met, the DD should work closely with RSOL to co-ordinate the defense of the Special Fund as necessary.
4. In the event that the 8(f) application is sent to the RSOL but not to the DO, the RSOL should immediately forward a copy to the DD and ascertain the Director's position on the issue.

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1. Purpose and Scope. This Chapter describes the procedures for obtaining payment from the Special Fund in cases involving EC insolvency and/or bankruptcy. It identifies the information and material which must be submitted to the DO, and by the DO to the National Office, to initiate payment from the Special Fund.

2. Definitions. The following definitions apply to this Chapter:

1. **U.S. Bankruptcy Act**. A federal law (Title 11 U.S.C.) for the benefit and relief of creditors and their debtors when the latter is unable to pay debts. The U.S. Bankruptcy Court is an adjunct to the U.S. District Court and Federal Rules of

Civil Procedure apply. Congress enacted the statute to provide for uniformity among the states within its Constitutional authority.

2. **Insolvency**. A financial condition in which a company is unable to meet its financial obligations during the ordinary course of business.
3. **Formal Bankruptcy**. The legal process wherein the debtor is granted legal protection from creditors so an orderly settlement of the financial affairs may occur. A company may be liquidated or reorganized. In a liquidation, assets are sold and creditors paid. In a reorganization, the debtor continues in business and pays creditors. Transactions occur under the direction of the bankruptcy court.
4. **Chapter 11**. Generally referred to as reorganization of the company. Under this chapter of the Bankruptcy Act a time limit is specified for filing claims against the estate and the debtor may continue to operate under court supervision.
5. **Chapter 7**. Generally referred to as liquidation of the debtor company where all assets are sold to pay debts and the company is ultimately dissolved. A time limit will also be specified for filing claims against the debtor.
6. **Automatic Stay**. A provision in the bankruptcy code under 11 U.S.C. section 362 which prevents commencement, issuance, or execution of any legal proceedings against the debtor until all assets are identified and an equitable distribution takes place. (See Exhibit 14, PM 10-300.)
7. **State Guaranty Fund**. A state run insurance program funded by fees from all licensed and admitted carriers which write business in the state. Its purpose is to pay obligations and claims of any member companies which are adjudged insolvent. The amount of coverage available to workers' compensation claimants varies widely by state. Some states exclude workers' compensation entirely and others specifically exclude Longshore cases.
8. **Unsecured Creditors**. Claims against the debtors estate which are not secured by lien or property such as bills of sale, etc. These are a general claims category into which workers' compensation cases fall.
9. **Trustee in Bankruptcy**. An official appointed by the Bankruptcy Court to hold the debtor's property and assets in trust to provide for an equitable distribution

to creditors. The trustee must concur with the issuance of a compensation order by the DD.

10. **Waiver from Automatic Stay**. A petition by the claimant to the bankruptcy court to permit lifting of the automatic stay so a case may be adjudicated under the U.S. Bankruptcy Act (11 U.S.C. section 362). (See Exhibit 15, PM 10-300.)
11. **Director's Compensation Award**. An award letter issued at the discretion of the Director, OWCP, awarding the claimant benefits under section 18(b) from the Special Fund. Prior orders issued by the DD or ALJ can only be awarded against the EC.
12. **Rehabilitation**. The take over of an insurance carrier's operations by a state insurance department to insure financial integrity of the company. Usually claims continue to be paid and most business operations continue under the close guidance of an appointed administrator.
13. **Parties in Interest**. A term used to include the claimant, his/her attorney, the insurance carrier, the employer, the state guaranty fund if liable for benefits, the state insurance department if the carrier is under active rehabilitation, the bankruptcy trustee if the employer is in formal bankruptcy, and the president, secretary and treasurer of a corporate employer if the employer was uninsured.

3. Section 18(a) Requirements. Except as noted further in these procedures relating to employers in formal bankruptcy, the following requirements of section 18(a) must be met prior to consideration of a case for payment from the Special Fund under section 18(b):

1. **Default** in the payment of compensation under an order for a period of thirty days after the compensation is due and payable.
2. **Issuance of a default order** pursuant to section 18(a).
3. **Filing** of a copy of the default order with a Federal District Court. (Requirement waived if employer is in formal bankruptcy.)
4. **Obtaining a judgment** pursuant to the filing of the default order. (Requirement waived if employer is in formal bankruptcy.)

5. **Documenting attempts** to satisfy the outstanding judgment which may include:
    a. Proof of service by the U.S. Marshal's Office.
    b. Copies of relevant correspondence.
    c. Answers to any interrogatories issued.
    d. Copies of any depositions taken.
    e. Copies of any credit or other investigations made. This requirement will be waived if the employer is in formal bankruptcy.

4. Obtaining Compliance Under Section 21(d). Section 21(d) provides for obtaining compliance with a final compensation order in the Federal District Court for the judicial district in which the injury occurred. This section provides that the court shall enforce obedience to the order by writ of injunction or by other proper process. It should be noted that this section applies only if the compensation order has become final, i.e., if the order has not been timely appealed. If the employer is not in formal bankruptcy or defunct, or if the employer was uninsured and the officers of the company are financially viable, consideration may be given to filing an action under this section to obtain compliance rather than proceeding under section 18(a) which requires the obtaining and execution of a judgment. If an action is filed under this section, and if as a result of the court proceedings it is determined that the employer/officers are insolvent, the judgment requirement under section 18(a) may be waived for the purpose of paying benefits in the case from the Special Fund.

5. Initial Determination.. Prior to consideration of paying benefits from the Special Fund under section 18(b), it must first be established that the liable insurance carrier, employer, officers (if an uninsured employer) and any State insurance guaranty association are unable to pay benefits. Documentary proof must be submitted to support any allegations concerning nonpayment of benefits.

6. Requirement for Compensation Order and Default Order. Before a case may be considered for payment of compensation benefits from the Special Fund, a compensation order must have been issued in the case which has been in default for a period of at least thirty days pursuant to section 18(a). A default order may be issued prior to thirty days if the employer is in formal bankruptcy and court approval is obtained or if it is certain that no claim will ever be made against the bankrupt employer's estate. If the case does not have a compensation order, and the district office cannot obtain the agreement of all parties in interest to issue an order, the case should be referred for a formal hearing and issuance of an order. Certain exceptions may apply such as in those

cases in which it can be conclusively shown that an insurance carrier cannot be identified and the employer is defunct, as in certain asbestos cases. In such cases, the district office may issue a compensation order with the concurrence of the claimant and the National Office.

7. <u>Situations Requiring Payment Under Section 18(b)</u>. The following situations may result in payment from the Special Fund:

1. **Uninsured Insolvent Employer**. In this situation, the employer is not making, or has refused to make, compensation payments but is not in formal bankruptcy. Since the employer is uninsured, the president, secretary and treasurer of the corporation are also personally liable for benefit payments pursuant to section 38(a) of the Act. These officers should be informed by letter (Exhibit 16, PM 10-300) of their personal liability under the Act.
    a. If a compensation order has not been issued in the case, and if all parties in interest will not agree to the issuance of an order, the matter must be referred to the Office of Administrative Law Judges for a formal hearing and issuance of a binding order. The names and addresses of the liable corporate offices should be forwarded to the OALJ so that they can be notified of the hearing.
    b. After issuance of an order, and whether or not an appeal has been taken by the employer, if the order has not been paid for a period of thirty days after compensation is due and payable, the claimant may apply to the DD to issue a supplementary order declaring the amount of the default.
    c. Before issuing a supplementary order, the DD shall, under section 19, cause such investigation to be made as is necessary to confirm that the employer exists, is in business and may be subject to a judgment. The DD will contact the employer, and determine its position relative to payment of the award. If it appears such action will encourage the cooperation of the employer, the DD may give appropriate notice and conduct a conference with the employer to further apprise it of the responsibilities and risks incurred in refusing to pay the award.

d. The claimant may then file a certified copy of the supplemental order with the clerk of the federal district court for the judicial district in which the employer has his principal place of business/or maintains an office, or the judicial district in which the injury occurred. If the compensation order has not been appealed and is therefore final, an action under section 21(d) against the company or its liable officers, if financially solvent, may be considered as an alternative to obtaining a judgment.

e. If the supplementary order is in accordance with law, the court, upon filing, shall enter judgment as in civil suits for damages at common law. Final proceedings to execute the judgment may be had by writ of execution in the form used by the court in suits at common law in actions of assumpsit.

f. Before payment can be authorized from the Special Fund, a diligent effort must be made to satisfy the judgment. To this end, it is appropriate for the DO to assist the court (U.S. Marshal) by attempting to locate the employer or senior corporate officers. Inquiries may be made to such organizations as:

    i. State Corporation Commission

    ii. State Corporation Tax Bureau or Commission

    iii. State Licensing Bureau, etc., or their counterparts within the State jurisdiction.

g. Once the employer (or one or more of the corporate officers) is located, the U.S. Marshal should proceed to execute the judgment, pursuant to section 18(a) of the Act. If the employer or its officers cannot respond by paying the full amount of the judgment, efforts should be made by the DO to reach a compromise concerning the method of payment of benefits and have the company or its officers pay as much as possible. However, any such compromise must be approved by the National Office.

h. If it is determined that the employer (with its officers) are judgment proof, the claimant must present adequate documentation of the

efforts made to execute the judgment. (An unsupported statement that the employer cannot be located or is judgment proof will not be adequate to justify payment from the Special Fund.) The claimant should file the following documents with the DD:

i. Certification that the supplementary order was filed with the appropriate U.S. District Court;

ii. A copy of the court's order to the U.S. Marshal to execute judgment;

iii. A copy of the Marshal's return and report to the court;

iv. Copies of all other pertinent documents which provide evidence of efforts to locate and pursue execution against the employer. (See subparagraph 3e, above.) Upon review and consideration of all actions taken to recover compensation from the employer, the DD shall submit all documents to the Director, DLHWC in the National Office, with a brief resume of the case and a recommendation that payment should be made from the Special Fund.

i. If the Director, OWCP, or the Director, DLHWC, approves payment from the Special Fund, an award letter will be issued authorizing payment from the Special Fund. When payment is approved from the Special Fund, such payment will cover necessary medical care, compensation and an attorney's fee if so ordered. No payment will be made for penalties or interest. If payment is not authorized, the Director, DLHWC shall advise the DD who shall inform all parties concerned. The Director, OWCP may delegate authority to the Director, DLHWC to authorize payment from the Special Fund and issue the award letter.

j. If payment is made from the Special Fund, the Secretary of Labor shall be subrogated to all rights of the person receiving such benefits and, through the SOL, will pursue the matter against the employer.

k. Cases arising under the jurisdiction of the District of Columbia Workmen's Compensation Act are processed in a slightly different

manner. To pursue a judgment against an employer within the District of Columbia, the petitioner must post a bond with the U.S. Marshal's office in an amount twice the sum of the judgment, before that office will undertake judgment proceedings. This procedure will prevent many claimants from pursuing defaults under sections 18(a) and 18(b). However, if the liable corporate officers are financially viable, an action to compel compliance with the outstanding order should be instituted under section 21(d) if the order has become final.

l. In such a situation, it is recommended that the DD issue the supplemental order under section 18(a) and that order be filed with the U.S. District Court for the District of Columbia to obtain a judgment. When the Marshal's office refuses to take action without posting of the above mentioned bond, the claimant may return to the DD with proof of that action and request that payment be made under section 18(b) based on the provision that there are ". . . other circumstances precluding payment . . . ."

m. The DD may then refer the matter, with all pertinent documents, to the National Office, recommending either approval or disapproval of payment under section 18(b).

n. If payment is made from the District of Columbia Special Fund, the Secretary of Labor shall be subrogated to all rights of the person receiving such benefits and, through the SOL, may pursue the matter against the employer. Where the bond is required, the Office of the Solicitor may, after careful consideration of the merits of the case, recommend posting the bond by the Special Fund and pursue the matter against the employer as provided by section 18(b).

2. **Uninsured Employer in Bankruptcy**. In this situation, the uninsured employer has filed a formal bankruptcy petition in bankruptcy court. The employer is thus protected by the bankruptcy laws and therefore no action can be taken which would represent a claim against its assets. Under these circumstances, a judgment cannot be obtained or executed.

a. If the employer is a corporation, the president, secretary and treasurer are also personally liable for the payment of benefits pursuant to section 38(a) of the Act. These officers should therefore be informed by letter (Exhibit 16, PM 10-300) of their personal liability under the Act. It should be determined if the officers are financially viable and if the corporate bankruptcy action also protects them against legal action. If they are not protected, and are financially viable, the claimant should pursue them for payment.

b. If a compensation order has not been previously issued in the case, an order awarding benefits cannot be issued by the DD without the express agreement of all parties in interest which would include the liable corporate officers and the bankruptcy court. A waiver from the automatic stay (see subparagraph 2.j., above) is also required. If approval cannot be obtained, the case should be referred to the OALJ for a formal hearing. The names of the liable corporate officers should be furnished to the OALJ so that any decision is also rendered against them personally.

c. After a compensation order is obtained, a default order may be issued after a period of thirty days has elapsed pursuant to section 18(a) of the Act. In some jurisdictions, the parties may object to the issuance of the default order as a violation of the section 362 automatic stay. If an objection is received, a waiver from the bankruptcy court must be obtained prior to issuing the default order.

d. Since the employer is in formal bankruptcy, a judgment cannot be obtained or executed and thus the requirement is waived as it applies to the corporation. However, if the corporate bankruptcy action does not extend to the liable corporate officers, and they are financially viable, and the compensation order issued in the case has become final (not timely appealed) an action against the officers to compel compliance with the outstanding order pursuant to section 21(d) of the Act should be considered. The financial ability of the liable officers must therefore be established. This documentary proof

can be in the form of either sworn interrogatories, depositions, comprehensive credit investigations, court documents relating to personal bankruptcy, or other such proof which clearly establishes the ability or inability of the officers to pay benefits.

e. If the liable corporate officers cannot be located, or if it has been determined that they are not financially viable, a waiver from the automatic stay must be obtained from the bankruptcy court to permit the issuance of an award letter by either the Director, OWCP, or Director, DLHWC to initiate payment from the Special Fund. The waiver would pertain to the bankrupt employer. (See Exhibit 15, PM 10-300, for a sample waiver.) The waiver should be obtained by the claimant's attorney. If a large number of claims are expected to be presented against the employer, the DOL Regional Solicitor should be contacted so that a blanket waiver can be obtained from the court which would cover all claims that would be presented.

f. After the appropriate waiver is obtained from the bankruptcy court, the case file containing the compensation and default orders, the results of the investigations relating to the financial viability of the liable corporate officers, copies of all relevant bankruptcy documents, and a memorandum summarizing the facts of the case should be referred to the National Office with the request that benefits be paid in the case from the Special Fund pursuant to section 18(b) of the Act.

3. **Insolvent Insurance Carrier and Viable Employer**. In this situation, the insurance carrier is insolvent and unable to pay benefits. However, the employer is not insolvent or in bankruptcy and is a financially viable entity.

    a. In all such cases, the employer is liable for the payment of all benefits due under the Act. The employer should therefore be made aware of its obligations under the Act by letter as soon as it is determined that the insurance carrier is insolvent and is unable to make the required compensation payments.

b. In carrier insolvency cases, a State Insurance Guaranty Fund may be liable for the payment of benefits. The claimant and the employer should be encouraged to request relief from the State Fund.

c. If the employer refuses to pay benefits, and there are no benefits payable by a State Guaranty Fund, the case should be referred for a formal hearing to obtain a compensation order if an order is not already contained in file. After an order is obtained, compliance with the order may be obtained pursuant to section 18(a) of the Act (see paragraph 3, above) or by commencing an action under section 21(d) of the Act if the order is final (not timely appealed). A judgment is not required to proceed under section 21(d).

4. **Insolvent Insurance Carrier and Employer in Bankruptcy**. In this situation, the insurance carrier is insolvent and the employer is in formal bankruptcy. The carrier may be under rehabilitation by a State insurance department.

    a. Obtain copies of the documents relating to the insolvency of the insurance carrier.

    b. Obtain copies of the documents relating to the bankruptcy of the employer.

    c. If a compensation order has not been previously issued, and agreement cannot be obtained from all of the relevant parties in interest to issue an order, the case must be referred for a formal hearing to determine entitlement to benefits and for issuance of an order. If objection to the referral is raised by any party in interest on the basis that it is in violation of the automatic stay, a waiver may be required from the bankruptcy court. The claimant's attorney should be requested to contact the bankruptcy trustee to determine what action needs to be taken so that the case can go forward for a hearing.

    d. After a compensation order has been issued, ascertain that payments are in default under the order for a period of thirty days after compensation is due and payable as required by section 18(a). This should be in the form of a letter to the District Director from the

claimant advising of the default and requesting issuance of a default order. Inquiry may also be made by the district office to the insurance carrier and the employer to verify that payments are in default.

e. Determine from the appropriate officials having jurisdiction over the carrier and employer if they will permit the issuance of a default order pursuant to section 18(a) and the subsequent issuance of an award under section 18(b) from the Special Fund. The automatic stay provisions of the bankruptcy code that relates to private employers will preclude the issuance of such orders unless an appropriate waiver is first obtained from the bankruptcy court. You may request the claimant's attorney to obtain this information and to obtain the appropriate waiver(s) or you may obtain assistance from the Regional Solicitor's Office. If it is anticipated that a large number of cases may be presented for payment as a result of the bankruptcies, the Regional Solicitor's Office should be requested to obtain blanket waivers for all required actions to avoid delays in the payment of benefits.

f. After obtaining all waivers which may be required, issue the default order pursuant to section 18(a). It is not necessary to obtain a judgment in such cases since the judgment requirement of section 18(a) is rendered invalid by the automatic stay provision and it would be fruitless to obtain a judgment since the court would not permit execution on it.

g. Refer the case file to the National Office by cover memorandum summarizing the facts of the case and attaching all relevant bankruptcy documents. Note: An appropriate waiver from the bankruptcy court must be attached to permit the issuance of an award from the Special Fund. A draft order awarding benefits from the Fund should also be attached which clearly shows the benefits which are to be paid to the claimant.

5. **Defunct Insurance Carrier and Defunct Employer**. In a situation where it can conclusively be shown that the employer and carrier are no longer in

existence, prior approval for a DD to issue a compensation order is required only from the claimant and the National Office. In such cases, the file, with a cover memorandum outlining the facts of the case, should be sent to the National Office. A draft compensation order, which the DD intends to issue, should also be attached to the memorandum. The memorandum must state how it was determined that the employer and carrier no longer exist, e.g., the corporate charter may have been retired, or the company's assets may have been liquidated in a prior bankruptcy action which has been concluded. After approval is received from the National Office, the DD may issue the appropriate compensation order. A default order must also be issued pursuant to section 18(a). However, in such cases it is not required that a judgment be obtained. After the default order is issued, the case should again be referred to the National Office, with the recommendation that compensation benefits be paid from the Special Fund under section 18(b).

6. **Cases in Which Payment Is Being Made by A State Guaranty Fund**. In all cases in which partial payments are being made at State compensation rates by a State Guaranty Fund, the Guaranty Fund must be considered as a party in interest, and therefore must be given notice of any proposed action. The Guaranty Fund has, in effect, become the insurance carrier, and therefore, where notice or agreement was required of the insurance carrier prior to taking an action, it is now also required of the Guaranty Fund. For those payments which are in addition to the State benefits which are in default under our Act, the requirements of section 18(a) apply relative to the issuance of default orders and judgments in the same manner as though total compensation benefits were in default. Also see PM 8-100.3 with regard to State Guaranty Funds and the assessment of penalties and interest.

8. <u>Maintenance of Records</u>. To facilitate the processing of carrier insolvency and employer bankruptcy cases, each district office should maintain a separate master folder for each insolvency or bankrupt carrier and employer. All documents relevant to each bankruptcy should be placed in their respective folders. These should include copies of the court documents filed in the bankruptcy actions, correspondence relative to obtaining waivers from the automatic stays of the bankruptcy laws, copies of judgments obtained,

documented efforts to satisfy the judgments, and any other relevant correspondence.

Chapter 6-0203, Payment Procedures

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1. Purpose and Scope. This Chapter describes the procedures to be followed by the DO when submitting cases for payment from the Special Fund. In addition, it outlines the steps to be followed when changes are to be made in cases being paid from the Special Fund.

2. Notification of National Office. In those cases where an Order is filed by the DD, and payments are due from the Special Fund, the NO must be notified at the same time the Order is filed. This notification should be in the form of a memorandum which includes the information listed in paragraph 3, below. This information is not to be held until the LS-208 is received. Service of the compensation order is not sufficient to initiate this action. Orders awarding section 8(f) relief must be sent to the NO by facsimile and regular mail. Subsequent orders (from the ALJ, BRB, district and appellate courts) affecting the liability of the Special Fund must be transmitted in the same manner.

3. Information To Be Submitted to the National Office. It is not necessary for the DO to calculate the benefits payable by the EC and the Special Fund as the NO has the ADP capability to perform these calculations automatically. The NO is to be advised of the exact date payments should commence. An LCMS print-out for the case is to be attached together with the following information:

1. **Claimant's present address** including zip code,

2. **Average weekly wage** and initial compensation rate,
3. **Date** the EC has or will suspend payments, if known,
4. **Amount of overpayment**, credit or third party recovery,
5. **Whether the Holliday decision** applies (see PM 3-202),
6. **The names, social security numbers, and ages** of eligible dependents in death cases (please include the birth dates),
7. **Any other** special payment instructions.

It is recognized that items c. and d. may not be available when the Order is filed. However, as with Form LS-208, the notification memorandum is not to be delayed. Any missing information should be forwarded as soon as possible.

4. Cases Are To Be Monitored by DO. The DO should closely monitor these cases to insure that the EC meets its statutory obligation to file a complete LS-208 in compliance with section 14(g). If an overpayment or credit is claimed by the EC, it must be fully documented as to the amount and periods paid. The EC must submit its correct address if there is to be a reimbursement. (See PM 6-300 for further information regarding the monitoring of Special Fund cases.)

5. Action by the National Office. Unless a complete and verified LS-208 is submitted, the initial payment from the Special Fund will not exceed two weeks of accrued compensation. Payments will be paid bi-weekly until the verified LS-208 is received. The claimant will be notified that only bi-weekly payments will be paid until the receipt of the LS-208. When the verified LS-208 is received, the NO will calculate the accrued compensation due and pay the balance to the claimant. A letter will be sent after this payment is made which outlines all payments due and paid to date and the rate of future payments. Any reimbursement due the EC will be made at this time. The EC reimbursement will be deducted from any accrued compensation due from the Special Fund. If the reimbursement exceeds this amount, the EC will be reimbursed out of the claimant's bi-weekly payments until the entire amount due is paid. This situation usually occurs when the EC has paid TTD or PTD benefits until the ALJ order is issued. The order may specify an award for PPD benefits. Thus, the EC has not only paid beyond its 104 week liability but has also paid the claimant at a higher weekly rate. This creates a large EC overpayment which is often in excess of the accrued Special Fund liability. Whenever this situation takes place the ALJ's order should be carefully reviewed to insure that the language ordering the Special Fund to reimburse the EC is consistent with NO policy which is to only reimburse the EC from the accrued Special Fund liability. Orders that specify a lump sum reimbursement of all amounts paid in excess of the EC's liability must be sent promptly to the Director, DLHWC so that a Motion for Reconsideration can be filed. If the EC's

overpayment does not exceed the accrued liability of the Special Fund, Reconsideration will not be necessary.

6. <u>Payment of Interest, Attorney Fees, and Other Costs.</u>

1. **Interest**. Interest will be paid, to claimants and ECs, in accordance with 28 U.S.C. section 1961 when specifically assessed in the Order.
2. **Attorney Fees**. Attorney fees cannot be assessed against the Special Fund but may be paid as a lien on the claimant's compensation in accordance with section 28 of the Act.

   The Benefits Review Board and Courts of Appeal have consistently held that attorney's fees may not be assessed against the Special Fund under section 28. However, it has been held in a limited number of cases that costs may be assessed against the Special Fund under section 26 where it is found the Director's non-participation caused unnecessary litigation. We will request Solicitor representation in any section 28 action.
3. **Penalties**. It has been consistently held that the section 14(e) penalty (10%) cannot be assessed against the Special Fund. The question of whether the section 14(f) penalty (20%) is to be paid by the Special Fund must be reviewed on a case by case basis. All such inquiries must be referred directly to the NO for consideration and action.

7. <u>Death of the Special Fund Recipient</u>. If the claimant dies while receiving benefits from the Special Fund, the DD should notify the NO in writing. This notification should include the exact date of death and whether there is a potential death claim. Death benefits will not be paid until a compensation order is issued awarding death benefits from the Special Fund. This order may not be issued without the prior agreement of the NO. Thus, the DD must submit a specific recommendation to the NO. If the NO agrees, the DD will be advised to prepare the appropriate order. The DD will submit the order in the same manner as all initial payment cases. The DD must also notify the NO in writing whenever there is a change in status of any beneficiary receiving benefits from the Special Fund. Thus, if a widow or widower dies, the NO is to be notified. If a child, entitled to benefits, reaches the age of eighteen or if the child's student status changes, the NO is to be notified. (See also PM 3-302.)

1. **The employer/carrier** remains a party in interest and must concur with the issuance of a compensation order awarding death benefits.
2. **Funeral expenses** are not considered "compensation" under section 8(f) as that section is intended to limit the employer's liability for periodic payments only. See Bingham v. General Dynamics, 20 BRBS 198, 205 (1988). The EC is to be charged with the payment of funeral expenses in Special Fund orders awarding death benefits.

8. Hearing Loss Cases. In hearing loss cases, the compensation order is to specify the date of maximum medical improvement and the date the Special Fund's liability commences. If the Order awarding benefits specifies a payment date in the future, the NO must also be notified at the time the Order is filed as to the exact date that payments are to be made from the Special Fund. These cases will automatically be picked up by the Fund. (See also PM 3-401.)

9. Address Changes and Missing Checks. The Special Fund recipient must notify the NO Fiscal Officer, in writing, of any address change or change in payment instructions. With respect to non-receipt of a check, the recipient must also advise the NO Fiscal Officer in writing. This notification must include the date of the missing check and should not be submitted until the check is seven calendar days overdue. It must be stressed that all such changes or requests must be in writing from the payee. Telephone messages will not be honored.

10. Direct Deposit of Compensation Checks. Claimants may have their payments paid by direct deposit into their checking or savings account. Any interested claimant should be directed to write to the National Office and request a Direct Deposit Sign Up Form. Form SF-1199 may also be obtained from the financial institution.

11. Garnishment. Benefits paid out of the Special Fund are subject to garnishment for child support and alimony. The Social Security Act Garnishment provision (42 U.S.C.§ 659(a)) enacted in 1975 provides that:

Notwithstanding any other provision of law...moneys (the entitlement to which is based upon remuneration for employment) due from, or payable by, [emphasis added] the United States or the District of Columbia (including any agency, subdivision, or instrumentality thereof) to any individual, including members of the Armed Forces of the United States, shall be subject, in like manner and to the same extent as if the United States or the District of Columbia were a private person...to any...legal process brought, by a State agency administering a program under a State plan approved under this part or by an individual obligee,

to enforce the legal obligation of the individual to provide child support or alimony.

Also, the Office of Personnel Management promulgated a regulation that expressly provides that LHWCA benefits are subject to garnishment pursuant to the SSA Garnishment provision. See 5 C.F.R. § 581.103(c)(5) which authorizes the garnishment of "[b]enefits received under the Longshoremen's and Harbor Workers' Compensation Act".

In the case of Moyle v. Director, Office of Workers' Compensation Programs, 147 F.3d 116, 32 BRBS 107(CRT) (9th Cir. 1998), cert. denied, 119 S. Ct. 1454 (1999), the United Court States of Appeals for the Ninth Circuit held that the later-enacted SSA garnishment provision impliedly repealed and anti-alienation provision of Section 16 of the LHWCA. As a result, benefits paid by the Special Fund are considered benefits payable by the United States and are subject to garnishment for delinquent spousal or child support. Garnishment is limited to benefits paid by the Special Fund and in no way affects benefits paid by the employer or carrier. In those instances, the anti-alienation provision of Section 16 of the LHWCA still applies.

Chapter 6-0300, Special Fund Entitlement Reviews

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1. Purpose and Scope. This Chapter contains the procedures for monitoring cases being paid by the Special Fund under sections 8(f), 10(h), 18(b) and 32(a) of the Act.

2. Policy. As authorized by 33 U.S.C. § 908(j) and implemented by 20 CFR 702.285 and 702.286, the Director may require an employee being paid compensation by the Special Fund to submit a report on earnings from

employment or self-employment, even where he or she has no earnings to report. In cases in which disability benefits are being paid, all injured workers are required to certify their employment status and provide earnings information by completing Form LS-200, Report of Earnings.

Survivors who are being paid death benefits are required to complete Form LS-267, Claimant's Statement, which certifies either their marital status or the beneficiary's status as a full-time student.

3. Issuance of Forms LS-200/267. On an annual basis, the National Office will mail to each claimant receiving benefits from the Special Fund a Form LS-200, if receiving disability benefits, or a Form LS-267, if receiving death benefits. At the time of the mailing, each case in the Longshore Case Management System (LCMS) is updated with code **200i** (LS-200 issued) or **267i** (LS-267 issued) to reflect that the form has been issued.

4. Timeframes. The Form LS-200/267 is to be returned within 30 days. 20 CFR 702.286(a). The District Office should review each case within 60 days of the mailing date and take follow up action as indicated in this chapter.

5. Form Not Returned. If a claimant fails to return a form LS-200/267, the District Office has broad discretion to investigate and take action to obtain a signed form before pursuing forfeiture (the loss of benefits) pursuant to 20 CFR 702.286. This includes sending a second request to a new address, sending a second request via certified mail (or other method where receipt can be verified), extending for good cause the date for the report to be returned, or temporarily suspending compensation until the claimant is located (so that the form can be returned) or confirmed to be deceased. If a claimant fails to respond to the original mailing of forms LS-200/267, the following action(s) should be taken by the Claims Examiner (CE), or designee.

1. **Returned as Undeliverable.** If the form is returned as undeliverable due to an incorrect or inadequate address (e.g. returned with no forwarding address), the CE should determine if the most recent address on file has been used. If there is not a more recent address on file, the CE should contact the claimant's attorney, if applicable, to determine if there is a current mailing address. If there is any indication in the file that employer/carrier is still in contact with the claimant, the CE should also reach out to them to see if they have a more recent address. The CE should also confirm the payment address with the National Office Fiscal Branch, if payments are not made by direct deposit.

If a more recent address is available, the CE should re-send the LS-200/267 form. Code **200f** (LS-200 follow up) or **267f** (LS-267 follow up) should be added to LCMS when the form is reissued. The case should be reviewed again within 60 days to determine the next appropriate action.

After all reasonable attempts are made and those have failed to ascertain a more recent address, the CE should request the National Office Fiscal Branch temporarily suspend benefits. See paragraph 5c.

2. **Not Returned.** If claimant does not return the completed form and the form was not returned as undeliverable, the CE should first determine if the most recent address on file was used. See paragraph 5a. If so, the CE should then send by certified mail (or other method where receipt can be verified) to claimant's most recent address another Form LS-200/267 for completion. The CE should indicate that the original form that was mailed was not returned and that failure to submit the form in a timely manner will result in temporary suspension of benefits. Code **200f** (LS-200 follow up) or **267f** (LS-267 follow up) should be added to LCMS when the form is reissued. The case should be reviewed again within 60 days to determine the next appropriate action.

   If the form is then returned, it should be reviewed as outlined in paragraph 6 of this chapter.

   If the form is not returned after a request was sent by certified mail or other method where receipt can be verified, the CE should request the National Office Fiscal Branch to temporarily suspend benefits. See paragraph 5c.

3. **Temporary Suspension of Compensation.** When the CE determines that reasonable efforts to contact claimant have been unsuccessful and claimant's failure to contact the District Office or return a completed form necessitates a temporary suspension of compensation, a request should be sent to the National Office Fiscal Branch. When the request for temporary suspension is sent to the National Office Fiscal Branch, the CE should send a letter to the

claimant and claimant's attorney or authorized representative, if applicable, to notify them of the temporary suspension of benefits. Code 200s (LS-200 suspension) or 267s (LS-267 suspension) should be added to LCMS when the suspension letter is issued. This completes the annual review process.

4. **Form Returned after Temporary Suspension.** If the claimant subsequently properly completes and returns the form, and the form supports the previous benefit level (see paragraph 6), temporarily suspended compensation should be reinstated retroactively to the date that it was suspended.

6. Form Returned. If the form is returned, it must be reviewed to determine that it has been completed properly, that all questions were clearly answered and that the signature matches the prior signature on file. The CE, or designee, performs the review and takes follow up action as necessary to confirm continuing entitlement to benefits.

1. **Form Complete - No Change**. If the signature matches previous years, the form was properly completed, all questions were answered, and no earnings are reported (on the LS-200), the CE should update LCMS with code **200r** (LS-200 received) or **267r** (LS-267 received). This completes the annual review process.
2. **Form Incomplete**. If the claimant did not answer a question on the form, the CE should identify the missing information and then contact claimant to obtain that information. Code 200f (LS-200 follow up) or 267f (LS-267 follow up) should be added to LCMS when the clarification letter is sent. The case should be reviewed again within 60 days to determine the next appropriate action.
3. **Signature Different**. If the signature appears different, the CE should obtain clarification by either correspondence or scheduling an informal conference. Written clarification should usually be attempted first. However, depending on the circumstances in the case, an informal conference can be scheduled and the claimant required to personally attend and bring with him/her proper photo identification. At the conference, the claimant should be asked to complete the Form LS-200/267. If it is not possible for the claimant to attend an informal conference due to travel restrictions, age or disability, the CE should obtain some other form of proof that the claimant is still alive. A current medical

report or medical bill, a statement from a medical or residential facility attesting to the fact that the claimant is still alive, or a notarized LS-200/LS-276 would usually be sufficient.

Code **200f** (LS-200 follow up) or **267f** (LS-267 follow up) should be added to LCMS when the clarification letter is sent or the conference is scheduled. The case should be reviewed again within 60 days to determine the next appropriate action.

If the CE is unable to verify that the claimant is still alive, the CE should notify the National Office Fiscal Branch to temporarily suspend compensation benefits until verification is obtained. See paragraph 5c.

4. **Form Not Completed by Claimant**. If forms are being completed by someone other than claimant, a power of attorney or other legal documentation for the individual completing the form must be on file. In this instance, there should also be evidence in the file contemporaneous with the form being returned that establishes the claimant is still alive. If this evidence is not on file, the CE should send a written request to obtain it. Code 200f (LS-200 follow up) or 267f (LS-267 follow up) should be added to LCMS when follow up action is taken. The case should be reviewed again within 60 days to determine the next appropriate action.

   If the CE is unable to obtain the documentation demonstrating that the other individual is authorized to act on claimant's behalf and that the claimant is still alive, the CE should notify the National Office Fiscal Branch to temporarily suspend compensation benefits. See paragraph 5c.

5. **Earnings on the LS-200**. If PTD benefits are being paid and the claimant reports earnings, a Section 22 Modification should be considered if the earnings are not de minimus and/or sporadic. If PPD benefits are being paid, the CE should review the initial Order that established the claimant's earning capacity and compare that determined wage earning capacity to the claimant's current earnings. If earnings have increased such that a reduction in benefits

is appropriate, a Section 22 Modification petition should be considered. Modification may not be appropriate in certain cases where earnings are reported such as sheltered work situations, where the claimant is only partially disabled and has low or moderate earnings, or where the reported employment was of short duration and has been discontinued.

a. Active Employer/Carrier. If earnings are reported the CE should send a letter to the employer/carrier, include a copy of the form, and ask the employer/carrier whether it intends to seek a modified order. The employer/carrier should be asked to respond within 30 days. The claimant, and authorized representative if any, should be copied on this letter.

   If the employer/carrier and/or the CE believes the earnings reported warrant a reduction in benefits, the CE should send a letter to the claimant and any authorized representative proposing a modified order and inquiring whether the claimant will voluntarily agree to such a modified order. The employer/carrier should be copied on this letter. Code **200r** (LS-200 received) should be added to LCMS when this action is taken. However, the case should be reviewed again within 60 days to determine the next appropriate action.

   If all parties in interest - the Director, the claimant and the carrier/self-insured employer - agree to modification, an agreed order should be issued by the DD in accordance with 20 CFR 702.315(a). If the claimant will not agree to a voluntary modification of the order, the CE may schedule an informal conference to consider the issue of modification. Because it impacts the carrier/self-insured employer’s annual Special Fund assessment, it is in the financial interest of employer/carrier to initiate a Section 22 modification in this instance. If the employer/carrier does not pursue modification, and the CE concurs that modification should not be pursued independently by OWCP, the annual review process can be considered complete.

b. Defunct/Bankrupt Employer/Carrier. If the CE determines that the earnings do not warrant modification, a memo should be placed in the file verifying that the CE has considered the earnings reported on the form and determined that no action is needed. The CE should update LCMS with code **200r** (LS-200 received) when this memo is placed into the file. This completes the annual review process.

   If the CE determines that the compensation order in the case should be considered for modification, but there is no active employer and all benefits are being paid under Section 18(b) or 32(a), the CE should take appropriate action to develop the case as needed. Code **200r** (LS-200 received) should be added to LCMS when follow up action is initiated. However, the case should be reviewed again within 60 days to determine the next appropriate action.

   A Section 7(e) impartial medical examination may be arranged if current medical reports contained in the case file do not adequately address the extent of the claimant's current disability. The CE may also schedule an informal conference to discuss a voluntary modification and/or develop any additional facts which relate to a possible modification. The DD should request that the Regional Solicitor (RSOL) attend the conference to represent the Special Fund. If, at the conclusion of the informal conference, the claimant will not agree to a voluntary modification of the order, and the DD and RSOL concur that modification is warranted, a referral should be made to the National Office Fiscal Branch when the conference memorandum is issued. If the National Office Fiscal Branch concurs with the DD's recommendation, the case should be transferred to OALJ for formal hearing to resolve the dispute between the Director and the claimant. The RSOL should also be requested to represent the Director in the modification proceeding before OALJ.

6. **LS-267 Indicates Remarriage**. If the LS-267 form received indicates that the widow(er) has remarried, the CE should notify the National Office Fiscal

Branch to terminate benefits. A two-year lump sum payment will be calculated by National Office in accordance with PM Chapter 3-0302.2.c.

7. Forfeiture of Compensation. As outlined in 33 U.S.C. § 908(j) and 20 CFR 702.286 the DD has the authority to declare a forfeiture of benefits if warranted. The DD also has discretion to determine that forfeiture is not warranted because good cause exists for the claimant's delay in returning Form 200/267. Forfeiture may be appropriate if there is evidence that the claimant knowingly and willfully fails to report earnings. Forfeiture may also be appropriate when the claimant knowingly and willfully omits or understates earnings.

In order to effectuate a valid forfeiture for failure to accurately report earnings, the DD must notify the employee of the proposed forfeiture; hold an informal conference; evaluate any evidence regarding the failure to accurately report; make a determination that the evidence is sufficient to support a conclusion that the claimant failed to accurately report; and issue an order finding forfeiture is warranted, the period during which compensation is forfeited, and setting forth the amount of compensation forfeited.

1. **Authority**.

   33 USC 908(j) provides:

   a. (1) The employer may inform a disabled employee of his obligation to report to the employer not less than semiannually any earnings from employment or self-employment, on such forms as the Secretary shall specify in regulations.
   b. (2) An employee who—

      (A) fails to report the employee's earnings under paragraph (1) when requested, or
      (B) knowingly and willfully omits or understates any part of such earnings, and who is determined by the deputy commissioner to have violated clause (A) and (B) of this paragraph, forfeits his right to compensation with respect to any period during which the employee was required to file such report.

c. (3)Compensation forfeited under this subsection, if already paid, shall be recovered by a deduction from the compensation payable to the employee in any amount and on such schedule as determined by the deputy commissioner.

20 CFR 702.286 (Report of earnings; forfeiture of compensation) provides:

d. (a) Any employee who fails to submit the report on earnings from employment or self-employment under §702.285 or, who knowingly and willingly omits or understates any part of such earnings, shall upon a determination by the district director forfeit all right to compensation with respect to any period during which the employee was required to file such a report. The employee must return the completed report on earnings (even where he or she reports no earnings) within thirty (30) days of the date of receipt; this period may be extended for good cause, by the district director, in determining whether a violation of this requirement has occurred.
e. (b) Any employer or carrier who believes that a violation of paragraph (a) of this section has occurred may file a charge with the district director. The allegation shall be accompanied by evidence which includes a copy of the report, with proof of service requesting the information from the employee and clearly stating the dates for which the employee was required to report income. Where the employer/carrier is alleging an omission or understatement of earnings, it shall, in addition, present evidence of earnings by the employee during that period, including copies of checks, affidavits from employers who paid the employee earnings, receipts of income from self-employment or any other evidence showing earnings not reported or underreported for the period in question. Where the district director finds the evidence sufficient to support the charge he or she shall convene an informal conference as described in subpart C and shall issue a compensation order affirming or denying the charge and setting forth the amount of compensation for the specified period. If there is a conflict over any issue relating to this

matter any party may request a formal hearing before an Administrative Law Judge as described in subpart C.

f. (c) Compensation forfeited under paragraph (b) of this section, if already paid, shall be recovered by a deduction from the compensation payable to the employee if any, on such schedule as determined by the district director. The district director's discretion in such cases extends only to rescheduling repayment by crediting future compensation and not to whether and in what amounts compensation is forfeited. For this purpose, the district director shall consider the employee's essential expenses for living, income from whatever source, and assets, including cash, savings and checking accounts, stocks, bonds, and other securities.

2. **Conference Requirement**. Prior to declaring a forfeiture for failing to report earnings or knowingly and willingly omitting or understating earnings, a conference must be scheduled. At the conference the claimant must be notified of the proposed forfeiture and the period of alleged non-compliance with the reporting requirement and given an opportunity to submit relevant evidence. The conference memorandum must evaluate the evidence and explain the basis for recommending forfeiture or not. If forfeiture is recommended, the DD may then proceed to issue a compensation order establishing the amount of, and period of time during which, compensation is to be forfeited and, if that compensation has already been paid, the weekly rate at which recovery is to be made. 33 USC 908(j)(2)-(3); 20 CFR 702.286(b)-(c). The period for which compensation is subject to forfeiture is the period shown in Item 6 on the LS-200 (or to the present and continuing if future reports are not submitted). See Hundley v. Newport News Shipbuilding and Dry Dock Co., 32 BRBS 254, 258 (1998). If the claimant fails to appear at the conference after receiving proper notice, the DD may proceed with issuance of a forfeiture order as outlined above.
3. **Claimant Disagreement**. If the claimant does not agree with the forfeiture determination, he or she is entitled to a formal hearing before an Administrative Law Judge (ALJ) pursuant to 33 U.S.C. § 919(d). Upon request

from either private party, the DD should transfer the case to OALJ for hearing on the matter of forfeiture.

8. <u>Student Status - Form LS-266</u>. In addition to the annual Form LS-267, the CE must verify a student beneficiary's full-time school attendance every 6 months if the student is over the age of 18 and has not yet turned 23. See 33 U.S.C. 902(18). Claimants who are being paid student benefits are required to complete Form LS-266, Application for Continuation of Death Benefit for Student, which certifies that the student still qualifies for continuing benefits after age 18. The CE must ensure that there is a current LS-266 (within the last 6 months) signed by the registrar of the school in all cases where the Special Fund is paying student benefits.

1. **Issuing the Form**. Sixty days before a dependent child turns 18 years of age, the CE should send form LS-266 to the parent/guardian for completion. At the time the form is issued, the CE should update the LCMS with code **266i** (LS-266 issued) to reflect that the form has been issued. The case should be reviewed within 60 days to determine the next appropriate action.
2. **Follow-up**. If the form is not received and/or follow up action is needed, the CE should take the same actions as outlined in paragraph 5a and 5b of this chapter. Code **266f** (LS-266 follow up) should be added to LCMS when follow up action is taken.
3. **Form Review**. If the form is properly completed and substantiates entitlement to continuing student benefits, the CE should update LCMS with code **266r** (LS-266 received). This completes the semi-annual review process. A call up should then be placed in the case to request another LS-266 in 6 months.

   If the form is not received or information is received indicating the dependent is no longer a qualified student, the CE should request the National Office Fiscal Branch to temporarily suspend benefits. See paragraph 5c. Code **266s** (LS-266 suspension) should be added to LCMS when the suspension letter is issued. This completes the semi-annual review process.

9. Death or Change in Status of a Special Fund Recipient. The National Office Fiscal Branch must be notified whenever there is a change in status of any beneficiary receiving benefits from the Special Fund. If a claimant dies while receiving benefits, the CE should notify the National Office Fiscal Branch immediately. This notification should include the date of death and whether there is a potential death claim, if known. Similarly, if a child entitled to benefits reaches the age of eighteen or if the child's student status changes, the CE should notify the National Office Fiscal Branch immediately.

1. **Death Claim**. If a death claim is filed, the employer/carrier remains a party in interest and is responsible for evaluating the death claim. In cases where the employer/carrier agrees that the death is work related, stipulations must be submitted along with supporting evidence explaining how the death is connected to the work injury. The District Office may not issue an order without the prior agreement of the National Office Policy Branch. The DD must submit a specific recommendation to the National Office Policy Branch. If the National Office Policy Branch agrees, the DD will be advised to prepare the appropriate order. The DD will submit the order in the same manner as all initial payment cases.

   If there is not an active employer/carrier and benefits are being paid under Section 18b or 32a of the Act, the DD should evaluate the death claim and provide a recommendation for consideration to the National Office Policy Branch.

Chapter 7-0100, (Reserved)

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Chapter 7-0200, Coverage - General

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1. Purpose and Scope. This chapter contains guidelines, policies, and other general requirements applicable to employers under the Act, and describes the means by which employers may secure their obligation to provide compensation and medical benefits. The functions described are performed by the National Office, DLHWC.

2. Authority. Each employer who has employees covered by the Longshore Act or one of its extensions must secure its obligation to provide compensation and medical benefits in accordance with section 32 of the Act. A contractor must secure the obligation of its subcontractor unless the subcontractor has secured his own obligations under the Act(s).

3. Responsibilities.

1. **The Director** for DLHWC is responsible for administering provisions of the Acts pertaining to the authorization of insurance carriers and self-insured employers and for establishing the policy for card reports of coverage and certificates of compliance.
2. **The DD** of the District Office is responsible for administering provisions requiring card reports of coverage and issuing certificates of compliance in accordance with the procedures and policies established by the DLHWC. It is the DD's responsibility to see that all employers having employees covered by any of the Acts under his/her jurisdiction have the required insurance coverage in accordance with the requirements of the Acts and regulations.

4. Employer Options. Every employer carrying on covered employment is required to secure its obligation to pay compensation and provide medical care to injured employees by either:

1. **Insuring** with any insurance company authorized by OWCP, or

2. **Becoming** an authorized self-insured employer.

5. <u>Authorization of Insurance Carriers</u>. To receive initial authorization under the Longshore Act or one of its extensions, an insurance company should have five years' experience in writing workers' compensation coverage and be listed in BEST's INSURANCE REPORTS, with a rating of "B+" or better.

6. <u>Authorization of Self-Insurers</u>. OWCP, in accordance with the Act, will authorize an employer to self-insure obligations when the company has established:

1. **That it has** ample financial resources to meet all obligations in regard to its potential liability under the Act.
2. **That it has** obtained adequate excess or catastrophic loss insurance.
3. **That it has** made adequate arrangements to provide promptly all necessary medical care.
4. **That it has** made a deposit in the name of the OWCP in the manner and amount prescribed by the OWCP.
5. **That it has** agreed to carry out all requirements of the Act(s) and the regulations for administering the Act(s).

7. <u>Uninsured Employers</u>.

1. **The LHWCA requires every employer subject to the Act** to secure payment of compensation either by insuring with an authorized company or by obtaining self-insurance authorization. Section 38(a) of the Act provides that any covered employer failing to secure compensation shall be guilty of a misdemeanor and upon conviction thereof, shall be punished by a fine of not more than $10,000, or by imprisonment of not more than one year, or both.
2. **An “uninsured employer” situation can arise** in a variety of ways. For example:
    a. Form LS-570, Card Report of Insurance (Exhibit 52, PM 10-200) is received naming an unauthorized insurance carrier as having issued a workers’ compensation insurance policy endorsed for Longshore Act coverage:

b. Form LS-202, Employer's First Report of Injury or Occupational Disease (Exhibit 16, PM 10-200) is received naming an unauthorized insurance carrier or from an employer who is not an authorized self-insurer and for whom there is no Form LS-570 on file;

c. A credible source contacts the DO to report that an employer is operating in the Compensation District without the required Longshore Act insurance coverage;

d. An injured worker contacts the DO to request assistance in filing a claim for benefits, and the DO does not have a report of injury from the employer and cannot otherwise identify the employer.

3. **There are other ways** in which this issue will arise. Once a DD identifies that an employer is involved who has not complied with the insurance provisions of the Act, the following actions are recommended:

   a. The form letter provided by the National Office (Exhibit __, PM 10-300), and modified by the DD as necessary to reflect unique circumstances, should be sent to all parties. It is important that this letter be distributed as widely as possible. This includes copies to the claimant, his attorney, and, in particular, the corporate officers of the uninsured employer.

      This letter should be used whenever and wherever there is a credible indication that an employer is operating without required Longshore Act insurance coverage.

      Note that the recommended form letter contains an optional paragraph for use whenever there is a general contractor standing behind the uninsured subcontractor.

   b. Where there are repeated instances of the same employer failing to meet the insurance requirement, with knowledge of the Act's application to its operations, or where the employer has large scale operations, the DD should consider making a recommendation to the Director, DLHWC, regarding prosecution under section 38(a). The recommendation should be accompanied by full information concerning the employer, and a record of contacts between the

employer and the DD. If determined appropriate, the Director, DLHWC will seek prosecution through the office of the U.S. Attorney.

8. Penalties. The exclusivity of (workers' compensation) remedy, provided for in section 5(a) of the Act, does not apply "if an employer fails to secure payment of compensation as required by this Act." In such a situation an injured employee, or his legal representative in case death results from the injury, may elect to claim compensation under the Act, or to maintain an action at law or in admiralty for damages on account of such injury or death.

Chapter 7-0300, Authorization of Insurance Carriers

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1. Purpose and Scope. Policies and procedures for the application, authorization, and certification of insurance carriers are contained in this chapter. Special instructions on annual reauthorization or reinstatement are also included. The functions described are performed by the Insurance Branch of the National Office, DLHWC.

2. General Policy. To receive initial authorization under the Longshore Act or one of its extensions, an insurance company should have 5 years' experience in writing workers' compensation coverage and be listed in Best's INSURANCE REPORTS, with a rating of "B+" or better. However, a company not meeting one or both of these requirements may still obtain authorization if other evidence is provided which indicates the company's ability to meet all obligations required of

a carrier under the Act(s). A security deposit may be required. Unless the company is a "marine protection and indemnity association" (marine P&I club) of vessel owners, it must show authorization by a state insurance regulator to write workers' compensation insurance.

3. <u>First Inquiry</u>. Upon receipt by the National Office, DLHWC, of an inquiry from an insurance company concerning the requirements for becoming authorized under any of the Acts:

1. **Consult** the latest edition of *Best's INSURANCE REPORTS.*
2. **If the insurance company is** listed in *Best's* with a policy holder's rating of at least "B+", inform the inquirer how the insurance company may file application.
3. **If the insurance company is:**
    a. listed in Best's, but has a policy holder's rating below "B+", or
    b. has no assigned rating, or
    c. is not listed in Best's at all -- notify the inquirer of the OWCP policy.

    Do not request an application or encourage the filing of an application if (1) or (2) apply.
4. **If the inquirer** insists, despite the company's failure to meet the general requirements of coverage, that the insurance company be considered for authorization to write coverage, suggest that the inquirer write a letter to the Director, DLHWC, explaining its position, and informing the Director of the reasons the company should be considered, so that a decision can be made upon receipt of the letter. The letter from the insurance company should contain copies of the financial statements of the company for the three most recent years, preferably the conventional form of report, together with a copy of the most recent report of examination that may have been made with respect to the company by the Insurance Department of any State, its experience in writing workers' compensation insurance, and any other evidence supporting its request for authorization. The Director may authorize a company not meeting all the requirements, if it is evident that the company is financially able to carry out all of the carrier's obligations under the Act, under which authorization is being sought.

4. Application. An application for authority to issue insurance coverage must be submitted in writing and be signed by an officer of the applicant duly authorized to make such application. A letter is sufficient for this purpose since the Office has no designated form for making application. The application should indicate the Act(s) for which authority is requested and be supported by the following documentation:

1. **A copy** of the applicant's charter and certificate of authority to write workers' compensation insurance issued by a State.
2. **Statutory annual financial reports** for the three most recent years submitted by the applicant to the Insurance Department of the State in which incorporated, together with any report of examination that may have been made with respect to the company by the Insurance Department of the State having direction over the company's affairs.
3. **Specimen copy** of the Card Report of Insurance (LS-570, Exhibit 52, PM 10-200) (for each Act), which the carrier proposes to use.
4. **Specimen copy** of the form of policy and applicable endorsement to be attached to the policy (for each Act under which authorization is requested) the company proposes to use.

5. Examination. A Workers' Compensation Claims Examiner (WCCE) in the Insurance Branch makes the initial examination of documents submitted by the applicant to determine whether they conform to OWCP's Regulations (20 C.F.R. part 703). The WCCE reviews the annual report for "loss experience" and general financial stability. Additional information may be requested by the WCCE prior to the review of the documents by the Director, DLHWC.

6. Charter. If the applicant company's charter does not clearly show authority to write workers' compensation insurance, any charter provision deemed sufficient for such purpose must be explained or supported by proper interpretation of the officer of the State of incorporation authorized to interpret powers under the State insurance law.

7. Policy and Endorsement. If the company is a member or subscriber to the National Council on Compensation Insurance, the Standard Workers' Compensation and Employers' Liability Policy promulgated by the National Council may be used. If any company proposes to use a form of policy other than the NCCI's current standard, it must prominently so state at the time of application. The policy is reviewed to determine that it is in accordance with the

requirements of the Act. Policies other than the NCCI Standard Policy must be very carefully scrutinized. All companies must use the form of endorsement, appropriate to the particular Act or extension. Non-members of the National Council may also use the standard policy set forth in the Regulations governing authorization of insurance carriers. Pursuant to the Administrative Regulations and the filing program of the National Council, the name of the insurance company must be printed (not typed), and facsimile signature(s) and counter-signatures of duly authorized representatives of the company should appear on the policy to which the endorsement is to be attached.

8. Card Report. The Card Report of Insurance is examined for the proper wording, color, and weight, as set forth in the Regulations. The name of the carrier should be printed on the card, which should conform substantially to Form LS-570.

9. Agreement. Every applicant for authority to write insurance under the provisions of this Act, or for the renewal of that authority, shall be deemed to have included in its application an agreement that the acceptance by the DD of a report of the issuance of a policy of insurance, as provided for by 20 C.F.R. Section 703.116, shall bind the carrier to full liability for the obligations under this Act of the employer named in said report as well as the distinct obligations imposed on carriers, themselves, by the Act. Every certificate of authority to write insurance under this Act shall be deemed to have been issued by OWCP upon consideration of the carrier's agreement to become so bound. It shall be no defense to this agreement that the carrier failed or delayed to issue the policy to the employer covered by this report.

10. Recommendation. After carefully examining the submitted material, the examiner makes a recommendation to the Director, DLHWC, as to whether or not it appears that the applicant should be authorized. The recommendation should include the applicant's rating by *BEST's INSURANCE REPORTS.*

11. Issuance of Certificate of Authority.

1. **When the application** of an insurance company is approved, a Certificate of Authority, Form LS-571 (Exhibit __, PM 10-200) under the Act or Acts for which application is requested is issued.
2. **A separate certificate is issued** under each Act.
3. **The certificate is signed** by the Director of the Office of Workers' Compensation Programs.

4. **The company is assigned a code** authorization number under each Act for which application is approved.
5. **Two 3x5 inch index cards** are prepared for each Act indicating the name of the company, address, effective date of authorization, and code authorization number. One card is filed alphabetically under the name of the insurance carrier and one by the company's code authorization number. A separate file is maintained for each Act.
6. **A memorandum is sent** to all District Directors informing them of each new authorization, and furnishing all necessary information, such as name and address of the company, effective date of authorization, code authorization number, and clearly indicating any limitations on writing coverage.

12. Mergers - Change of Name.

1. **When a company's name is changed**, or an authorized insurance company is merged into a non-authorized one, the new company may not issue or renew any policies under the Act without obtaining a new authorization in it's new name. A new Certificate of Authority will not be issued until the following documents are submitted:
    a. Copy of the minutes or other company record accomplishing the change of name or merger.
    b. Copy of the merger agreement (if applicable).
    c. Certificate of authority to write workers' compensation insurance issued by the proper official of the Department of Insurance of the State where such change of name or merger is filed in the new name of the company.
    d. All new filings in the new name of the company must be made with the OWCP: policy, endorsement(s), agreement(s), and card report(s).
2. **Any other change** in a company's corporate entity requires the same procedures as a new company making application for authority.

13. Security. Each insurance carrier rated lower than "A" by the A.M. Best Company is subject to a security requirement. Security may be provided in three ways:

1. **A surety bond** written by a surety company authorized by the U.S. Treasury.
2. **Negotiable securities** deposited in an Office of Workers' Compensation Programs account in a Federal Reserve Bank. Securities must be fully guaranteed as to principal and interest by the U.S. Government.
3. **Letters of Credit** issued by banks meeting DLHWC'S rating requirement based on Standard & Poor's rating service. The security requirement is designed to fill in the exposure to claimants and the Special Fund created by a lack of reliability on the part of state guarantee funds or where a state fund is inapplicable. The type and amount of security is determined by National Office. The requirement is waived for insurance carriers rated "A" or higher by the A.M. Best Company, or that write Longshore insurance coverage through the National Reinsurance Pool operated by the National Council of Compensation Insurance, and for state funds, which are supported by the full faith and credit of a state government.

Chapter 7-0400, Authorization of Self-Insurers

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1. Purpose and Scope. This chapter contains guidelines and procedures for the application, authorization, and certification of employers to act as self-insurers under the LHWCA or any of its extensions. The functions described are performed by the Insurance Branch of the National Office, DLHWC.

2. General Policy. OWCP, in accordance with the Act, will authorize an employer to self-insure obligations when the company has established that it has:

1. **Ample financial resources** to meet all obligations in regard to its potential liability under the Act.
2. **Obtained adequate excess** or catastrophic loss insurance.
3. **Made adequate arrangements** to provide prompt authorization of and payment for all necessary medical care.
4. **Made a security deposit** in the name of the OWCP in the manner and amount prescribed by the OWCP.
5. **Agreed to carry out all requirements** of the Act and the regulations for administering the Act, under which authorization is sought.

3. First Inquiry. Upon receipt of an inquiry at the District Office regarding authorization for a specific employer to be a self-insurer under any of the Acts, the District Office shall immediately refer caller to the Insurance Branch of the National Office.

4. Application Procedure.

1. **Application for Authority** should be made on Form LS-271, Application for Self-Insurance (Exhibit __, PM 10-200). The self-insurance privileges granted under each Act are separate and distinct. A separate application is required under each Act, as well as a separate deposit of security.
2. **Parent and Subsidiaries**. If the applicant includes a parent company and subsidiaries, a separate application must be submitted for each incorporated entity. However, the parent company may deposit securities or file a single surety bond or letter of credit on behalf of itself and subsidiary companies.
3. **Information and Material Which Must Be Submitted.**

a. Completed Form LS-271, Application for Self-Insurance. A separate application must be completed under each Act for which authorization is requested.

b. Certified financial statements for the three most recent years.

c. Loss information under the Act for the last five years showing the amount of paid and reserved losses. This should be in the form of a letter from the present insurance carrier(s) and should show the loss of information for each year.

d. Information pertaining to specific excess insurance. The net retention and maximum limit should be given, and a specimen copy of the policy should be submitted.

e. Statement showing amount of annual payroll under the Act by insurance classification.

f. Statement pertaining to the proposed processing of claims. If claims are to be processed "in house", a statement should be submitted showing the qualifications of those individuals who will process claims. If a self-insured service organization is to be used, a profile of the organization should be submitted showing its experience in the administration of claims in general and specifically under the Longshore and Harbor Workers' Compensation Act or its extensions.

5. Examination of Application. The examiner reviews the documents submitted in support of the application. After determining that an application meets the requirements of the Office, conditioned on the filing of an indemnity bond with the Office or depositing negotiable securities with a Federal Reserve Bank or Branch thereof, the examiner recommends to the Director, DLHWC, an amount which the OWCP considers necessary and sufficient to secure the performance by the applicant of all obligations imposed upon him by the Act as an employer. Such amount shall not be less than $200,000 for any one employer. The following specific requirements are evaluated:

1. **Security**. In determining the amount of the security, the Insurance Branch will take into account the financial standing of the company, the nature of the work in which it is engaged, the degree of hazard of the work in which the

employees are employed, the payroll exposure, the accident experience shown in the application, and any other pertinent data submitted, including provisions of excess insurance against catastrophic loss.

2. **Bond**. If the applicant elects to file an indemnity bond with the Office, Form LS-405, Indemnity Bond (Exhibit, PM 10-200), is forwarded to the applicant to be executed and returned in an amount fixed. The bond must be signed by the appropriate officer of the principal, and be duly attested; signed by the surety and duly attested; and the corporate seals of both principal and surety must be affixed to the bond. If the bond is executed by an attorney-in-fact, a written power of attorney must be attached to the bond. The surety company on a bond shall be approved by the United States Treasury Department under the laws of the United States and applicable rules and regulations governing bonding companies that write Federal bonds.
3. **Negotiable Securities**. If the applicant chooses to deposit negotiable securities in a Federal Reserve Bank, a letter is written to the Federal Reserve Bank designated by the OWCP, authorizing the bank to accept and hold such securities subject to the order of OWCP, in accordance with the regulations. The OWCP has the discretionary power, in the event of default of the self-insurer, to sell any or all of the securities as may be required to discharge the obligations of the self-insurer under the Act(s). The OWCP is furnished the original receipt from the Federal Reserve Bank which is kept in the self-insurer's file.
4. **Letters of Credit**. Letters of credit, issued by banks meeting DLHWC's requirement and which are based on the rating system published by Standard & Poor's, are acceptable.
5. **Agreement and Undertaking**. An applicant for the privilege of self-insurance shall, as a condition subsequent to receiving authorization to act as a self-insurer, execute and file with the OWCP an Agreement and Undertaking, Form OWCP 1.

6. Approval by the Director, OWCP, Is Required of an Employer to Act as a Self-Insurer. Upon favorable action on the application for self-insurance, the

OWCP issues to the Self-Insurer Form LS-572, Decision Granting Authority to Act as Self-Insurer (Exhibit __, PM 10-200), signed by the Director.

7. Notification - Recording.

1. **Notification**. Memorandums are sent to DDs, furnishing the name and address of the employer, effective date of each new authorization, code authorization number, and indicating any limitations on the employer's self-insurance privilege.
2. **Numbering and Indexing**. A code authorization number is assigned to each self-insurer under each Act. Two 3x5 index cards are prepared for each self-insurer under each Act, indicating: the name of the company, the company's principal address, effective date of authorization, and code authorization number. The cards are filed alphabetically by name of self-insurers and by code authorization number assigned. A separate file is made up for each self-insurer under each Act for which authorization is granted. These records are maintained in the National Office.

8. Reauthorization of Self-Insurers.

1. **A review** of self-insurers is made annually and the OWCP may request that employers submit reports of all outstanding obligations on Form LS-274, Report of Injury Experience (Exhibit 36, PM 10-200).
2. **Whenever**, in the opinion of the OWCP, the principal sum of the indemnity bond or the amount of negotiable securities deposited by a self-insurer is insufficient to provide adequate security for the payment of anticipated compensation and medical expenses under the Act, the self-insurer shall upon demand by the OWCP, file such additional indemnity bond or deposit such additional amount of securities as may be required.
3. **Each time** there is any change in the deposit of securities or the amount of bond, an Agreement and Undertaking, Form OWCP 1, must be executed by the self-insurer.
4. **All employers** who file indemnity bonds are furnished Form LS-405, Indemnity Bond (Exhibit __, PM 10-200), each year, to be executed for the

next authorization year beginning July 1 and ending June 30, with a request that the executed bond be mailed so that it will reach the NO's Insurance Branch by June 1st before the beginning of the new year.

5. **Letters** are sent each year to self-insurers whose deposit of securities with a Federal Reserve Bank or Treasurer of the United States appears adequate, informing them that their self-insurance privilege will be continued for the next authorization year.

9. Changes or Terminations.

1. **If the self-insurer** enters a merger with a change of name, but without a change in corporate entity, a copy of the merger agreement and change of name shall be furnished the Office. The Agreement and Undertaking, Form OWCP-1 (Exhibit __, PM 10-200), must be executed in the new name.
2. **If the company** has secured its obligations by filing an indemnity bond with the Office, a properly executed rider may be attached to the current bond on file reflecting the new name of the company.
3. **In the event** of a merger, resulting in a change of corporate entity, the former company's self-insurance privilege is not transferred to the new company. A new application must be filed by the surviving company.
4. **If the authorization** of a self-insured employer who has filed an indemnity bond with the OWCP is terminated prior to the expiration date of the bond, the effect of such termination is to relieve the surety company of any further liability under the bond for liabilities arising from employment after the date of such termination. The bond, however, remains permanently on file with the OWCP.

10. Audits. A variety of audits are performed, involving either contractors, National Office staff, or district office personnel.

1. **Form LS-513, Report of Payments**. The reporting forms for compensation payments, on which the Special Fund assessment is based are selectively audited by a firm under contract with the DLHWC.

2. **Form LS-274, Report of Self-Insurer's Outstanding Liabilities**. This report is required annually from each self-insurer and from those insurance carriers required to post security. Up to five of these reports, generally involving the largest exposures, are audited annually by National Office staff, by reviewing case files in the district office and comparing reserve estimates with those of the self-insurer/carrier. Each district office also reviews up to five of these reports each year, as assigned by National Office. District Office reviews are limited to reports involving small exposures.

Chapter 7-0500, Card Reports and Certificates

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9. Filing of Coverage Cards	09/00	00-01

1. Purpose and Scope. This chapter contains guidelines and procedures for the verification and certification of employer's coverage/self-insurance, and prescribes detailed procedures for examining and filing coverage cards, Form LS-570, Card Reports of Insurance (Exhibit 52, PM 10-200). The functions described are performed in the District Offices.

2. Carrier's Report Requirement. Each policy and Longshore Act (or other related statute) endorsement issued to an employer must be reported by the carrier to each DLHWC District Office in which the employer conducts business under the Act, under which coverage is reported. The report is made on Card Report of Insurance, Form LS-570, and is filed with the DD. When accepting the card report, the NO considers it conclusive evidence that the carrier has provided the coverage stated, and the carrier is bound by the report to provide compensation benefits due employees and survivors of the insured employer. The Card Report should clearly indicate, if applicable, that the policy in question is site-limited.

3. <u>Receipt of Coverage Card by District Office</u>. Upon receipt of a Card Report of Insurance, LS-570, by a DO, the Insurance Clerk or other employee assigned to perform the function will:

1. **Date Stamp** Card on date received.
2. **Write on Back** of the Card the address of the carrier's office submitting the report, if the address is not shown on the face of the card.
3. **Acknowledgments**. If requested, acknowledgment of transmittal letters may be made by date stamping with the official stamp and returning letter to carrier.

4. <u>Examination and Verification of LS-570</u>. Check the card report for the following:

1. **Dual Coverage of Employer**. Under the Longshore Act, an employer should be insured by only one insurance company for all the employer's operations within a State for a period of one year or more.
2. **Insurance Carrier Must be Authorized**. The carrier filing the card report must be a company authorized by the OWCP. Carrier's number may be entered in space provided on the coverage card, if desired, although this practice is optional.
3. **Employer: One Card for Each Insured Employer**. Separate card reports should be filed for each employer covered. The correct name of the employer must be written in full, as well as the trade name if the business is conducted under a trade name. If there is a "partnership", the correct name of the partnership must be shown. In no case may the expression "et al." be used on a card. Cards bearing such entries should be returned to the carrier for correction.
4. **Employer's Address Should be Complete, Including ZIP Code Number**. If it appears that card report was submitted to the wrong DO, send the card report to the correct district with a brief memorandum or transmittal slip.
5. **Coverage Dates**. The beginning and expiration dates of policies must be clearly indicated on the card. They should be written plainly, such as "July 1, 1999 through June 30, 2000". Uncertain abbreviations should not be

accepted. The period of coverage should be for at least one year. An explanation must be given if the coverage is for a shorter period.

6. **Check Card to be Certain Full Coverage is Provided**. Limited coverage is not permitted. There should be nothing inserted or written on the card which limits the coverage provided by the carrier filing the card. The coverage should be extended generally by one carrier for all federally covered activity in an entire compensation district. If an employer or insurance company attempts to limit the coverage provided, the issue should be referred to NO.
7. **Signature of Official**. Each card report must bear the manual signature or a stamped signature of an official authorized by the carrier. The DD will decide whether to accept cards with stamped signatures. Cards with printed signatures are acceptable only if the National Office, DLHWC, has given written authorization to a carrier to file such cards. District Offices are notified if printed signatures are approved for a carrier.

5. <u>Issuing Certificates of Coverage</u>. Certificates of coverage or compliance, Forms LS-240 and LS-239 (Exhibits 29 and 28, PM 10-200), are issued under the following circumstances (resolve any questions which may arise with the carrier by sending Form Ltr. LS-502, Exhibit __, PM 10-200):

1. **LHWCA Certificates.**
    a. **Certificate Form LS-240**. This form will be issued by the DD to any employer approved by the Director, OWCP, as a self-insurer under the appropriate Act.
    b. **Certificate Form LS-239**, will be issued by the DD, upon receipt of an acceptable card report, Form LS-570 to "active employers" (those employers who have known exposure) and to others if requested.
2. **The District Office** will issue only one certificate to an employer in a compensation district. An employer desiring duplicates may have photocopies of the Certificate made for use in different places and/or locations within the compensation district. Certificates are issued only to the employer concerned and never to an insurance carrier, agent, or broker.

6. Termination of Policy. When the Card Report of Insurance indicates that the Employer's insurance has expired, the Coverage Clerk, or other employee assigned to perform the function, should send Form LS-501 (Exhibit __, PM 10-200) requesting information regarding renewal of coverage.

7. Cancellation of Policy. Notices of cancellation of insurance policies are acceptable only if in accordance with section 36(b) of the Longshore Act. The policy is considered in full force and effect until properly canceled. Cancellation notices on unexpired policy terms require that Form LS-501, be sent to the employer requesting return of the Certificate. The certificate should be retained for thirty days after receipt.

8. Reinstatement of Policy. If a cancellation notice is received and the carrier reinstates the policy before the expiration of the thirty day period provided in section 36(b) of the Act, the Certificate should be returned to the employer without alterations. If the Certificate is not received, no further effort should be made to obtain it and the DO's records should be denoted only that the policy has been reinstated.

9. Filing of Coverage Cards.

1. **Active Cards**. Coverage cards are filed alphabetically by the Employer's name. "Active Employers'" cards (cards for employers having known exposure) should be filed separately from "inactive employers'" cards.
2. **"No Exposure" Cards**. District Offices receive numerous cards (Form LS-570) for policies issued to employers who have no conceivable exposure under the Longshore Act in the district where they are filed. Coverage cards should not be filed, even though Longshore Act coverage is provided and the approved endorsement has been added to a compensation policy in the following instances:
    a. The insured employer, though having exposure under the Act or one of its extensions, has no regular business operations and/or no specific address in an OWCP district; or
    b. The insured employer has no Maritime employees and/or the insured's operations clearly do not bring about exposure of its employees within the purview of the Act or one of its extensions.
3. **Misdirected Cards**. Insurance coverage cards filed in a DO showing no address within the compensation district should be returned to the insurance

carrier, giving the reason for their return. Cards received for another DO should be forwarded immediately to the DO having jurisdiction.

4. **Late Filing**. Should an injury be sustained, which comes under the coverage of the Longshore Act or one of its extensions (for which the employer had obtained insurance coverage, but in attempting to follow the instructions above the insurance carrier did not file a coverage card with the District Office), the carrier may at such time be permitted to file a coverage card without being considered to be in violation of its agreement with the National Office of OWCP in this regard. Questions about coverage raised by this provision should be referred to and may be resolved by the DD.

Chapter 7-0600, DBA Waivers

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1. Purpose and Scope. This chapter contains guidelines and procedures for the requesting, evaluating, and granting of waivers to the application of the Defense Base Act (DBA). The functions described are performed in the National Office. Waivers are signed by the Director, DLHWC. See Procedure Manual Chap. 4-0400, Para. 6, Delegation of Authority; Director, OWCP delegates authority to act on DBA waivers to Director, DLHWC.

2. Background and Effect of DBA Waivers. The DBA provides DOL with discretion to waive the application of the DBA "with respect to any contract, subcontract, or subordinate contract, work location under such contracts or classification of employees," upon the request of an agency head. DBA section 1(e), 42 U.S.C. § 1651(e). Once DOL has granted a waiver, employees who fall within the scope of the waiver are excluded from coverage by the DBA. As a result, the employer of waived employees is not required to pay, or secure the payment of, DBA benefits for those DBA-waived employees; the employer is neither required to purchase DBA insurance or obtain authorization from DOL to self-insure. However, if the same employer also has DBA-covered employees who fall outside the scope of the waiver, the employer remains required to pay and secure benefits for those DBA-covered employees. See DBA section 1(a)(4)-(5); 42 U.S.C. § 1651(a)(4)-(5); LHWCA section 4(a), 932, 33 U.S.C. §§ 904(a), 932.

3. Types of Waivers and DOL Policies on Waivers

a. DOL is authorized to grant three different kinds of DBA waivers: contract waivers; geographic waivers; and waivers for a particular class of employees.

b. When DOL grants a geographic waiver for a particular location, the geographic waiver applies for all U.S. agencies and contracts for all work performed in that location, not just the requesting agency and its contractors. Other more specific waivers apply only as their terms provide.

c. Waivers only apply to (exclude from DBA coverage) foreign workers hired outside of the United States. Waivers do not exclude from DBA coverage citizens or legal residents of the United States or employees hired in the United States.

d. All waivers are granted for a finite period of time and the terms of the waiver will include the date upon which the waiver automatically expires, unless renewed.

4. Waiver Request. Only the head of a United States department or other federal agency (or an official duly delegated or authorized by the head of an agency) may submit a written request for waiver of the DBA to the Secretary of Labor (and to the Director of DLHWC by delegation). The Director may waive the application of the Defense Base Act with respect to any contract, work location, or class of employees. The waiver request and materials package may be sent by email to DLHWC-Public@dol.gov or may also be mailed to the Director, OWCP, U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, 200 Constitution Avenue NW, Rm C-3524, Washington, DC 20210.

a. Upon receipt of a request for a waiver, the employee responsible for checking the public mailbox or the mail should refer the materials to the National Office, specifically to the Director, DLHWC or their designee to evaluate waiver requests.

5. Waiver Request Package. A complete DBA waiver request package consists of:

a. The Form BEC 565, signed by the head of a department or other agency of the United States or an appropriate and duly authorized delegate of that person. Form BEC 565 is available online and is fillable.

b. A comparison of the workers' compensation benefits available in the relevant country to the benefits under the DBA. A DBA Waiver Comparison Chart may be used for this requirement, filled in completely with the relevant terms of the local workers' compensation provisions. Include specific references to the provisions of the local law. The Comparison Chart is available online in the format of an Excel spreadsheet.

c. English translations of the local workers' compensation provisions or other relevant law or policy.

d. Website addresses from which the requestor has obtained any information.

A memo or letter explaining any differences between the benefits and scope of coverage under the DBA and the relevant local workers' compensation law may also be submitted, but is not required, along with any other information the agency head deems relevant to the waiver request. DOL may also consider other pertinent factors not listed on the comparison chart and the items on that chart are not necessarily an exhaustive list.

6. Evaluation of Waiver Request. The Director, DLHWC or their designee will:

a. **Make sure** that all of the required materials in the Waiver Request Package have been submitted. See Section 5 above.

b. **Acknowledge** receipt to the requester, noting any missing materials.

c. **Evaluate** the materials for the required information to support a waiver request by checking to see that the request meets the following criteria.

i. **Signed**. An agency head or appropriate delegate must have signed the request. The signature should appear on Form BEC 565.

ii. **Each element of the chart**. For each listed element on the Comparison Chart:

- Compare the local workers' compensation benefits available in the relevant country to the benefits available under the analogous provisions of the LHWCA which provides the substantive provisions for the DBA.
- Make sure significant differences from LHWCA/DBA are adequately explained such that the compensation entitlement and outcome for any covered injured claimant would be comparable under the LHWCA/DBA's provisions.
- Check references to the local law to verify they are accurately summarized on the chart.
- If necessary, or if any red flags are apparent, require that the requester undertake additional research into the local workers' compensation situation in the relevant country.

iii. **Translated laws**. Copies of the relevant foreign local workers' compensation laws should be submitted in English. The requesting agency must obtain any necessary translation at its own expense.

iv. **Any other materials**. Evaluate any other materials sent in, such as a memo in support of the waiver request or links to news or other online materials.

v. **Examples**. Some examples of what to look for in evaluation of the Comparison Chart responses are:

- that the local compensation system in place covers the workers for whom the DBA will not apply if the waiver is granted, including citizens of the local country and third-country nationals;
- that the local compensation system is not based on fault;
- that the local compensation system does not exclude coverage for war risks or chemical, biological, radiological, or nuclear exposures;
- that the local compensation system has no limits regarding the duration for which benefits are payable except as in the DBA for temporary partial disability benefits and scheduled permanent partial disability benefits;

- that the local compensation system has no aggregate maximum dollar limits on benefits;
- that the worker does not lose their benefits if they move out of the country following their injury or illness;
- that eligibility for benefits and benefit amounts are equitable with respect to gender; and
- that the injured worker does not have to pay or contribute anything into the compensation system.

This is not an exhaustive list, just a few highlighted areas for consideration.

d. **Write up** any deficiencies in the local workers compensation system as compared to the DBA system. An email listing any issues is sufficient.

e. **Obtain SOL review** of the recommended course of action. Most waiver decisions are policy decisions, but SOL will review waiver requests to verify that there are no legal barriers or other significant issues with the particular waiver request. An email to SOL with the write up of deficiencies is sufficient. Copy the Director, DFELWHC if the issues are significant enough to warrant a discussion.

f. **Send any follow up questions** to the agency making the request, if necessary. Email the contact person at the agency about any deficiencies and afford them an opportunity to explain with more information. Advise them that DOL will grant or deny the waiver after fully evaluating all of the information.

g. **Make a recommendation to the Director, DLHWC to grant or deny the waiver**, based on all of the information available.

7. Issuing a Decision Granting a Waiver. DBA waivers are typically granted for a period of five years from the date the waiver is signed by the Director, DLHWC. The waiver automatically expires on the listed expiration date, absent a request from the department or agency head or appropriate delegate for the waiver to be renewed.

Using the waiver template, prepare a waiver document for the relevant country, contract, or classification of employee. Ask the Director, DLHWC to sign and date the document. Waivers are typically effective as of the date the document is issued and uploaded to the DOL website.

8. Denying a Waiver. To deny a waiver request, send an email to the requesting agency through the contact that sent in the request. Explain the deficiencies in the request, tell them that no waiver will be granted, and inform them that further information can be submitted with a future waiver request. There is no minimum amount of time that a requester must wait before submitting a new waiver request.

9. Update the Website. Notice of the existence of DBA waivers to federal agencies and to the public is provided by DLHWC through posting on the DOL website. All current active waivers are listed on DOL's Longshore program website, both by geographic area and by expiration date. Simultaneously with, and in coordination with, the issuance of a waiver, the DOL website should be updated to reflect the grant of the waiver. This may mean requesting an update to the website through the website contact for the Longshore program in advance of final grant of the waiver. To get the website updated:

a. Send an email detailing the additions and the signed waiver document to be attached/linked online.

b. Approve the updates in development, when the website contact asks for approval, pointing out any errors.

c. Check the website to see the updates posted correctly.

10. Remind the Requesting Department or Agency to adjust Contract Provisions

a. Federal contracts, and certain grants and cooperative agreements, which call for work to be conducted overseas bring the employees performing that work within the coverage of the DBA. Thus, when a DBA waiver is granted or expires, the department or agency which requested the waiver should be reminded to disseminate information about the status of any waiver to all of its contracting personnel. Those contracts and other instruments that are covered by the DBA should include FAR clauses 28.305, 28.309(a) and 52.228-3. Upon the issuance of a DBA waiver, those FAR clauses should be replaced by FAR clauses 28.309(b) and 52.228-4.

b. When a DBA waiver expires, all contracts and other instruments subject to the DBA must be modified or otherwise revised to contain language reflecting the requirement that the employer secure the payment of compensation under the DBA. The Director, DLHWC or their designee will communicate to the requesting department or agency the need to modify any existing or newly issued contracts for work overseas to reflect the accurate status of the application of the DBA.

11. Renewal. The procedures for waiver renewal are the same as those for granting an initial waiver. It is the responsibility of the department or agency heads to monitor the expiration dates for the various waivers, so that waiver renewal requests may be timely submitted to DOL for evaluation. DOL will not grant or renew a waiver absent a request from a department or agency head or appropriate delegate.

a. A request for a waiver renewal should be sent to the National Office, to the Director, DLHWC or their designee responsible for waivers.

12. Monitor the Website for Waiver Expiration Dates

a. a. When a waiver is within six months of expiration, highlight it on the website, on the list of current active waivers – by expiration date. If a request for a renewal has been submitted, note that on the website as well:

Active DBA Waivers – by expiration date

Location	Type	Number	Issued Date	Expiration Date
Greenland	Geographic	2016-1	04/01/2016	03/31/2021 *renewal application received
Japan	Geographic	2016-2	04/01/2016	03/31/2021
South Korea	Geographic	2016-3	04/01/2016	03/31/2021
Israel	Geographic	2016-4	04/22/2016	04/21/2021
Turkey	Geographic	2016-5	04/22/2016	04/21/2021
India	Geographic	2016-6	06/21/2016	06/20/2021
Vietnam	Geographic	2016-7	08/09/2016	08/08/2021
Denmark	Geographic	2017-01	11/30/2016	11/29/2021
Iceland	Geographic	2017-02	11/30/2016	11/29/2021
Norway	Geographic	2017-03	11/30/2016	11/29/2021
Mexico	Geographic	2017-04	02/28/2017	02/27/2022

b. b. When a new waiver has been added or an expiring waiver has been renewed, arrange to have it added to DOL's current active waivers list by requesting that the DOL website be updated. See Section 7 above.

13. Responsibilities.

a. United States Department or Agency Heads:

- Submit DBA waiver request packages and include all of the required information.
- Monitor the Longshore website for current active waivers and waiver expiration dates.
- Submit requests for renewal of existing waivers for evaluation approximately three months before the expiration date.

b. Contracting Agencies:

- Ensure all contract terms and other instruments comply with the DBA where applicable.
- Include DBA insurance requirements for any procurement of services to be performed by contractors outside the United States (but not for any contract to exclusively furnish materials or supplies) by inserting FAR clauses 28.305, 28.309(a) and 52.228-3. Keep in mind that some funding instruments other than contracts may also result in employees being subject to coverage by the DBA.
- Upon the issuance of a DBA waiver, if all employees have been waived, then those FAR clauses should be replaced by FAR clauses 28.309(b) and 52.228-4. If any employees remain covered by the DBA, such as US citizens and residents, FAR clauses 28.309(a) and 52.228-3 should remain in the contract.
- Also, when relying on a waiver, provide and maintain for all waived employees adequate local workers compensation with no exclusions (such as war hazards).
- Monitor the Longshore website for current active waivers and waiver expiration dates.
- When a DBA waiver expires, all contracts and other instruments subject to the DBA must be modified or otherwise revised to contain language reflecting the requirement that the employer secure the payment of compensation under the DBA.
- Respond to questions about the application of particular waivers to specific contracts.

c. DOL:

- Respond to waiver requests in a timely fashion and request further. information or clarification as needed.
- Grant or deny the waiver request after fully evaluating all of the information.
- Post new and active waivers online.
- Post notice of waiver expiration dates online.

14. Responses to inquiries. DOL occasionally receives inquiries from insurance companies, brokers, or employers regarding DBA waivers. The response to each should be as follows:

a. DOL should refer to the contracting agency most questions about the application of a waiver to a particular contract or contractor.

i. If a question about a particular waiver's application is received, it should be forwarded to the National Office, to the Director, DLHWC or their designee.

ii. The Director, DLHWC or their designee should evaluate the inquiry to determine whether there is a general waiver policy question that DOL can answer. If the question does not relate to a matter of waiver policy, the person making the inquiry should ordinarily be referred to the department or agency which entered into the contract calling for overseas work to be performed.

b. Insurance Companies should be encouraged to:

- Monitor the DOL website for current active waivers and waiver expiration dates.
- Direct questions regarding the application of particular waivers to specific DBA claims or particular contracts to the contracting agency.

c. Brokers should be encouraged to:

- Monitor the DOL website for current active waivers and waiver expiration dates.
- Direct questions on application of particular waivers to specific contracts to the contracting agency.
- Understand that brokers may face E & O claims exposure if an employer who has DBA-covered employees is not advised to procure appropriate insurance.

For example, if there is doubt as to whether particular employees are covered by the DBA or if the application of the DBA to those employees was waived, a broker may wish to advise the employer to obtain DBA insurance.

d. Employers should be encouraged to:

- Monitor the DOL website for current active waivers and waiver expiration dates.
- Direct questions regarding the application of particular waivers to specific employees, claims, or contracts to the contracting agency.
- Understand that employers may face penalties under LHWCA section 38, 33 U.S.C. § 938, and may be exposed to civil suit under LHWCA section 5(a), 33 U.S.C. § 905(a), if they do not properly secure the payment of compensation as required under LHWCA sections 4(a) and 32, 33 U.S.C. §§ 904(a), 932. For example, if there is doubt as to whether particular employees are covered by the DBA or if they are covered by a DBA waiver, the employer may wish to purchase insurance or apply for authorization to self-insure.

Further Information - Explaining DBA

Chapter 8-0100, Introduction

Paragraph and Subject	Date	Trans. No.
Table of Contents	12/01	02-01
1. Purpose and Scope	12/01	02-01
2. Authority	12/01	02-01
3. State Guaranty Funds/Associations	12/01	02-01

1. Purpose and Scope. This part of the LHWCA PM describes the various penalties which may be assessed under certain sections of the Act. It describes the criteria necessary for the assessment of the penalty and the procedures to be followed.

Chapter 8-201 deals with the assessment of interest against the EC for the late payment of compensation. Chapter 8-202 deals with the section 14(e) penalty assessed for failure to timely controvert a claim. Chapter 8-203 provides guidance on the section 14(f) penalty assessed for failure to timely pay a final award of compensation.

The chapters listed in the preceding paragraph deal with a penalty or interest

paid directly to a claimant in addition to the compensation due. Chapters 8-301 through 8-400 deal with penalties that are assessed against the EC and are paid directly to the Department of Labor. Instructions are provided for penalties under section 14(g) (late filing of Form LS-208), section 30(e) (late filing of Form LS-202), and section 48(a) (discrimination motivated by the filing of a claim).

2. Authority. The District Director, and in some instances Claims Examiners, are authorized to assess penalties and interest against the EC. Guidance is provided for the enforcement and/or collection of the penalty and/or interest in each chapter.

3. State Guaranty Funds/Associations. Several states have a state guaranty fund or association designed to protect claimants from financial loss caused by the insolvency of the original insurer.

In cases where the original insurer becomes insolvent and there is a state guaranty fund, applicable penalties and/or interest should be assessed against that guaranty fund. If the guaranty fund responds and shows that it is not liable for penalties or interest because, for example, it is exempt under state law from paying any federal longshore claims, or is exempt from paying any penalties or interest, the responsible employer should be assessed the liability for penalties and/or interest (see Canty v. S.E.L. Maduro and Florida Insurance Guaranty Association, 26 BRBS 147, and the cases cited therein). Any exemption of a state guaranty fund or association does not absolve the responsible employer from its liability under the Act.

If a guaranty fund shows that it is exempt from the payment of penalties and/or interest in a particular case, it should not automatically be considered exempt in all future similar cases. The fund/association should submit documentation in support of the alleged exemption in each case.

If the responsible employer is also insolvent and liability for the payment of benefits falls to the Special Fund under section 18(b), the Special Fund will not pay penalties or interest (see the Longshore (LHWCA) Procedure Manual, Chapter 6-202.7a(10)).

Paragraph and Subject	Date	Trans. No.
Table of Contents	05/13	13-01
1. Purpose and Scope	05/13	13-01
2. Policy.	05/13	13-01
3. Rate of Interest	05/13	13-01

4. Items on Which Interest is Payable 05/13 13-01
5. Uniform Method of Calculating Interest 05/13 13-01

1. Purpose and Scope. This Chapter presents the policy, procedures, and criteria for assessing interest, which is to be applied to all compensation payments which are past due.

2. Policy.

1. **Interest Allowed on Compensation Due Under the Act**. It is the Director's policy to impose interest on all compensation payments which are past due. This policy is supported by longstanding case law recognizing the appropriateness of requiring the assessment of interest for failure to pay compensation when it becomes due and payable. The Board and courts have held that interest is appropriate despite the fact that the Longshore and Harbor Workers' Compensation Act and regulations are silent regarding interest.
2. **Mandatory Application of Interest**. The Board has long held that payment of interest is mandatory on past due compensation and runs from the date the compensation is owed. Ryan v. McKie Co., 1 BRBS 221, 229-30 (1974). The Board has recently reaffirmed the mandatory nature of interest holding that a claimant cannot waive the right to interest in an agreed compensation order, but may waive interest in a section 8(i) settlement. Aitmbarek v. L-3 Communications, 44 BRBS 115, 118-19 (2010). Even before the Board was created, the courts held that if payments were unjustly withheld (and under the law, payments are wrongfully withheld if it is eventually determined that they should have been paid), the party who withheld payment should be compelled to pay lawful interest from the date of the claimant's entitlement to the payment to the date the payment is actually made. Strachan Shipping Co. v. Wedemeyer, 452 F.2d 1225, 1229-30 (5th Cir. 1971). In Wedemeyer, the Fifth Circuit held that the deputy commissioner had authority to include interest on compensation not paid when due because a claimant is not made whole and does not receive the full amount of compensation due unless interest is added.
3. **Procedure**. As a matter of general procedure, entitlement to interest must be included in all compensation orders awarding benefits after specifying the amount of the award. Such an order must include the following language:

"together with interest payable on each past due installment of compensation in accordance with the rate established under 28 U.S.C. Section 1961."

4. **A Timely Controversion Does Not Excuse Interest**. An Employer/Carrier's timely controversion of the right to compensation under section 14(d), i.e., the filing of a Form LS-207 within fourteen days of the employer's knowledge of the injury, does not relieve the responsible party from paying interest on unpaid compensation later determined to be due.
5. **Interest Applicable to Unpaid Balance Only**. Interest Applies Only to Unpaid Compensation. If an EC has made partial payments, for example, in compliance with the terms of a state compensation law, or has made payments at a compensation rate less than that which is determined to be correct, interest applies only to the portion of the compensation which was not paid.

3. Rate of Interest - Title 28 U.S.C. Section 1961. Interest is to be paid at the rate determined under 28 U.S.C. Section 1961 as of the time an award is filed (or payment of past-due benefits without an award is made). It is a uniform rate based on the United States Treasury constant maturities (1 year) yield immediately prior to the date the compensation order is filed in the office of the District Director. The application of this interest rate was upheld in an en banc decision by the U.S. Court of Appeals for the Ninth Circuit in Price v. Stevedoring Services of America, Inc./Director, 697 F.3d 820, 836-39 (9 th Cir. 2012) (en banc), 46 BRBS 51 (CRT). Interest rates are available via links posted to the program web site.

4. Items on Which Interest is Payable. Interest is payable on all items that are included in the statutory definition of compensation under section 2(12). Thus, interest is due on all unpaid accrued disability and death compensation and also on funeral expenses if not timely paid. Adams v. Newport News Shipbuilding and Dry Dock Co., 22 BRBS 78, 84 (1989). Likewise, interest is payable on assessments of additional compensation under section 14(f) that are not timely paid. McKamie v. Transworld Drilling Co., 7 BRBS 315, 320 (1977). Interest is also payable on overdue medical expenses, whether reimbursement is owed to the claimant or the medical provider. Ion v. Duluth, Missabe & Iron Range Ry. Co., 31 BRBS 75, 80 (1997); Hunt v. Director, OWCP, 999 F.2d 419, 421-22 (9 th Cir. 1993), 27 BRBS 84 (CRT). It is also the Director's policy to impose interest on assessments of additional compensation under section 14(e), despite the fact that the Board long ago held that interest is not allowed on such

assessments. Cox v. Army Times Publishing Co., 19 BRBS 195 (1987). The Director plans to challenge the Board's ruling on this issue in Wakeley v. Knutson Towboat Co., BRB Nos. 13-288/A, which is currently pending before the Board.

5. Uniform Method of Calculating Interest. In light of the reasoning set forth by the Ninth Circuit in Price v. Stevedoring Services of America, Inc./Director, 46 BRBS 51 (2012), the Director has adopted a new procedure for calculating interest on accrued unpaid compensation. Prior procedure involved using two formulas to calculate “sliding” and “straight” interest. Current procedure calls for a single calculation of “compound” interest (with an annual compounding interval). This compounding interest formula is to be used by all District Offices, both inside and outside the Ninth Circuit.

1. **For purposes of illustration**, assume an employee injured in July of 2010 is permanently partially disabled as of August 1, 2010 based on a loss in earning capacity, with a PPD rate of $1,000 per week. The case was controverted, and no benefits were paid by the EC. The employee then received an ALJ Decision and Order Awarding Benefits plus interest, served on December 1, 2012. Assume the interest rate is 0.18%.

   The basic compound interest formula is:

   $A = P(1+r/n)^{nt}$

   Where:

   A = the amount accumulated after n years, including interest
   P = the principal amount
   r = rate of interest (as a decimal)
   n = number of times interest is compounded per year
   t = number of years the amount is overdue (number of days overdue ÷ 365)

   Because interest is compounded only once per year, the value of “n” will always be one. When the above example is placed in a spreadsheet with the formula, the table would appear like this (first four payments only):

Interest spreadsheet example - sample

Begin	End	Bi-Week	Interest	Total
8/10/2010	8/14/2010	$2000.00	$8.40	$2008.40[1]
8/15/2010	8/28/2010	$2000.00	$8.26	$2008.26
8/29/2010	9/11/2010	$2000.00	$8.11	$2008.11
9/12/2010	9/25/2010	$2000.00	$7.97	$2007.97

2.

Note that the amount of interest due on each biweekly principal payment decreases; this is because the value of "t" decreases due to the reduced amount of time elapsed between when the compensation became due (10 days after the December 1, 2012 compensation order), and the end of the period for which the compensation was payable. Note also that the amount of the second, third and fourth principle payments do not increase by the amount previously paid in interest. This is because interest is calculated on each overdue principal payment individually, and interest is compounded only once per year for each payment.

[1]Applying the formula to the first payment would yield: $2000(1 + .0018/1)^{849/365} = 2000(1.0018)^{2.33} = 2000(1.0042) = 2008.40$.

3. **For actual calculations**, use the version contained in the LCMS interest calculator. Problems or discrepancies should be brought to the attention of the Director, DLHWC.

Chapter 8-0202, Late Payment: Section 14(e) Penalty

Paragraph and Subject	Date	Trans. No.
Table of Contents	09/00	00-01
1. Purpose and Scope	09/00	00-01
2. General	09/00	00-01
3. Definition of Late Payment	09/00	00-01
4. Effect of Controversion of Claim	09/00	00-01
5. Claim for Further Compensation	09/00	00-01
6. Payment by Check	09/00	00-01
7. Delayed Payment Excused by DD	09/00	00-01

8. Calculation 09/00 00-01
9. Period of Assessment 09/00 00-01

1. Purpose and Scope. This Chapter contains guidelines, procedures, and instructions for computing and applying the 10 percent additional compensation due. It is payable to a claimant when an installment (or any part of an installment) of compensation that is payable without an award is not paid within fourteen days after it becomes due. In these cases, the 10 percent additional compensation is to be applied and awarded in addition to the interest granted for delayed and past due payments. (See PM 8-201 for details on interest.)

2. General. Section 14(e) provides that if any installment of compensation payable without an award is not paid within fourteen days after it becomes due, an additional 10 percent shall be added to the compensation. This 10 percent is applicable unless a notice of controversion, stating good-faith grounds for non-payment, is filed pursuant to section 14(d) of the Act within 14 days after the employer obtains knowledge of the injury or after a controversy arises (e.g., the unilateral reduction or termination of payments). However, the delay in payment may also be excused by the DD if timely payment could not be made as a result of conditions beyond the employer's control.

3. Definition of Late Payment.

1. **Section 14(b) requires that compensation be paid** initially on the fourteenth day after the employer is notified or aware of the injury, and that all compensation then due shall be paid. Following the initial payment, compensation is to be paid bi-weekly unless the DD determines otherwise. The usual practice is to pay compensation at two-week intervals. Since the 10 percent penalty does not apply to the first installment until fourteen days after the "due" date, this in effect allows 28 calendar days (from the date the employer first obtains knowledge of the injury) in which to pay the first installment. Compensation is “paid” when it reaches the claimant. If payment is not made within 28 days, 10 percent additional compensation must be paid. Note that in cases of delay between the injury (or the onset of disability) and employer awareness, all back compensation then accrued is due and subject to 10 percent augmentation if not paid with 14 days or controverted within 28 days (see PM 8-202.5). This often occurs in hearing loss and other occupational disease cases.

2. **The 10 percent may also be applied** to each bi-weekly installment not paid within fourteen days after it becomes due. Until fourteen days have passed following the due date of any installment, however, the additional payment is not applicable.
3. **If partial payments are made by the employer**, the Section 14(e) provisions apply only to the difference between the amount owed and the amount paid. This usually occurs when the employer pays benefits under a State Workers' Compensation Act and is then held liable under the LHWCA and a timely controversion has not been filed.

4. Effect of Controversion of Claim. If the claim is controverted within the time allowed by section 14(d) of the Act, the additional 10 percent is not assessed against the employer/insurer. The controversion notice should be submitted to the DO on or before the fourteenth day after the employer had knowledge of the injury or death. In the event that the controversion is not filed within that period, the 10 percent penalty applies to each unpaid installment until payments are current. However, the period of assessment stops on the date the notice of controversion is filed in the DO or the date an informal conference is held, whichever came first.

5. Claim for Further Compensation.

1. **If an employee sustains a compensable injury** and the employer pays compensation without an award, in accordance with the provisions of Act, payments for temporary total disability continue until maximum medical improvement is reached and/or the injured employee returns to work at his/her usual rate of pay. When the EC suspends payments, Section 14(c) mandates that the employer immediately notify the DD by filing a Form LS-208, Notice of Final Payment or Suspension of Payments (Exhibit 21, PM 10-200), that payments have been stopped or suspended. If, however, the worker actually remains disabled, totally or partially, at that time, the additional 10 percent will apply to all payments thereafter that are not made timely, unless the EC has also filed a notice of controversion.
2. **The fact that the injured worker has reached maximum medical improvement**, or has returned to work, or both, is not an adequate ground, in and of itself, for the suspension or termination of payments. The occupational

duties may have to be modified to accommodate the claimant's work restrictions (so that there may be a continuing loss of wage-earning capacity, temporary or permanent, even if there is no continuing loss of actual earnings), or the worker may have a permanent schedule impairment that constitutes a permanent partial disability. Therefore, as long as the employer has actual knowledge of the injury, any payments that in fact turn out to have been due that are not paid within 14 days of the due date are augmented by 10 percent, unless the EC has filed a notice of controversion of the right to that payment by 28 days after the due date of that payment.

6. Payment by Check.

1. **Payment by check** is considered proper tender for compensation, unless the check is found to be invalid because of insufficient funds, it is not promptly honored upon presentation, or for other reasons.
2. **No distinction** is made between payment by check or by draft. If the check or draft is promptly honored by the drawee bank, the time of payment relates back to the date the check or draft is received by the payee. If the check or draft is not promptly honored by the drawee bank, payment is not considered to have been made until the check or draft is honored.

7. Delayed Payment Excused by DD.

1. **The DD may excuse delay in payment** of compensation, thereby obviating assessment of the 10 percent penalty.
2. **Procedure**. Delayed payment of compensation may be excused by the DD after the EC shows that, due to conditions over which it had no control, such payments could not be paid within the period prescribed for the payment. The CE handling the case shall request the reason in writing from the EC for any delayed payments, and on receipt of the reply recommend to the DD either that the 10 percent penalty be assessed or that it be excused. The DD will make the determination as to whether the explanation is sufficient to excuse the 10 percent penalty.

8. <u>Calculation</u>.

1. **This is not a "time-interest" payment** based on a per annum rate; consequently, the 10 percent penalty is to be applied to all past due installments wherein compensation has not been paid within fourteen days following the due date. For example, if there are ten payments of $200 each, all of which are overdue, the total amount of unpaid compensation is $2,000, and 10 percent of that figure is $200, which is to be added to the $2,000, making $2,200 payable to the claimant.
2. **If, for example, the worker is entitled** to $300 a week under the Act but the EC timely pays on the $200 a week due under state law, its first biweekly of $400 is $200 short; the second payment of $400 should be applied first to what is then already past due under the Act ($200 plus an additional 10 percent, or $220), so that only $180 of it is treated as satisfying the employer's liability for the second $600 payment due. Since this leaves $420 due and unpaid, an additional $42 falls due under section 14(e) by the time the of the third biweekly payment. All of the third $400 payment goes to satisfy the EC's overdue liability of $462 under the Act, and none of that payment counts as a timely satisfaction of the Claimant's LHWCA rights. Thus section 14(e) will apply to all of the $600 payment then due under the Act, and of any subsequent payments until and unless the EC becomes current with respect to its LHWCA liability or files a valid notice of controversion.
3. **Interest is also applicable** to all cases of delayed payments of compensation. That calculation must be made subsequent to and separately from the 10 percent penalty. The 10 percent penalty is applied only to the actual untimely paid compensation due, not including interest.

9. <u>Period of Assessment</u>. The Benefits Review Board and the courts have held that the employer's liability under section 14(e) does not apply to payments falling due on or after the date notice of controversion is filed in the office of the DD or the date of the informal conference, whichever occurs first. However, if the employer makes any further voluntary payments of compensation it is once again liable under section 14(e), and the various rules mentioned above are effective, if payments are again suspended without the filing of a new notice of controversion.

Chapter 8-0203, Late Payment: Section 14(f) Penalty

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7. Interruption of Continuing Payments	09/00	00-01
8. Strict Enforcement of Ten Day Period	09/00	00-01

1. Purpose and Scope. This Chapter contains guidelines, procedures, and instructions for computing and applying additional compensation of twenty percent which becomes due and payable whenever any compensation payment awarded in a formal order is not paid within ten days after it becomes due.

2. Authority.

1. **Section 14(f)** provides that if any compensation payable under the terms of a compensation order is not paid within ten days after it becomes due, there shall be added an additional amount equal to 20 percent, which shall be paid at the same time but in addition to such compensation.
2. **Exception to the above provision** may be obtained only by review of the compensation order making the award (as provided in section 21 of the Act) and an order staying payments, issued by the Benefits Review Board or a court of competent jurisdiction, within ten days following filing of the compensation order. However, the mere filing of a motion for reconsideration does not stay the payment (**see LHWCA Circular 88-02, January 29, 1988**).

3. Definition of Late Payment.

1. **The ten day period** in which compensation must be paid under an award begins to run from the date the compensation order is "filed" by the DD. "Filed" is interpreted to mean the day the DD dates the original compensation order. If the order is one issued by the ALJ, the filing must be no later than the

business day following its receipt by the DO. On the day the order is filed, the DD shall send by certified mail a copy of the order to the parties.

2. **In the event that the ten day period expires** on a Saturday, Sunday, or a legal holiday, the business day immediately following shall be considered the last day of the ten day period.
3. **No distinction is made** between payment by check or by draft. If the check or draft is promptly honored by the drawee bank, the time of payment relates back to the date the check or draft is received by the payee. If the check or draft is not promptly honored by the drawee bank, payment is not considered to have been made timely, until the check or draft is honored.

4. Mandatory Application. Payment of the additional 20 percent is mandatory where no exception is applicable and a violation has occurred. To insure that such amount is paid, about fifteen days after it is filed and served, the DD should investigate to determine that the order has been fully complied with by the employer/carrier. If not, the DD should take appropriate steps to see that the EC is notified that an additional 20 percent is due and payable with the compensation.

5. Notice to the Parties. The compensation order should contain the following paragraph at the conclusion of the monetary award provision: If payment is not made within ten days following the date of this order, because of the delay an additional 20 percent of the amount of compensation due and unpaid shall be paid in accordance with section 14(f) of the Act. If default continues over thirty days, application should be made to the District Director within one year after such default for a supplementary order for enforcement of this award by the Federal Courts in accordance with Section 18(a) of the Act.

6. Calculation.

1. **The 20 percent** is based directly on the amount of unpaid compensation including any amount awarded under section 14(e). It is not to be calculated after adding interest or the section 14(e) 10 percent penalty.
2. **When compensation payable** under the terms of the compensation order is unpaid after expiration of ten days following the order, the amount of additional compensation is determined by multiplying the unpaid compensation by 20

percent. This is not a "time interest" calculation — but rather a simple percentage.

7. Interruption of Continuing Payments.

1. **Compensation which is being paid at regular intervals** in installments pursuant to a compensation order can be properly terminated only in accordance with an appropriate order issued under sections 7(d), 7(f), 8(j), or 22 of the Act. The EC cannot arbitrarily terminate payments until the compensation order requiring continuation of such payments is amended.
2. **If the EC believes** there is a basis for terminating payments, it should make application for modification of the order under the appropriate section of the Act and support the request by submitting evidence that the claimant is no longer entitled to the compensation provided by the award.
3. **If compensation is terminated** without an appropriate compensation order, the EC again becomes subject to the 20 percent additional compensation on all past due payments.

8. Strict Enforcement of Ten Day Period.

1. **Determining the end of the ten day period** is straight forward. If the decision is filed on April 30, benefits must be paid on or before May 10. If May 10 is not a business day, payment is due on the first business day thereafter.
2. **The Fifth Circuit (Mississippi, Alabama and Texas) has held** that the ten-day period means ten **business** days, but the Office disagrees, and all other courts that have examined the question (the Second, Third, and Fourth Circuits, and some district courts elsewhere) have sustained the Office's view. The calendar-day rule should be applied in all cases arising outside the Fifth Circuit. With that circuit, the DD should seek advice from the NO in any case in which the timeliness of payment depends on the distinction (i.e., payment reached the claimant later than 10 calendar days, but by the tenth business day, after the award was filed).

Paragraph and Subject	Date	Trans. No.
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1. Purpose and Scope. This Chapter provides guidelines and procedures for assessing penalties for late reports of final payment of compensation.

2. Authority. Section 14(g) of the Act requires every EC to notify the DD within sixteen days after the "final payment of compensation has been made" or be subject to a penalty of $100 applicable to violations prior to November 17, 1997, or $110 for violations on or subsequent to November 17, 1997 (see paragraph 8-301.8 below).

3. Report Requirements. The notification is made on Form LS-208, Notice of Final Payment or Suspension of Compensation Payments, (Exhibit 21, PM 10-200). This form should show: the total amount of compensation paid; the name of the employee, and any other person to whom compensation has been paid; the date of the injury or death; and the inclusive dates for which compensation was paid. The LS-208 is used to report both final payments under Section 14(g) and suspensions of payments under Section 14(c). Section 14(g) does not apply to notification of the suspension of payments.

4. Guidelines.

1. **Final Payment**. For purposes of a section 14(g) penalty, a final payment is defined in the regulations at 20 CFR section 702.235 as any one of the following:
    a. Any payment of compensation which anticipates no further payments under the Act.

b. The last payment of compensation made in accordance with a compensation order awarding disability or death benefits, issued by either a DD or an administrative law judge.

c. The payment of an agreed settlement, approved under Section 8(i).

d. The last payment of compensation made pursuant to an agreement reached by the parties through informal proceedings.

2. **Timely Filing**. The sixteen days allowed by Section 14(g) is considered adequate time for an EC to prepare and transmit the Form LS-208. Although a report is not “filed” until it reaches the DO, it will not be treated as untimely if it is mailed early enough that it would ordinarily have been delivered timely to the DO, even if the delay in mail service or some unforeseeable circumstance leads to late delivery. If the report is received after expiration of the sixteen day period, but the postmark shows it was mailed before, the report should be considered as timely filed. If practical, the envelope in which the report is received should be retained until this issue is resolved if the form is received more than sixteen days after the date of payment shown on Form LS-208. The date of postmark may also be noted on the form by the mail clerk as follow: Postmarked July 27, 19XX" followed by the clerk's initials.

3. **Late Report.** If the report arrives at the DO bearing a postmark more than sixteen days following the date of "final payment," it is a late report under Section 14(g).

5. Initial Action. If it is determined that the report of final payment, LS-208, is late as defined above, the DD will release a narrative letter to the EC giving full particulars of the tardy report. The letter should be released within ten days after it is determined that the report was submitted late. The EC will be requested to explain the delay within thirty days, if they wish to do so in an effort to avoid assessment of a penalty.

6. Employer/Carrier's Explanation of Delay.

1. **Sufficiency of Explanation**. When an EC submits an explanation within thirty days as indicated above, the DD shall carefully consider the explanation and determine whether it is sufficient. The assessment of the penalty under section 14(g) is mandatory if it is determined that the LS-208 was untimely filed. The

statute states, "If the employer fails to so notify the deputy commissioner within such time the Secretary shall assess against such employer a civil penalty . . ." (emphasis added). Therefore, an explanation may only be considered sufficient if the EC satisfactorily explains that it was not, in fact, a final payment of compensation as defined in paragraph 4a., above. Otherwise the penalty should be assessed. An explanation such as, the party responsible for filing the form was not aware of the requirement, is clearly insufficient.

2. **Explanation Found to Be Acceptable**. If the DD believes the EC's explanation is sufficient, the DD releases a brief narrative letter informing the EC of that determination.
3. **Explanation Found to Be Unacceptable**. In the event the explanation received is not acceptable, the D should proceed to assess the penalty by releasing Form Letter LS-552, Notice to EC of Penalty for Late Filing of Form LS-208, (Exhibit 50, PM 10-200).

7. Employer/Carrier Fails to Provide Explanation. If no explanation for the delay is received from the EC after thirty days have elapsed, the DD should proceed to assess the penalty utilizing Form Letter LS-552. Prompt follow-up is essential.

8. Impact of Debt Collection Improvement Act of 1996. Effective November 17, 1997, the penalty amount was increased from $100 to $110. This increase came about as a result of the Federal Civil Penalties Inflation Adjustment Act of 1990 (FCPIAA), as amended by the Debt Collection Improvement Act of 1996 (DCIA). The DCIA, amending the FCPIAA, requires that the civil money penalties be adjusted by a cost-of-living increase equal to the percentage, if any, by which the Department of Labor's Consumer Price Index (CPI) for all urban consumers for June of the calendar year preceding the adjustment exceeds the June CPI for the calendar year in which the civil penalty amount was last set or adjusted. Due to inflation since the LHWCA civil money penalties were last set or adjusted, the increase effective on November 17, 1997 was the maximum 10% initially permitted under the DCIA. The adjusted penalty amount of $110 **applies only to violations occurring on or after November 17, 1997**. The previous $100 penalty amount applies to violations prior to November 17, 1997.

9. Amount of Penalty. The Act provides no latitude in the amount of the penalty assessed. If a penalty is applicable, the amount is $100 for violations prior to

November 17, 1997, and $110 for violations on or subsequent to November 17, 1997.

10. Transmittal of Penalty Check to National Office. Upon receipt of the penalty check, the DD shall immediately forward it, with a copy of the penalty letter and a DL Form 1-303, Cash Transfer Receipt, (Exhibit 57, PM 10-200) to the Director, DLHWC, for deposit in the Special Fund (see PM 1-200.9f). A copy of the penalty letter should be retained in the case file with a notation of the date the above action was taken.

11. Penalty Log. Each DO shall maintain a penalty log (Exhibit 20, PM 10-300) recording each penalty assessment, with information as to the outcome of the action in each instance a penalty is assessed. Any payments received shall also be recorded on the Cash Receipt Register. It should be noted that there is no SBREFA waiver or reduction of this civil penalty (see Chapter 9-700).

12. Inaction by EC.

1. **No Reply**. If no reply to the LS-552 is received from the EC after thirty days have elapsed, the DD should write and again request the penalty payment or a written explanation for the failure to make payment. If no reply is received to this follow-up letter within thirty days a second follow-up letter should be released. If no reply is received to this second letter within another thirty days, the DD shall notify the NO as outlined in subparagraph 12b, below.
2. **Refusal to Pay Assessment**. In the event the EC refuses to pay the assessment, the DD shall promptly notify the NO. This can be accomplished by a brief transmittal memorandum to which the pertinent documents relating to the section 14(g) assessment are attached. Any unusual or unique replies should be outlined in the transmittal memorandum.

13. Action by National Office.

1. **Deposit of Penalty Check**. Upon receipt of the copy of penalty letter and check at the NO, the check will be deposited in the Special Fund. A copy of the penalty letter, check, and certificate of deposit shall be retained in the NO. A signed receipt (pink) copy of DL Form 1-303 will be returned to the DO.
2. **Continued Refusal**. If, after the NO attempts to collect the penalty, the EC continues to refuse to make payment or fails to reply, the NO will refer the

matter to the Associate Solicitor for Employee Benefits requesting appropriate action.

Chapter 8-0302, Penalty: Late Report of Injury (30e)

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4. Time for Filing and Methods of Submission	01/16	16-03
5. "Knowingly and Willfully" Requirement	01/16	16-03
6. Initial District Director Action	11/16	17-02
7. Evaluating the Response	01/16	16-03
8. Determining the Penalty Amount	11/16	17-02
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11. False Statement or Misrepresentation	01/16	16-03

1. Purpose and Scope. This chapter provides guidelines and procedures for assessing penalties for late or misrepresented reports of injury or death. It also provides procedures for recording employers' penalties.

2. Statutory and Regulatory Authority.

1. **Statutory Authority**.
    a. Report Requirement. Section 30(a) of the Act provides that an employer must give the Secretary of Labor (OWCP) a report within 10 days of death or an injury resulting in the employee losing at least one shift of work. 33 U.S.C. 930(a). If an employer learns that an employee has a disease or infection in respect to an injury, the employer must report to the Secretary within 10 days of the employer's knowledge of the disease or infection. *Id*.
    b. Penalty. Section 30(e) of the Act provides that "any employer, insurance carrier, or self-insured employer who knowingly and willfully fails or refuses to send any report required by this section or knowingly or willfully makes a false statement or misrepresentation in

any such report shall be subject to a civil penalty not to exceed $10,000 for each such failure, refusal, false statement, or misrepresentation." 33 U.S.C. 930(e).

2. **Regulatory Authority**.
    a. Report Requirement. The regulation at 20 C.F.R. 702.201 provides that the 10 day period within which the employer must file a report of injury or death commences on the date of the injury or death, or on the date the employer has knowledge of the injury or death.
    b. Penalty. The regulation at 20 C.F.R. 702.204 provides that the District Director has the authority and responsibility for assessing civil penalties for missing, late, or misrepresented injury and death reports and designates the current maximum penalty amount. The statutory maximum was initially increased as a result of the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended by the Debt Collection Improvement Act of 1996, and is now increased annually as a result of the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015.
3. **Additional Statutory Authority: SBREFA**.
    a. Under section 632 of the Small Business Regulatory Enforcement Fairness Act (SBREFA), 15 U.S.C. 632, if an employer qualifies as a "small business," the agency assessing a civil penalty against the small business for violation of a statutory requirement must consider waiving or reducing the penalty. (See Chapter 9-700 for a fuller discussion of SBREFA and its definition of a "small business.") Because section 30(e) fits this category -- it involves a civil penalty for violation of the statutory requirement of a timely report of injury or death -- the District Director must consider waiving or reducing any penalty to be assessed against a qualifying small business. (But see paragraph 8f of this chapter discussing why the Director may reduce but not waive a Section 30 penalty.)

3. Report Requirement (Form LS-202). An employer must file a report of death in all cases of death, and a report of injury in all cases where the injury results in

loss of one or more shifts of work. The employer must also file a report of injury in all cases involving diseases and infections resulting in a loss of one or more shifts of work. The reporting requirements are met by timely submission to OWCP of Form LS-202, Employer's First Report of Injury or Occupational Illness.

Note: The employer should also file a report of injury in cases where the employee does not lose time from work but suffers a permanent impairment covered by the schedule for permanent partial disability in section 8(c) of the Act; however, a penalty may not be assessed for a late report in these instances.

4. Time for Filing and Methods of Submission. Section 30(a) of the Act and section 702.201 of the regulations require the employer to file a report of injury or death within 10 days of its knowledge of the death or injury, and within 10 days of the employer's knowledge of a disease or infection as a result of an injury.

Section 30(d) provides that reports mailed within the 10 day time limit (as verified by postmark or some other delivery verification) are deemed timely. The regulation at 20 C.F.R. 702.203, revision effective June 10, 2015, provides that a report may be mailed or sent by commercial delivery service, and is considered filed on the date the employer mails the document or gives it to the commercial delivery service. The regulation further provides that if the employer sends its report of injury or death by a permissible electronic method, the report will be considered filed on the date the employer completes all steps necessary for the transmission.

5. "Knowingly and Willfully" Requirement. For purposes of imposing a penalty, the report of injury or death is not necessarily late simply because the employer failed to file a report within 10 days of the injury or death. This is because section 30(e) has a prerequisite before a penalty may be imposed: the employer must "knowingly and willfully fail or refuse" to file the required section 30(a) report of injury or death within the time allotted. (emphasis added).

1. **To satisfy the "knowingly" requirement**, the employer must know about the death or injury; know that the death or injury is likely covered by the Act; and know that a report is required. The employer's "knowledge," however, need not be actual. It is enough that the employer had a "reason to know." *See Freeman United Coal Mine Co. v. Federal Mine Safety and Health Review Com'n*, 108 F.3d 358, 364 (D.C. Cir. 1997) (holding that the "knowingly" standard does not necessarily require a showing of actual knowledge but may also be satisfied by reason to know). Because the "knowingly" requirement may be based upon "reason to know" rather than actual knowledge, the

employer's explanation that it was unaware of the filing requirement, for example, is not a sufficient excuse if the employer reasonably should have known of the requirement. Similarly, once an employer has been advised in writing of its responsibility to file a timely report, any further failure should be considered knowing and willful.

2. **To satisfy the "willfully" requirement**, the employer must "intentionally disregard the statute or [be] plainly indifferent to its requirements." U.S. v. Illinois Cent. Ry. Co., 303 U.S. 239, 243 (1938).
3. **In most situations, the "knowingly" and "willfully" requirements** will be satisfied at the time of the injury or death, i.e., at the time of injury or death the employer will know about the injury or death, know that the injury or death is likely covered by the Act, and know that a report is required. And in most situations, there will be nothing preventing the employer from timely filing on the due date. In those situations, the report of injury or death must be filed within 10 days of the injury or death.

If, however, the employer did not know of the injury or death, or know of the requirement to report at the time of the injury or death, the 10 days do not start to run until the date of the employer's knowledge. For instance, if the employer did not become aware of the injury (or reasonably could not have become aware) until 20 days after the injury -- for example, in a DBA case where the employee was on a mission to a remote location -- then the 10 day time limit does not begin to run until the 20th day after the injury. Similarly, but in a different situation, if the employer was aware of the injury and reporting requirements on the day of the injury, but was unable to report because of a serious 3-day blizzard starting on the 10th day, then the employer's report is not due until the 13th day after the injury because the failure to report on the 10th day was not willful.

6. <u>Initial District Director Action</u>. The District Director must solicit evidence establishing if and when the "knowingly and willfully" requirements were met. Form letters **30e1** and **30e2**, discussed immediately below, aid in this determination. The letters also seek information that may be relevant in determining whether a penalty, if warranted, should be reduced.

1. **When no report (Form LS-202) is filed**, the District Director (or designee) should send form letter **30e1** to the employer. Form letter **30e1** describes the evidence OWCP has received that indicates an injury or death has occurred on a particular date; notifies the employer of its responsibility to file a report

within 10 days of that date; and requests an explanation for the employer's failure to file a report within the required time limit. The form letter also notifies the employer that it may be subject to a penalty for failure to timely submit a report; requests that the employer provide reasons why the full amount should not be assessed against the employer; and asks the employer if and why it qualifies as a "small business" under SBREFA. Finally, the letter instructs the employer that its response should be filed within 30 days of the date of the letter.

Form letter **30e1** should be sent to the employer within 30 days of a determination that the form is missing. It may be sent by regular mail unless there is need for a record of receipt. Code **30e1** should be entered into the Longshore Case Management System (LCMS) when the letter is issued. The date of the code is the date of the letter.

2. **When the report (Form LS-202) is late**, the District Director (or designee) should send form letter **30e2** to the employer. Form letter **30e2** includes the date the report was received; notifies the employer of its responsibility to file a report within 10 days of that date; and requests an explanation for the employer's failure to file a report within the required time limit. The form letter also notifies the employer that it may be subject to a penalty for failure to timely submit a report; requests that the employer provide reasons why the full amount should not be assessed against the employer; and asks the employer if and why it qualifies as a "small business" under SBREFA (see paragraph 8(f) of this chapter). Finally, the letter instructs the employer that its response should be filed within 30 days of the date of the letter.

   Form letter **30e2** should be sent to the employer within 30 days of a determination that a report is late. The letter may be sent by regular mail unless there is need for a record of receipt. Code **30e2** should be entered into LCMS when the letter is sent. The date of the code is the date of the letter.
3. **When the employer files a form other than LS-202**. In some instances the employer files a form other than LS-202, e.g., form LS-206 (Payment of

Compensation without an Award) or form LS-208 (Notice of Final Payment). The District Director should send form letter **30e1** to the employer since no LS-202 form was filed, but should acknowledge receipt of the other form(s).

7. Evaluating the Response.

1. **No Response**. If no response is received within the 30 day period, the address should be verified and a second request (either **30e1** or **30e2**) should be sent. This letter should be sent by certified mail or via some other method that allows tracking of receipt.

   At the expiration of the second 30 day period, if there is still no response, the District Director should assess a penalty. See paragraph 8 of this chapter.
2. **Response Received**. The District Director must consider all of the evidence relevant to the "knowingly" and "willfully" requirement, especially any evidence submitted by the employer following the **30e1** or **30e2** letters, to determine (1) the date the employer knew about the injury or death, knew that the injury or death was likely covered by the Act, and knew that a report was required; and (2) the date the employer was not prevented by circumstances beyond its control from filing a report on the due date.
3. **The employer's explanation cannot prevent the District Director** from finding there was a willful late filing if the explanation is based solely on one or more of the following reasons:
   - The employer's personnel office failed to complete and/or mail the report on time;
   - The employer was short of staff at the time;
   - The delay was occasioned by routing the reports through the insurance carrier's office; or
   - The report was sent to the insurance carrier and it failed to submit the report on time.
4. **In addition, because the "knowingly" requirement** may be based upon "reason to know" rather than actual knowledge, the employer's explanation

that it was unaware of the filing requirement, standing alone, is also not sufficient to excuse a missing or late report if the employer reasonably should have known of the requirement.

5. **Once the District Director determines the date the 10 day period** began to run, he/she must determine if the employer filed a report of injury or death within 10 days of that date.
    a. **If the employer filed a report within 10 days** of having knowledge of the death or injury and knowledge of the reporting requirements, the report is timely, and there is no penalty.
    b. **If the employer did not so file**, but filing on the due date was prevented by circumstances beyond the employer's control, and the employer filed the report on the first day possible after the due date, the report is timely, and there is no penalty.
4. **If the District Director determines that no penalty should be assessed**, a brief narrative letter should be issued informing the employer that its report was considered timely and that no penalty is being assessed. Form letter **30eX** should be used for this purpose, and code **30eX** should be entered into LCMS when the letter is issued. The date of the code is the date of the letter. This action should be taken within 60 days of the expiration of the 30 day response period allowed by **30e1** or **30e2**.
5. **If the District Director determines that a penalty should be assessed**, he/she must determine the amount. See paragraph 8 of this chapter.

8. <u>Determining the Penalty Amount</u>. If the District Director determines that the employer "willfully" failed to file a report of injury or death within 10 days of having known about the injury or death and the reporting requirements, the District Director must assess a penalty.

1. **Penalty Schedule**. The District Director should review the Penalty Log to determine how many penalties, if any, have been assessed against the employer in the last 2 years. Based upon this information, the District Director should use the annually adjusted Penalty Schedule, which is based on the number of offenses, to determine the starting point for the penalty amount.

Note: The Penalty Schedule is adjusted each year when the maximum penalty amount is adjusted in accordance with the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015. When this annual adjustment occurs, the Program will issue an Industry Notice outlining the adjusted amount(s) for all DLHWC penalties. Therefore, consult the most recent annual Industry Notice related to this topic for the current Penalty Schedule.

2. **Consultation with the National Office and the BLLLS Division** of the Solicitor of Labor. Before assessment of any penalty above $2,000, the District Director should consult with the National Office and the BLLLS Division of the Solicitor of Labor. Since enforcement of the penalty may involve further review of whether a violation has occurred or whether the penalty amount is reasonable, input from the National Office and the BLLLS Division will help insure that there are sufficient facts to support both the assessment and the penalty amount should the employer seek review.
3. **A penalty is considered to have been "assessed against the employer"** in the last two years when the District Director issued a **30e3** form letter (see paragraph 9 of this chapter), even if the employer subsequently contested or disputed the penalty and the dispute has not yet been finally resolved.
4. **If the District Director assesses a penalty against a subsidiary**, the penalty is considered assessed against the parent company as well. Similarly, if the District Director assesses a penalty against the parent company, the penalty is considered assessed against the subsidiary company.

   For example, if the parent company is the employer who has filed a late report, to determine how many penalties the parent company has had in the last 2 years, count the parent company's late penalties and the late penalties of any subsidiaries. Similarly, if the subsidiary is the employer who has filed a late report, count the subsidiary's late penalties and the late penalties of the parent company.
5. **Penalty outside of the schedule**. If extenuating and/or aggravating circumstances exist, and the scheduled amount is less than $2,001, the District Director may assess a penalty amount other than that set forth in the

schedule, i.e., the District Director may assess a penalty more or less than the scheduled amount.

The amount may be decreased based upon mitigating factors such as:

- The employer brought the claim to the District Director's attention;
- The employer is paying disability compensation to the claimant;
- The employer timely complied with the District Director's requests once failure to timely file was brought to the employer's attention;
- The lateness was due to unusual circumstances such as a large number of injuries or death at one time;
- Payment of the penalty will lead to the employer's financial hardship; and
- The employer has a history of timely submitting notices in other claims.

The amount may be increased based upon aggravating factors such as:

- Significant lateness of the report;
- The employer failed to timely pay compensation due the employee;
- The employer failed to submit information sufficient to determine if correct compensation has been paid;
- The employer attempted to conceal the injury or death; and
- The employer failed to timely submit evidence requested by the District Director or otherwise failed to cooperate with the District Director's investigation.

6. **Effect of Small Business Regulatory Enforcement Fairness Act** (SBREFA). SBREFA requires agencies to consider waiver or reduction of civil penalties for violations of statutory requirements by small businesses. Because section 30(e) fits this category -- it involves a civil penalty for violation of the statutory requirement at 30(a) to provide a timely report of injury -- SBREFA's requirement of waiver or reduction of penalties must be considered for those employers who qualify as "small businesses" under SBREFA. (See

Chapter 9-700 for a general discussion of SBREFA, including the method of determining whether an employer qualifies as a small business.)

SBREFA's suggestion of "waiver" of the penalty, however, cannot be applied here because section 30(e) uses mandatory language when a violation has occurred: it provides that an employer that knowingly and willfully fails or refuses to send an injury report "shall be" subject to the civil penalty. Consequently, section 30(e) gives the District Director no discretion to waive the penalty in its entirety.

While "waiver" of section 30(e)'s penalty is not permissible, there is no bar to the District Director's "reduction" of the penalty of an employer that qualifies as a small business (so long as the reduction is not to $0). Consequently, after the District Director determines the scheduled penalty for the small business based upon the employer's past history of late filings, the District Director must consider reducing that penalty based upon any of the mitigating factors described above or other reasonable factors. The size of the employer will automatically be a mitigating factor in light of the fact that only employers with a limited number of employees or limited annual receipts will be viewed as a "small business" requiring consideration of penalty reduction under SBREFA.

SBREFA's requirement to "consider" reduction means the District Director must "think about" reducing the penalty of the small business but is not required to do so. One half of the scheduled penalty amount listed above, however, may be an appropriate reduction for a SBREFA small business. (In contrast, if the employer does not qualify as a SBREFA small business, the District Director is not required to "consider" reduction but has the discretion to do so.)

9. <u>Issuing the Penalty</u>. Once the District Director determines the appropriate penalty amount, form letter **30e3** should be issued allowing 30 days for payment of the penalty. The District Director must explain how the "knowingly and willfully" two-prong test was met, specify the number of prior offenses (if any) in the prior 2 years, specify the penalty amount, and note whether the employer is a SBREFA

“small business.”

Form **30e3** should be entered into the LCMS when the letter is issued. The date of the code is the date of the letter. This action should be taken within 60 days after the expiration of the 30 day response period allowed by form **30e1** or **30e2**.

At the same time form letter **30e3** is issued, the Penalty Log should be updated. The number of offenses should be added in the “Notes” box (e.g., 3 prior late reports).

10. Follow Up Actions after Penalty Assessment.

1. **Payment Received**. If the assessed penalty is received, the Penalty Log should be updated with the date of payment receipt and the amount of the payment. The payment should be processed for deposit into the Special Fund. An acknowledgment letter, form letter **30ep**, should also be sent to the employer.

   Code **30ep** should be entered into the LCMS when the letter is issued. The date of the code is the date of the letter. This action, as well as the update to the Penalty Log, should be taken within 30 days of receipt of the payment.
2. **No Payment**. If the employer does not submit full payment within the 30 day period, the District Director should send a second letter, again requesting the penalty payment or a written explanation for the failure to submit payment. Form letter **30e4** should be used for this purpose and should be sent via certified mail.

   Code **30e4** should be entered into LCMS when the letter is issued. The date of the code is the date of the letter. The Penalty Log should be updated with the date of the second request.
3. **Notification to the National Office and the BLLLS Division** of the Solicitor of Labor. If payment is not received within 30 days of the **30e4** letter, the District Director should notify the National Office and the BLLLS Division of the Solicitor of Labor, refer the matter to the National Office, and update the Penalty Log with the date of the referral.

4. **Refusal to pay assessment**. If the employer replies and refuses to pay the assessment, the District Director should notify the National Office and the BLLLS Division and update the Penalty Log with the date of the notification.
5. **National Office Action**. The National Office will review the facts with the BLLLS Division to determine the next appropriate step.

11. False Statement or Misrepresentation. While this chapter focuses primarily on the penalty for a missing or late report of injury or death, section 30(e) also authorizes civil penalties when the employer "knowingly or willfully makes a false statement or misrepresentation in any such report." This means that the District Director must assess a penalty if the misrepresentation was either knowing or willing. Unlike an untimely report, there is no requirement that both conditions be met before a penalty may be assessed for a false statement or misrepresentation.

Chapter 8-0400, Discrimination: Section 48(a)

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3. Initial Complaint by Employee	09/00	00-01
4. Informal Recommendation by District Director	09/00	00-01
5. Assessment of Penalty by DD	09/00	00-01
6. Transmittal of Penalty Check to National Office	09/00	00-01
7. Penalty Log	09/00	00-01
8. Action by National Office	09/00	00-01
9. Employer's Refusal to Pay Penalty	09/00	00-01
10. The 1984 Amendments and the Federal Civil Penalties Inflation Adjustment Act of 1990	09/00	00-01
11. Small Business Regulatory Enforcement Fairness Act (SBREFA)	09/00	00-01

1. Purpose and Scope. This Chapter contains guidelines and procedures for the assessment of penalties against an employer who has discriminated against an employee because of a workers' compensation matter.

2. Authority. Section 48(a) of the Act makes it unlawful for any employer to discharge or in any other manner discriminate against an employee because such employee claimed or attempted to claim compensation, or because the

employee has testified or is about to testify in a proceeding under the Act. If it is demonstrated that the employer did in fact discriminate against the employee on this basis, the employer (not the carrier) shall be liable for a penalty payable to the Special Fund.

3. Initial Complaint by Employee.

1. **Initial Inquiry by District Office**. When a District Director (DD) receives a complaint from an employee covered by the LHWCA, alleging discrimination as defined under section 48(a), the DO shall within five working days initiate a specific inquiry to determine the facts and circumstances pertaining to the allegation. This will be done by interviewing the employee and requesting information from the employer's representative(s), and other parties who may have information about the matter.
2. **Method of Inquiry**. Information may be obtained by written correspondence, telephone, or personal interview. If necessary, the DD or DD's designee may also conduct an informal conference to obtain information concerning the allegations.
3. **Consideration of Evidence**. Considering the medical evidence available in the case file, the DD will also determine whether the employee is qualified to perform the duties of employment. In the event there is disagreement, which cannot be resolved without another medical evaluation, the DD should have the employee examined by a physician selected by the DD, the cost of which may be charged to the Special Fund. The examination should be directed toward resolving the question of whether the employee is able to perform his/her former duties.

4. Informal Recommendation by District Director.

1. **Agreement with DD's Recommendation**. If the DD determines that discrimination against the employee has occurred as defined under section 48(a), and the employee is able to resume his or her duties, the DD will recommend that the employer make restitution to the employee as indicated by the circumstances of the case, to include reinstatement of employment and payment for any wage loss suffered as a result of discrimination. The DD shall

also assess an appropriate penalty against the employer (see paragraphs 10 and 11, below). If the employer and employee accept the DD's recommendation, it will be incorporated in a written memorandum and mailed to each party within fourteen days. They will be asked to indicate their agreement or disagreement with the recommendation within another fourteen days.

2. **Disagreement with DD's Recommendation**. If either of the parties indicates disagreement with the recommendation, the DD shall, within ten days of receipt of such notice, prepare a narrative memorandum summarizing the disagreement, mail a copy to all interested parties, and within fourteen days thereafter refer the case to the OALJ for a formal hearing as to whether discrimination under section 48(a) has occurred, and any other issues requiring formal adjudication. (See PM 4-600 for full details on preparing cases for formal hearings.)

5. Assessment of Penalty by DD. Following the hearing, if a penalty is to be assessed, the matter is referred to the DD by the ALJ, for assessment and collection of the penalty.

6. Transmittal of Penalty Check to National Office. Upon receipt of the penalty check, the DD shall immediately forward it, with a copy of the penalty letter and a DL Form 1-303, Cash Transfer Receipt (see Exhibit 57, PM 10-200 and PM 1-200.9f), to the Director, DLHWC, for deposit in the Special Fund. A copy of the penalty letter should be retained in the case file with a notation of the date the above action was taken.

7. Penalty Log. Each DO shall maintain a log (Exhibit 20, PM 10-300) recording each penalty assessment, with information as to the outcome of the action in each instance a penalty is assessed. Any payment received shall also be recorded on the Cash Receipt Register (see PM 1-200.9). Note the requirement on the log by indicating whether or not the penalty is being assessed against a small business, as required by SBREFA.

8. Action by National Office. Upon receipt of the copy of the penalty letter and check at the NO, the check will be deposited in the Special Fund. A copy of the penalty letter, check and certificate of deposit shall be retained in the National Office files. A signed receipt (pink) copy of DL Form 1-303 will be returned to the DO.

9. Employer's Refusal to Pay Penalty. In the event the employer refuses to pay the penalty assessed, the DD shall prepare a memorandum summarizing his/her attempts to collect the penalty. The DD shall then refer the complete administrative file to the Director, DLHWC for subsequent transmittal to the Associate Solicitor for Employee Benefits, with a request that appropriate legal action be taken to recover the penalty.

10. The 1984 Amendments and the Federal Civil Penalties Inflation Adjustment Act of 1990. The amended Act specifically provides that the discharge or refusal to employ a person who has been adjudicated to have filed a fraudulent claim for compensation (see LHWCA section 31(a)) is not a violation of Section 48(a). The penalty for a violation under section 48(a) was also increased to a sum not less than $1,000 and not greater than $5,000. However, effective November 17, 1997, the penalty was increased to the amounts of not less than $1,100 or more than $5,500. This increase came about as a result of the Federal Civil Penalties Inflation Adjustment Act of 1990 (FCPIAA), as amended by the Debt Collection Improvement Act of 1996 (DCIA). The DCIA, amending the FCPIAA, requires that the civil money penalties be adjusted by a cost-of-living increase equal to the percentage, if any, by which the Department of Labor's Consumer Price Index (CPI) for all urban consumers for June of the calendar year preceding the adjustment exceeds the June CPI for the calendar year in which the civil penalty amount was last set or adjusted. Due to inflation since the LHWCA civil money penalties were last set or adjusted, the increase effective on November 17, 1997, was the maximum 10% initially permitted under the DCIA. **The adjusted penalty amounts of not less than $1,100 or more than $5,500 apply only to violations occurring on or after November 17, 1997**. The previous penalty amounts of not less than $1,000 or more than $5,000 apply to violations prior to November 17, 1997.

11. Small Business Regulatory Enforcement Fairness Act (SBREFA). SBREFA requires agencies to consider the waiver or reduction of civil penalties for violations of statutory requirements by small businesses (see PM 9-700 for a full discussion of SBREFA). Section 48(a) is a civil penalty under the LHWCA. However, Section 48(a) indicates that if it is determined that a violation has occurred, the violator "**shall be**" subject to the civil penalty. Thus, there is **no allowance under the LHWCA for waiver of this penalty**. Nevertheless, since the LHWCA does not specify a fixed amount of penalty for violations under Section 48(a), the provisions of SBREFA for reduction of this civil penalty for small businesses may be applied. No fixed amount of reduction is specified. Taking into consideration the gravity of the violation and the range in amount of penalties, which may be assessed under Section 48(a), the District Director should also consider the size of the business before determining the penalty amount to be paid by the employer to the Special Fund. The Small Business

Act's Standard Industrial Classification codes (SIC), giving size standards for small businesses, may be helpful in considering the size of the reduction in penalty for a small business (see PM 9-700.3).

Chapter 9-0100, Introduction

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2. Data Sources	09/00	00-01
3. Operation Planning	09/00	00-01
4. Accountability Reviews	09/00	00-01

1. Purpose and Scope. This Part of the Procedure Manual describes the various ways and means used in the Longshore Program to evaluate and improve performance and effectiveness in the delivery of benefits to injured workers. To meet the need for a formalized evaluation system, the Longshore Program utilizes a series of regular management information reports, and in addition, the NO conducts periodic accountability reviews of each of the LHWCA DOs. The Chapters in this Part describe this system.

2. Data Sources. Three monthly reports provide statistical data that constitute the basic information sources for managing the Longshore Program and measuring the performance of the DOs.

1. **The LHWCA DO Statistical Report**, LS-3 (Exhibit 2, PM 10-200), provides statistics on the number of case processing activities, such as new cases created, cases closed and conferences, during the reporting month. This report is described in PM 9-200.
2. **The Supplemental Statistical Report**, LS-3s (Exhibit 3, PM 10-200), provides current case workload (pending case inventory) and unattached mail inventory data at the end of each month. This report is described in PM 9-300.
3. **The Workload and Performance Standards Report**, (Exhibit 21, PM 10-300), provides statistical information on the timeliness of key workload processing functions in the Longshore Program's DOs. This report is described in PM 9-400.

3. Operational Planning. In conjunction with the Office of the Director, OWCP, each year the Longshore Program's National Office prepares operational planning instructions for the Program. It includes general management objectives and individual workload output and performance standard goals for each DO. Progress in achieving these goals is tracked in a Quarterly reporting system known as Quarterly Review and Analysis. The system is described in PM 9-500.

4. Accountability Reviews. The Longshore National Office conducts periodic on-site reviews of each DO. These reviews are carried out by a team of National and district office staff who make findings and recommendations about the quality, quantity and timeliness of the actions of the DO during the twelve month period preceding the accountability review. The Accountability Review system is described in PM 9-600.

Chapter 9-0200, Do Statistical Report: LS-3S

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3. Responsibilities	09/00	00-01
4. Reporting Period	09/00	00-01
5. Definitions	09/00	00-01
6. Submission of Report	09/00	00-01

1. Purpose and Scope. This Chapter describes the LHWCA District Office (DO) Statistical Report, Form LS-3 (Exhibit 2, PM 10-200), and the procedures for its preparation and submission to the National Office (NO). It applies to all DOs administering the LHWCA, as extended, with the exception of the District of Columbia Workmen's Compensation Act. This report provides the DOs and the NO with statistical information on a number of case processing activities such as new cases created, cases closed, conferences, etc., during the reporting period.

2. Related Chapters. This Chapter incorporates and augments Chapter 2 Part 9 (Statistical Report Generation) of the Longshore Case Management System (LCMS) Manual which describes the procedures for generating the automated statistical reports. Chapter 9-300 of the LHWCA Procedure Manual deals with preparation of Form LS-3s, the Supplemental Statistical Report.

3. Responsibilities.

1. **The District Director (DD)** is responsible for insuring the accuracy of the reports by providing necessary training to DO staff on the timely and accurate entry of required data into the LCMS. When the LS-3 is generated by the LCMS, the DD is also responsible for reviewing the report for accuracy and consistency.
2. **All DO staff** must enter accurate and timely data into the LCMS for case processing actions within their individual areas of responsibility.

4. Reporting Period. The LS-3 covers the period from the beginning of business of the first work day of the month through the last work day of the month. To insure accurate and complete statistics the report should be run on the evening of the last work day of the month or first thing on the morning of the first work day of the new month.

5. Definitions. The LS-3 reports on seventeen categories of case status and case processing activities, several of which are further delineated into subcategories (see Form LS-3, Exhibit 2, PM 10-200). For example, Item 3 summarizes case status for the current month in three categories: a. Open Cases, b. Closed Cases, and c. Total Cases. Each of these in turn is broken out by the particular LHWCA extension under which the case was reported.

6. Submission of Report. The LS-3, LS-3s and the Workload and Performance Standards report should be telefaxed or e-mailed to the National Office at the end of each month. The reports should be sent so as to be received in the National Office no later than 5 work days after the last workday of the report month.

Chapter 9-0300, Supplemental Statistical Report: LS-3S

Paragraph and Subject	Date	Trans. No.
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1. Purpose and Scope	09/00	00-01
2. Responsibilities	09/00	00-01
3. Procedures	09/00	00-01
4. Definitions	09/00	00-01

1. Purpose and Scope. This Chapter describes the preparation and use of Form LS-3s, Supplemental Statistical Report (Exhibit 3, PM 10-200) and its submission to the National Office. These procedures apply to all DOs administering the

LHWCA, as extended, with the exception of the District of Columbia Workmen's Compensation Act. The LS-3s Report provides the DO and the NO with the current case workload (pending case inventory) and unattached mail inventory at the end of each month.

2. Responsibilities.

1. **District Director**. The District Director (DD) is responsible for insuring the accuracy of the Report by providing training on the procedures for the counts and by reviewing the Report for accuracy and consistency prior to submission to the NO.
2. **Index and File Area**. The appropriate supervisor, or other individual designated by the DD, must keep a daily running count of all incoming mail received during the month. This person will also provide the DD with a count of the cases to be created and the unattached mail on hand at the time the monthly inventory is taken.
3. **Other DO Personnel**. Each CE, CEC, vocational rehabilitation specialist (RS) and clerk/typist is responsible for counting the secondaries and cases with letters to be typed that are in their work area when the inventory is taken.

3. Procedures.

1. **The DO will conduct the inventory** at 3:30 p.m. of the last work day of each month. It may be started earlier in the day if more time is needed to complete the inventory.
2. **By the end of count day**, each individual listed in paragraph 2, above, will be responsible for providing their respective counts to the DD or the individual designated by the DD to prepare the LS-3s Report.
3. **The LS-3s is to be submitted** to the Director, DLHWC. It is to be timely submitted so as to insure receipt in the NO no later than the fifth work day of the month following the reporting period.

4. Definitions.

1. **Incoming Mail**. Total number of separate pieces of LHWCA mail received within the reporting period. Note, however, that a multiple page document is counted as "one piece" of mail. Each page of a multi-page document may be date stamped. However, the document counts as only one piece of mail. Offices which date stamp each page with a stamper that automatically keeps count are not to use this figure on Form LS-3s as it will convey an inaccurate impression regarding the amount of incoming mail.
2. **Cases To Be Created**. Injury report forms received to date of inventory, which are identifiable as new cases, but which have not yet been entered into the LCMS as new cases at the time of inventory count.
3. **Primaries**. Newly created cases which have not been reviewed by the CE/CEC. The count of the number of primaries may be obtained from the LCMS Report Tab (Ad Hoc).
4. **Secondaries**.
    a. Cases other than primary which require additional review and/or claims action, e.g., cases out of file which are on a CE's, RS's or DD's desk with some type of pending action.
    b. Cases in index and files unit with mail attached.
    c. Cases which are temporarily out of the DO at the time of inventory for conferences in another city, or are in the NO.
    d. Cases with overdue call-ups other than those in categories (1), (2) and (3) above.
5. **Letters**. All cases on typists' desks at the time of inventory, i.e., those assigned for typing and those on which typing has been complete, but the case has not been returned to the CE, RS, or DD for signature.
6. **Unattached Mail**.
    a. **Numbered**. The number of pieces of mail not attached to a case file but on which the case file number has been placed.
    b. **Unnumbered**. The number of pieces of mail which have not been identified by the case file number.

Chapter 9-0400, Workload and Performance Standards Report

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1. Purpose and Scope	09/00	00-01
2. Responsibilities	09/00	00-01
3. Definitions	09/00	00-01
4. Submission of Report	09/00	00-01

1. Purpose and Scope. This Chapter describes the Workload and Performance Standards Report (See Exhibit 21, PM 10-300) and the procedures for its preparation and submission to the National Office. It applies to all DOs administering the LHWCA, as extended, with the exception of the District of Columbia Workmen's Compensation Act. This report provides statistical information on the timeliness of six key workload processing functions in the Longshore Program's DOs. The DO's actions concerning these functions are compared to pre-established timeliness output goals which are represented as a percent of the cases timely processed during the reporting period.

2. Responsibilities.

1. **The District Director (DD) is responsible** for insuring the accuracy of the reports by providing necessary training to all DO staff on the timely and accurate entry of required data into the LCMS. When the Workload and Performance Standards Report is generated by the LCMS, the DD is also responsible for reviewing the report for accuracy and consistency.
2. **All DO staff members must exercise care** for the accurate and timely entry of data into the LCMS for case processing actions within their individual areas of responsibility.

3. Definitions.

1. **Cases Referred for Formal Hearing**. Length of time, in whole calendar days, from receipt of last Pre-Hearing Statement form, to date the file is referred to the Office of Administrative Law Judges (OALJ) for a formal hearing.

   Each party is furnished with a Pre-Hearing Statement form (Form LS-18,

Exhibit 5, PM 10-200) with instructions to serve the completed form on each other and to submit them to the DO within twenty-one days. Case files are to be transmitted to the OALJ within ten days of receipt of the final Pre-Hearing Statement form if additional information is not necessary, if new issues have not been raised, and if the Pre-Hearing Statements have been properly completed. If the only party to return the LS-18 is the one requesting the hearing, the case should be referred within ten days after expiration of twenty-one days from the date the LS-18s were sent to the parties.

If it is necessary to cancel or postpone the transmittal of the case to the OALJ after receipt of an LS-18 (e.g., because of the receipt of a section 8(f) application), the reason for the delay in transmittal should be documented in the case file. The appropriate diary action code should also be entered into the LCMS.

2. **Cases First Reviewed by Claims Staff**. Length of time, in whole calendar days, from the date the case is jacketed to the date the case is first reviewed and a call-up is placed on the file. Primary cases should be reviewed and appropriate action taken to request missing information or reports within thirty days of the date the case is jacketed and entered into the LCMS.
3. **Section 8(f) Applications Processed**. Length of time, in whole calendar days, from the date the section 8(f) application is received in the DO to the date it is either: (1) returned to the EC for submission of additional information, or, (2) denied by the DO or, (3) in the case of a recommendation for approval, referred to the NO for review. The DO is review the section 8(f) application within forty days of receipt and take one of the following actions:
    a. Identify any deficiencies in the application and return it to the EC for the submission of additional information;
    b. Deny the application or;
    c. Make a recommendation for approval and transmit the case to the National Office for consideration.
4. **Conferences Held**. Length of time, in whole calendar days, from the date the request for a conference is received to the date it is held. Informal conferences

are generally held within forty-five days of request, except in cases involving death or scheduled loss. Conferences are generally held in death cases within sixty days of request and within ninety days of request in scheduled loss cases.

5. **Conference Recommendations Issued**. Length of time, in whole calendar days, from the date the conference is held to the date the written conference recommendation is issued. A recommendation should be issued within ten days after a conference has been held.
6. **Responses to Congressional Inquiries**. Length of time, in whole calendar days, from receipt of a written congressional inquiry to final response, including a telephone response if that is considered satisfactory by the congressional office. However, when a telephone response is used, documentation of the telephone response by memorandum to file must be made. The standard response time is fourteen days.

4. Submission of Report. This report should be telefaxed or e-mailed to the National Office at the end of each month. The report should be sent so as to be received no later than 5 work days after the last work day of the report month.

Chapter 9-0500, Quarterly Review and Analysis

Paragraph and Subject	Date	Trans. No.
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1. Purpose and Scope	09/00	00-01
2. Definitions	09/00	00-01
3. QR&A Reports and Forms	09/00	00-01

1. Purpose and Scope. At the beginning of each fiscal year the Office of Workers' Compensation Programs (OWCP) issues Operational Planning Instructions for all Programs in OWCP. They contain the general management objectives of OWCP and specific instructions and workload goals for each Program for the fiscal year. The progress of Programs in achieving these objectives is tracked through a system of management reports on a quarterly basis according to established procedures contained in OWCP's Procedure Manual. This process is known as Quarterly Review and Analysis (QR&A). This Chapter provides general instructions for the completion and submission of the

Longshore Program's QR&A reports. It incorporates and augments procedures contained in the OWCP Procedure Manual, Chapter 4-400.

2. Definitions.

1. **Plan Figures**. These are workload output goals and performance standard levels established in the annual program operational plan.
2. **Deviations**. Deviations from plan are actual variances from plan. A significant deviation, in the case of Output and Inventories is defined as any negative variance in excess of 10%. The Timeliness standards as presented in the program plans must be met, with no allowable variance, for the district office to be considered to have met its performance goals. For discussion purposes, all timeliness standards will be analyzed on a cumulative as well as a quarterly basis. However, the district will be considered to have met standard for the planning year if the cumulative statistics equal or exceed the goal. When quarterly statistics begin to equal or exceed the goal while the cumulative statistics do not, it should be taken as an indication that the district office's corrective actions are having a positive effect.
3. **Corrective Actions**. A corrective action is defined as a positive measure planned to remedy a performance shortfall, and which describes the course of action to accomplish a particular goal according to a specified timeframe. These are positive steps taken to remedy deviations from plan.
4. **Management Conference Calls**. These calls are made between National and regional offices to assess and reach agreement on problem areas and corrective actions concerning the program operational plan. Calls are scheduled after each quarter's preliminary date has been reviewed and analyzed by the NO.
5. **Preliminary Data**. These are statistics obtained from automated and manual reports about the program operational plan's output and performance goals. The reports containing preliminary data are submitted to the NO by the DO shortly after the close of each quarter.

3. QR&A Reports and Forms.

1. **The LS-3 and LS-3s Reports** and the Workload and Performance Standards Report (see PM 9-200, 9-300 and 9-400, respectively) are the sources for the preliminary statistical data.
2. **QR&A Corrective Action Report** (Exhibit 22, PM 10-300). In the QR&A process this is a written confirmation of a corrective action agreed upon during conference calls.
3. **AR-10 Accountability Review Corrective Action Report** (Exhibit 54, PM 10-200, see also PM 9-600, Accountability Reviews). When a DO has been the subject of an Accountability Review, an AR-10 must be included with the QR&A submission until all recommendations for corrective actions resulting from the Review have been completed.
4. **Summary of District Office Operations Report** (Exhibit 23, PM 10-300). This includes comments from District Directors (DD) about the general condition of the DO, problems encountered in meeting program goals and an appraisal of the quality of DO work.
5. **QR&A Feedback Report** (Exhibit 24, PM 10-300). This is an assessment by the NO of a DO's corrective action report.

Chapter 9-0600, Accountability Reviews

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2. Definitions	09/00	00-01
3. Schedule	09/00	00-01
4. Tracking of Corrective Actions	09/00	00-01

1. Purpose and Scope. This Chapter outlines the process for National Office accountability reviews of District Offices. It incorporates and augments the procedures contained in Chapter 4-300, Accountability Reviews, of the Federal (OWCP) Procedure Manual.

2. Definitions.

1. **Accountability Review**. An accountability review is an assessment of the movement towards excellence, effectiveness, and efficiency of an individual office. This assessment is made primarily by applying the accountability standards contained in the Accountability Review Manual (ARM) in terms of making findings and determinations about the quality, quantity and timeliness of actual performance.
2. **Performance Period**. The review focuses on performance over the last four fiscal quarters preceding the review date, or the period since the date of the last National Office accountability review, whichever is less.

3. <u>Schedule</u>. Each year the Longshore Division issues the schedule of District Offices to be reviewed during the fiscal year. The OWCP Procedure Manual (Chapter 4-300) provides that each OWCP division should try to review its district offices biannually with National Office review teams (contingent on staff and funding availability). The following outline provides a schedule of the pre and post accountability review activities:

1. **At least thirty days prior to the review** the Regional Director is provided with a notice of the review confirming the on-site review dates, identifying the accountability review team members and providing any other pertinent information concerning the review. The notice also transmits the Off-Site Accountability Report, (Exhibit 25, PM 10-300) which contains relevant statistical data about the office to be reviewed.
2. **At the on site close-out conference** the review team will provide a comprehensive oral report, a list of proposed corrective actions and a completed copy of the Accountability Review Summary Sheet which contains the sample size, errors, and percent correct for each of the standards reviewed. A written accountability review report will be sent to the regional director within 10 days of the on-site review completion date (see OWCP Procedure Manual Chapter 4-300.6.b.).
3. **Within 15 days of receipt** of the accountability review report, the regional director reviews the report and provides the team leader with any comments, including any reasons for disagreeing with the report. The team leader has 15 days from receipt of the regional director's response to prepare and issue a

response to the regional director, district director, and National Office program head over the signature of the Director, Division of Longshore and Harbor Workers' Compensation. This response clearly states the reasons for agreement or disagreement with the regional office's position. Copies of the Final Report are sent to the Director, OWCP, the Division of Planning, Policy and Standards, and the Office of Management, Administration and Planning.

4. Tracking of Corrective Actions. The AR-10, Corrective Actions Report (Exhibit 54, PM 10-200), is a part of the final review report. The team leader lists the final recommendations which resulted from the accountability review. The reviewed office is then required to complete the AR-10 indicating the actions taken to implement the accountability recommendations. The AR-10 should be submitted with the Quarterly Review and Analysis Report until all recommendations have been implemented.

Chapter 9-0700, Small Business Regulatory Enforcement Fairness Act

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1. Purpose and Scope. This Chapter describes the district office requirements for reporting annually on their penalty reduction and technical assistance efforts as required under the provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA).

2. SBREFA requires agencies regulating small businesses to implement a guidance program, whereby agencies provide technical assistance to and answer inquiries by small businesses concerning compliance with their statutes and regulations as it applies to those businesses. Agencies are also to establish programs to provide for the reduction, and under appropriate circumstances for a waiver, of civil penalties for violations of a statutory requirement by a small

business. Finally, agencies are required to report annually to Congress on these two SBREFA requirements.

3. "Small Business". There is no simple definition of "small business" under SBREFA. However, it is described in general in the Small Business Act (15 U.S.C. section 632) as one which is independently owned and operated and which is not dominant in its field of operation. Further, under the Small Business Act, the Small Business Administration sets "size standards" to determine what is a small business. It makes that determination for each industry based on the number of employees and/or sales. What constitutes a small business therefore varies from industry to industry. The Small Business Administration has produced a list of industries and businesses at 13 C.F.R. section 121.201 that indicates for each the maximum number of employees and/or sales allowed for a business and its affiliates to be considered "small". Industries and businesses are classified in the list using "Standard Industrial Classification" (SIC) codes. Following are SIC codes and size standards for several major business categories covered under the LHWCA. Size standards are given in number of employees or millions of dollars in gross sales receipts. **Businesses equal to or smaller than these size standards should be considered to be "small businesses."**

Small business codes

SIC Codes		Size Standards
1302	Oil and Gas Field Exploration Services	$5,000,000
3731	Shipbuilding and Repair	1,000 employees
4491	Marine Cargo Handling	$18,500,000
6331	Fire, Marine and Casualty Insurance	1,500 employees
8744	Facilities Support Management Services	$20,000,000

A degree of judgment will be necessary when making determinations on whether or not a business is "small." When applying the SIC standards to a particular business, keep in mind the general definition of small business as one independently owned and operated. Also bear in mind that the Small Business Administration counts the gross receipts or number of employees of a business and all of its affiliates in determining its size. Therefore, the size of a shipyard or insurance company should be considered in conjunction with all its affiliates. Under the Small Business Act businesses are affiliates of each other when one controls or has power to control the other, or a third party controls or has the power to control both. Taking affiliations into consideration, therefore, most insurance companies and self-insured employers are not "small businesses" under SBREFA.

4. Penalties. SBREFA requires agencies to consider the waiver or reduction of civil penalties for violations of statutory requirements by small businesses. There

are three civil penalties under the LHWCA: Section 14(g), late notice of final payment; section 30(e), late report of injury; and section 48(a), discrimination against employees who bring proceedings.

1. **Section 14(g)**. Chapter 8-301 describes in detail the procedures for handling penalties for violations under section 14(g). However, in this Chapter it should be noted that the provisions of **SBREFA for reduction or waiver of the penalty do not apply when there is a violation under section 14(g)**. Section 14(g) requires the employer to submit a notice of final payment within 16 days and states that, "If the employer fails to so notify the deputy commissioner within such time the Secretary shall assess against such employer a civil penalty in the amount of $100." ($110 for all violations on or after November 17, 1997). The amount of the penalty is mandatory. If the notice is late the Secretary "shall assess" the penalty and assess it in the prescribed amount. Therefore, it cannot be reduced or waived.
2. **Section 30(e) and Section 48(a)**. Chapters 8-302 and 8-400 describe in detail the procedures for handling penalties for violations under section 30(e) and section 48(a) respectively, including guidelines for consideration of reductions of penalties under the provisions of SBREFA. Here, however, it must be noted that both section 30(e) and section 48(a) indicate that if it is determined that a violation has occurred, the violator "shall be" subject to the civil penalty. There is **no allowance under the LHWCA for waiver of the penalty**. However, since the LHWCA does not specify a fixed amount of penalty for violations of these sections of the LHWCA, the provisions of SBREFA for reduction of these two civil penalties may be applied.

5. <u>Penalty Log</u>. Each district office is required to maintain a penalty log (Exhibit 20, PM Chapter 10-300) recording each penalty assessment. An inquiry response box is provided on the log specifically asking whether or not the penalty is being assessed against a small business. Using the guidance provided in paragraph 3, above, in each instance a penalty is assessed make a determination of whether or not it is being assessed against a small business and indicate "yes" or "no" in the space provided on the log. If "yes", indicate in the dollar amount of the reduction, if any, in the "Comments" column provided on the penalty log. This information is necessary for preparation of the annual SBREFA report described in paragraph 7., below.

6. <u>Guidance Program</u>. SBREFA requires agencies regulating small businesses to implement a small business guidance program, whereby agencies "answer inquiries by small entities concerning information on, and advice about, compliance . . . with statutes and regulations, interpreting and applying the law to specific sets of facts supplied by the small entity." DLHWC has such a program. The program's offices provide technical advice and assistance on compliance and other issues to small businesses through an active seminar program, by written instructions on standard forms, and through general publications. Telephone numbers and addresses for specific inquiries are listed. The program responds to all telephone and written inquiries about specific provisions of the statute, regulations and procedures affecting entities having coverage under the statute or carrying on regular business with the program. The Longshore program also maintains an active home page on the Internet.

7. <u>Annual Report</u>. Each agency is required to report annually to Congress on their SBREFA penalty reduction program and SBREFA guidance program. The report is due each calendar year in January, covering activity during the prior calendar year.

1. **Report for SBREFA Penalty Reduction Program**. During the first week of each calendar year, using the data on their penalty logs for the previous 12 months, district directors shall count:
    a. The total number of section 30(e) and section 49 penalties assessed against small businesses;
    b. The number of such penalties assessed against small businesses in which the amount of the penalty was reduced taking into account the fact that it was a small business; and
    c. The total dollar amount of penalty reductions in which penalties were assessed against small businesses.

    Each district director shall submit a report on the penalty reductions for small businesses, including counts in each of the above three categories, to the Director, DLHWC by COB January 15 of each year.
2. **Report for SBREFA Guidance Program**. An actual count of each small business contact during the year will not be necessary. Instead, a two-week survey count will be carried out and the NO will calculate annual projections from the two-week survey results. Therefore, each year during the period November 1 through November 15, district office shall maintain a count of all

contacts (telephone, letter or in person) in which the DO's personnel provided guidance to small businesses concerning compliance with the LHWCA, its regulations or procedures. The DD for each DO shall submit his/her office's survey results to the Director, DLHWC by COB November 20 of each year.

Chapter 9-0800, Government Performance and Results Act (GPRA)

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2. Intent of the Government Performance and Results Act of 1993 (GPRA)	07/04	04-01
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9. GPRA Tracking and Performance Reports	07/04	04-01

1. Purpose and Scope. This Chapter describes the performance measurement adopted by DLHWC under the Government Performance and Results Act of 1993 (GPRA) and provides guidance and instruction for tracking and measuring program performance with respect to that performance goal.

2. Intent of the Government Performance and Results Act of 1993 (GPRA). In 1993, Congress enacted GPRA which required federal agencies to develop long-term strategic plans defining goals and objectives for their programs in terms of “outcomes” rather than “outputs,” to develop specific measurable performance goals and methods of measurement, and to report on actual results compared to the annual performance goal. The intent of GPRA is not to inflict a new measure of processes on federal programs, but to improve performance in a measurable way. The measure, that is the data entry, is not the goal of GPRA. District Office staff members are expected to make a good faith effort to improve the level of services provided in our informal dispute resolution mechanism in a number of areas. These areas may include:

- telephonic intervention,
- technical assistance,

- compliance assistance,
- prompt scheduling and conducting of Informal Conferences,
- individual meetings with the parties,
- streamlining the processes (paper handling, data entry, mail service, distribution to OALJ, etc.), and
- other means of improving service in the district office.

The GPRA measure is simply the methodology of reporting the effort to shorten the length of time it takes the program to resolve disputed issues. Program staff must keep in mind that GPRA outcome measures are the criteria by which Congress will distribute limited resources to programs, and our success in meeting our goals and documenting the achievement in our GPRA reports is the key to our future funding and staffing levels.

3. DLHWC GPRA Objective, Goal and Strategies.

1. **Objective**. It is the GPRA objective of DLHWC to foster the kind of cooperative spirit and open communication among the parties to a claim with disputed issues that results in a smoother, more efficient process and quicker resolution of those disputes.
2. **Goal**. To quantify the objective so it is measurable, the GPRA goal is to reduce the average time it takes to resolve certain types of disputes which arise in cases under the LHWCA and its extensions. The time taken by the OALJ in connection with the formal hearing process is to be included in measuring the time it takes to reach resolution. Advance notification of the annual fiscal year goal (i.e., the average number of days for dispute resolution) will be provided to the district offices by the National Office.
3. **Strategies**. Program strategies to achieve the objective include, but are not limited to:
    - Improve, streamline, and better manage district office dispute resolution processes and tracking.
    - Exercise prompt and effective case management.
    - Use outreach to encourage voluntary compliance with the provisions of the Act.

- Use outreach and technical assistance to institutionalize accelerated submissions of injury reports, required filings from employers/carriers, and other evidence so as to reduce the time to decision.

4. GPRA Tracking Codes. GPRA disputes and their resolution are tracked in the Longshore Case Management System (LCMS) using specific diary action codes. These codes are discussed below.

5. Documentation. Documentation of GPRA disputes and resolutions, as well as district office actions directed at resolution, is a necessity and will usually be satisfied by routine case documents such as LS-207, written correspondence from the parties, request for a conference, LS-206, LS-208, written documentation of phone calls, compensation orders, etc. However, where there is no such evidence in file or where the actions or determinations of the district office need explanation or clarification, legible notes are to be placed in the case file. A GPRA Log (Exhibit 27, PM Chapter 10-300) should be placed on the top of every file upon case creation, and updated as each GPRA entry is made. The Log is used to document the date and basis of each GPRA code entered or changed in the LCMS. It will make review and tracking less time consuming. The Log is designed so that it can be folded in half and turned over when one side is completely filled. Additional sheets may be added if needed. The top part of the Log may be used as an optional call-up sheet.

6. Disputes. Disputes that are to be tracked through the GPRA process are those genuine disputes involving temporary disabilities, permanent disabilities, medical treatment and/or payment, average weekly wage, occurrence of injury, or jurisdiction. Disputes concerning other issues such as attorney fees, penalties and interest, entitlement to section 8(f) relief, etc., are not disputes subject to the GPRA process.

1. **Identifying Disputes**. Disputes are generally identified based on the receipt of a LS-207, a letter or telephone call from the claimant or the employer/carrier (or their representative) describing the disagreement, or a request for an informal conference. However, the mere receipt of a LS-207 or a request for conference does not, in and of itself, establish the existence of a dispute. For example, issues contained in an employer/carrier's protective controversion that serves only to preserve due process rights (and which are often followed by the submission of a LS-206 or LS-208) are excluded as legitimate disputes.

Further, receipt of a LS-207 which contains a reason for controversion such as “Section 8(f) relief” or “Claimant seeking benefits under the applicable State Act” does not constitute evidence of a legitimate dispute or disagreement.

On the other hand, if the E/C submits a LS-207 with what appears to be a legitimate controversion, but the claimant does not respond within a reasonable period of time, the circumstances would support the conclusion that no dispute truly exists and no dispute code should be entered. If previously entered, the code should be overridden (see below concerning overriding dispute codes).

The submission of a request for an informal conference may not necessarily constitute evidence of a genuine dispute. For example, if the employee’s representative submits medical evidence in support of permanent impairment along with a request for an informal conference, and shortly thereafter without any action by the district office other than possibly scheduling the conference, the employer advises that appropriate payment will be made, there is insufficient evidence to support that a genuine dispute existed. If previously entered, the dispute code should be overridden.

2. **Entering Dispute Codes in LCMS**. GPRA disputes should be entered into the LCMS at the time the dispute is identified or as soon as possible thereafter. It is not recommended that disputes be entered at the time of primary review unless there is a strong indication that a dispute exists at that time. Indications of a dispute very early in the case may be misleading and may not represent the existence of a genuine dispute. Therefore, if a LS-207 is received with the LS-202, but the existence of a genuine dispute is not clear, it is acceptable to wait a reasonable time (e.g., 30 days) for the E/C to complete its investigation and possibly submit other documentation such as a LS-206 or LS-208 showing that, in fact, there is no disagreement with the claim.
3. **Date of Dispute**. The date of dispute to be entered in the LCMS is the date of receipt of the evidence showing the existence of a dispute and not the date the evidence is reviewed or the date it is being entered into the system. The

start date for tracking a dispute is the date the evidence showing the dispute is received in the district office.

4. **Multiple Disputes in a Single Case**. If there are multiple disputes in a case, each dispute is to be entered separately in LCMS using the appropriate code. For example, if the employer contests the claimant's right to temporary total disability for a particular period (207t) as well as the need for further medical treatment (207m), both disputed issues are to be entered in LCMS.
5. **Threshold Issues**. Where one of several disputes in a case involves a threshold issue such as occurrence of injury or jurisdiction, all disputed issues should be entered in LCMS at the time they arise and not just the threshold issue. It should not be assumed that all the other issues are simply subsumed by the threshold issue and that only one code (e.g., 207j) need be entered. If the threshold issue is resolved in the claimant's favor, other concurrent disputes such as AWW and entitlement to TTD, for example, are to be in LCMS and tracked to resolution.
6. **LCMS GPRA Dispute Codes**. The following diary action codes are to be entered in the LCMS to identify the occurrence of a GPRA dispute. Note that diary action code 207r (LS-207 Received) is not a GPRA dispute code, but it should be entered separately to document the receipt of the LS-207.
    a. 207a - There is a dispute with regard to the injured worker's average weekly wage.
    b. 207i - There is a dispute as to whether the injury arose out of and during the course of employment. (This is a threshold issue; however, any concurrent disputes should also be entered and tracked in LCMS.)
    c. 207j - There is a dispute with regard to situs, status or other related jurisdictional issues. (This is a threshold issue; however, any concurrent disputes should also be entered and tracked in LCMS.)
    d. 207m - There is a dispute is related to the necessity, authorization, cost, or payment of medical treatment.
    e. 207p - There is a dispute concerning the entitlement to permanent total or permanent partial disability including causal relationship,

nature and extent. This code should also be used to identify a dispute involving causal relationship in a death case.

f. 207t - There is a dispute concerning the entitlement to temporary total or temporary partial disability including causal relationship, nature and extent.

7. **"Overriding" a Previously Entered Dispute Code**. If it is necessary to negate a previously entered dispute code because, for example, the claimant never responded to the employer's genuine controversion of a claim for employment-related hearing loss, enter the code 207d in the diary action function of LCMS. This will negate, but not delete, the corresponding dispute code. Although still visible in the diary history, the overridden dispute code will not be reflected in any of the GPRA tracking or performance reports available through LCMS. Overriding a dispute code using 207d is not a GPRA resolution. A separate 207d override code should be entered for each previously entered dispute code to be negated. To help ensure that each 207d override code is associated with the correct dispute code, the 207d code should be given an LCMS sequence number which is one number greater than the sequence number for the dispute code to be overridden.

7. <u>Resolutions</u>. A resolution occurs when the parties to the disputed issue in a claim agree to a common position that ends the adjudication on that issue, or when a decision is rendered which resolves the disputed issue. For the purposes of GPRA, a decision on the disputed issue by the OALJ represents a resolution, and any subsequent appeal of that decision to the BRB or beyond does not fall within the GPRA tracking process. See the discussion of the GPRA resolution codes below for additional information on what constitutes a resolution.

1. **Identifying Resolutions**. Resolutions are most frequently identified by the filing of an order issued by the District Director or the OALJ, the receipt of a LS-206 or LS-208, or other communication from the parties documenting that the dispute has been resolved.
2. **Entering Resolution Codes in LCMS**. Resolutions should be entered into the LCMS at the time the resolution is identified or as soon as possible thereafter.

3. **Date of Resolution**. The date of resolution to be entered in the LCMS is the date of filing of the compensation order or the date of receipt of the evidence showing the parties have resolved the dispute. Where the resolution involves the payment of compensation for wage loss or permanent impairment without an order, the date of resolution should be the date of receipt of the LS-206 or LS-208. The date of resolution is not the date the documentation is reviewed or the date it is being entered in LCMS.
4. **LCMS GPRA Resolution Codes and Dates**. The following diary action codes are to be entered in the LCMS to identify the occurrence of a GPRA resolution. Note that diary action code 207d is not a GPRA resolution code. It is to be used to negate or cancel out a dispute code that was previously entered in error. To help ensure that each resolution code is associated with the correct dispute code, the resolution code should be given an LCMS sequence number which is one number greater than the sequence number for the dispute code being resolved.
    a. adj1 - Resolution as a result of an informal conference. The scheduling or holding of an informal conference or the issuance of conference recommendations does not, by itself, constitute a GPRA resolution. If the parties agree with the office's recommendation and take the action agreed to, then resolution occurs at that point and the adj1 code should be entered in LCMS. The date of the resolution depends on the actions taken. As examples, the date of resolution would be the date of the compensation order (if an order is specifically requested by the parties), the date of receipt of the LS-206 or 208 confirming payment (if no compensation order was issued), the date of the communication advising that a disputed medical bill will be paid, etc. If communication is by telephone, the call must be documented in the file. The date of the conference or the date of the release of the conference recommendations is not the date of resolution.
    b. adj2 - Resolution as a result of a section 8(i) settlement **approved by the district director**. This would include cases remanded by the

OALJ for consideration of a settlement agreement by the district director. Even though a compensation order is issued, the code adj2 should be used rather than adj4. The date of the resolution to be entered in LCMS is the date the order approving the section 8(i) settlement is filed. If resolution is reached by a section 8(i) settlement approved by the OALJ, resolution code adj5 should be used.

c. adj3 - Resolution as a result of correspondence and/or telephone calls. Resolution of disputes involving unpaid medical bills or the need for further medical treatment may be resolved through this process. Disputes concerning the percent of permanent impairment may also be resolved through the exchange of medical evidence and other correspondence rather than through the informal conference process. The date of resolution would be the date of receipt of the communication indicating that agreement has been reached or that appropriate payment has been made. If the dispute concerns an unpaid medical bill, a communication from the E/C that the bill will be paid is sufficient. If resolution involves the payment of compensation, the date of resolution should be the date of receipt of the LS-206 or LS-208 showing payment. If the efforts of the district office through correspondence and telephone calls produce agreement among the parties but they request the issuance of a compensation order, code adj4 should be used rather than adj3, and the date of resolution would be the date the order is filed.

d. adj4 - Resolution as a result of a compensation order issued by the district director. If actions by the district office result in agreement by the parties and the issuance of a compensation order (other than an order approving an 8(i) settlement), code adj4 should be entered in LCMS. If the order approves a section 8(i) settlement, adj2 should be used. This code would also be applicable where the case was remanded by the ALJ to the district office for additional action that culminated in the issuance of an order by the district director. (Also

see code adj5 below concerning remand orders.) The date of resolution would be the date the order is filed in the district office.

e. adj5 - Resolution as a result of an order issued by an ALJ, including those orders approving a section 8(i) settlement. This code should also be used for those ALJ orders remanding the case to the district office because the parties resolved their differences prior to the formal hearing. For example, if a dispute on the nature and extent of disability is resolved through evidentiary discovery prior to hearing (resulting in remand) and the E/C pays appropriate compensation, code adj5 should be used. The date of resolution would be the date the ALJ's order is filed in the district office. If following the remand, additional adjudicatory action is required of the district office before resolution is reached by the parties, a code other than adj5 should be used.

f. adj6 - Resolution as a result of 8(i) settlement approved by the district director in which the parties had obtained pre-approval from Medicare. This code is used in lieu of the adj2 resolutions. It is similar to the adj2 resolution but with the added qualification that the parties had submitted pre-approvals to Medicare. The purpose of separately tracking these settlement resolutions from the adj2 settlement resolutions is to account for the extra time it takes to resolve a case with Medicare pre-approval. The date of the resolution to be entered in LCMS is the date the order approving the section 8(i) settlement is filed.

g. adj7 - Resolution as a result of a settlement order issued by an ALJ in which the parties had obtained pre-approval from Medicare. This code is used in lieu of the adj5 settlement resolutions. It is similar to the adj5 settlement resolutions but with the added qualification that the parties had submitted pre-approvals to Medicare. The purpose of separately tracking these settlement resolutions from the adj5 settlement resolutions is to account for the extra time it takes to

resolve a case with Medicare pre-approval. The date of resolution would be the date the ALJ's order is filed in the district office.

8. Non-GPRA Tracked Cases. Beginning in FY 2002 the measurement of overall program GPRA performance for the first time included certain cases which had not been previously coded for tracking since GPRA was implemented on May 22, 2000. These cases are those with ALJ decisions issued after May 22, 2000 but which do not have a GPRA dispute code in the system. Since there is no dispute code and start date the LCMS cannot calculate the number of days in such cases. Therefore, a construct was designed to account for these disputes. For each such OALJ case, an average of 1.61 disputes and an average resolution time of 663 days for each dispute is counted. This construct of average disputes and resolution time was based on historical data. This results in a resolution time of 1,067.43 days for each non-GPRA tracked case returned from the OALJ.

1. **Definition**. "Non-GPRA tracked cases" are those cases in the LCMS/GPRA tracking system with an LCMS code of "adec," but without any GPRA dispute codes having been entered in the system. In other words, there is a diary action code of an ALJ adjudication ("adec" code) within the reporting period, but there is no applicable GPRA dispute or resolution code in the diary history. Not all non-GPRA tracked cases contain disputes that are to be tracked through the GPRA process, but only those with disputes involving temporary disabilities, permanent disabilities, medical treatment and/or payment, average weekly wage, occurrence of injury, or jurisdiction (i.e., those that can be identified by the GPRA codes 207t, 207p, 207m, 207a, 207j, or 207i).
2. **Coding Non-GPRA Tracked Cases**. Cases identified by LCMS as Non-GPRA tracked must be reviewed first to determine whether there are disputes that should be included in the category of GPRA Resolution by the OALJ; i.e., a GPRA dispute arose after May 22, 2000 and was resolved by the OALJ. If so, the appropriate GPRA codes and dates should be entered into the system. This will remove these cases from the Non-GPRA tracked measurement. There will still be cases that cannot be GPRA-coded because the dispute(s) started before May 22, 2000. When GPRA tracking was first implemented on May 22, 2000 a decision was made not to backfill data for disputes which arose prior to that date. For this reason, the LCMS was designed not to accept

a GPRA dispute code with a date of dispute earlier than May 22, 2000. These true "Non-GPRA Tracked" cases must be reviewed to eliminate those which do not contain one of the six GPRA tracked dispute issues. Instead of "adec", the following substitute ALJ adjudication codes should be used to eliminate them from GPRA tracking. These substitute codes are:

- adea - Cases with attorney fees as the **sole** disputed issue.
- Eadef - Cases with 8f relief as the **sole** disputed issue.
- adeo - This code should be used when an ALJ order is received in the district office that does not result in substantive dispute resolution, such as a notice of hearing or a pretrial order, and procedural and discovery orders (continuance, order to compel, show cause, joinder or dismissal of party defendant, etc.) This code is also used for errata or amended orders, ALJ decisions on reconsideration, and decisions on remand in cases where the initial Decision and Order had been issued sometime in the past. It should also be used in cases in which only Non-GPRA tracked disputes were resolved by the ALJ decision. Examples of Non-GPRA tracked issues are last responsible employer, employer-employee relationship, dependency, penalties and interest, discrimination, garnishment, misrepresentation and third party credit and forfeiture.
- The adec code should continue to be used in all other ALJ Decisions and Orders. Do not use adea, adef, or adeo if the ALJ decision includes resolution of **any** GPRA-tracked issues.

3. **Inactive or Closed Cases**. If inactive or closed files are reopened in order to consolidated with an active case for the purpose of a section 8(i) settlement, or for referral to the OALJ, these "companion" cases should not be separately GPRA-coded or tracked. They should be coded as "adeo" when they return from the OALJ. However, if there are genuine GPRA disputed issues in each (or some) of these reactivated cases, the usual GPRA coding should be used.
4. **Note**: If a "ctoa" code has been entered in LCMS when the case is referred to the OALJ, an ALJ adjudication code, i.e., adec, adeo, adea, adef or rmd, must

be entered when the case is returned from the OALJ. LCMS will not allow closure of a case with an open "ctoa" code.

9. <u>GPRA Tracking and Performance Reports</u>. GPRA tracking and performance reports are available through LCMS. Reports can be obtained based on either disputes or resolutions.

1. **Disputes**. By selecting “Dispute,” specifying the period to be covered, and selecting “Include all cases,” LCMS will provide GPRA information for disputes (both resolved and unresolved) which occurred during the period. To see information for all disputes which have been entered in LCMS, the beginning date of the period should be set to 05/01/2000. The last page of this report also shows (1) the total number of disputes occurring during the specified period and (2) the average number of days to resolution for those disputes that were resolved. Note that this average time does not indicate the office’s performance against the GPRA goal. Rather it represents only the average time to resolution where the dispute occurred within the specified period. Performance is computed based on the resolutions that occurred within the fiscal year, regardless of when the dispute actually occurred (see paragraph b below). For those resolved disputes where the case was referred to the OALJ (i.e., the diary history reflects the code ctoa), the report also shows the average number of days from referral to resolution. Similar information can be obtained through this report function for the following subcategories of disputes:
    - Only those disputes occurring within the specified period where the case was referred to the OALJ (based on diary code ctoa).
    - All disputes occurring within the specified period excluding those referred to the OALJ (in effect, those disputes being handled exclusively by the district office).
    - Those disputes occurring within the specified period which are still unresolved.
2. **Resolutions**. By selecting “Resolutions,” specifying the period to be covered, and selecting “Include all cases,” LCMS will provide GPRA information for

resolutions that occurred during the period. To see information for all resolutions which occurred during the fiscal year to date, be sure the beginning date is set to October 1. The last page of this report also shows (1) the total number of resolutions that occurred during the specified period and (2) the average number of days it took to reach those resolutions. Where the period covers the fiscal year to date, the average number of days shown on this report indicates the district office's GPRA performance. For those resolutions where the case was referred to the OALJ (i.e., the diary history reflects the diary code ctoa), the report also shows the average number of days from referral to resolution. Similar information can be obtained through this report function for the following subcategories of resolutions:

- Only those resolutions occurring within the specified period where the case was referred to the OALJ (based on diary code ctoa).
- All resolutions occurring within the specified period excluding those referred to the OALJ (in effect, those resolutions handled by the district office).

Listed at the top of the page of each report is a breakdown of the types of resolutions for the specified period. The breakdown shows the number and percentage of resolutions listed separately for each adj code.

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1. Purpose and Scope	09/00	00-01
2. Policy	09/00	00-01

1. Purpose and Scope. This Part of the Procedure Manual contains the Forms and Exhibits referenced throughout the Manual. Chapter 10-200 contains all numbered LS, OWCP, and other Forms. Chapter 10-300 contains all Exhibits such as unnumbered form letters, charts, directories, excerpts from other documents, etc. Each Chapter contains an Index which lists the Exhibit number, the title of the Form/Exhibit, its distribution (if it is to be sent by a DO) and a reference to an appropriate Chapter of the Procedure Manual.

2. Policy. Many of the Forms contained in PM 10-200 can be produced by the LCMS. Only those forms which have been developed by the NO and approved by the Office of Management and Budget are to be used to collect information. A DO is not to use independently developed forms to collect information.

Chapter 10-0200, Index and Numbered Forms

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1. Forms	09/00	00-01

1. Chapter 10-0200, Forms

Longshore Forms

FORM NO.	EXHIBIT NO.	TITLE	DISTRIBUTION	PM REFERENCE
LS-1	1	Request for Examination and/or Treatment		5-200.3
LS-3	2	District Office Statistical Report	Orig: NO	9-200
LS-3s	3	Supplemental Statistical Report and Definitions for Form LS-3s	Orig: NO	9-300
OWCP-14	4	Referral to OWCP Rehabilitation	Distribute Copies As Shown on Form	3-301.3g
LS-18	5	Pre-Hearing Statement	To All Parties	4-200.10, 4-600.3a
LS-19	6	Certificate of Filing and Service (for use with ALJ orders)	Orig: Case File cc: All Parties	4-600.8b
LS-19a	7	Certificate of Filing and Service (for use with DD orders)	Orig: Case File cc: All Parties	4-200.9c, 4-600.8b
LS-20	8	Notification of ALJ Decision	Orig: All Parties cc: Case File	4-600.8c
LS-21	9	Guidance for Completion of LS-18	To All Parties	4-600.3a
LS-33	10	Approval of Compromise of Third Person Cause of Action	Orig: Claimant cc: Case File	3-600.2
CA-58	11	Case File Transfer	Orig: Case File cc: With Case File Releasing Office	1-501.4a
CA-67	12	Case File Transmittal Sheet	Orig: Receiving Office cc: Releasing Office Case File	1-501.4c
LS-141	13	Notice of Informal Conference	To All Parties	4-200.5a(2), 6-201.5b
LS-200	14	Report of Earning	Disability Benefit Recipients	6-300.2
LS-201	15	Notice of Employee's Injury or Death		15 1-400.3, 2-201.4a
LS-202	16	Employer's First Report of Injury or or Occupational Disease		16 1-400.3, 2-201.2, 3-301.3f(1), 8-302.3a

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FORM NO.	EXHIBIT NO.	TITLE	DISTRIBUTION	PM REFERENCE
LS-203	17	Employee's Claim for Compensation		1-400.3, 2-201.4a, 4-403.5c
LS-204	18	Attending Physician's Supplementary Report		1-400.3, 5-300.4
LS-206	19	Payment of Compensation Without Award		1-400.3, 2-201.2b, 3-301.3b, 3-301.5
LS-207	20	Notice of Controversion of Right to Compensation		2-201.3d, 3-301.3d
LS-208	21	Notice of Final Payment or Suspension of Compensation Payments		1-400.3, 2-201.3b, 3-301.3f(2), 3-301.5b, 3-301.10b
LS-209	22	Request for Employee's Reply to Employer's Objections	Orig: Claimant cc: Claimant's Representative EC, Case File	2-201.3d, 3-301.3d
LS-210	23	Employer's Supplementary Report of Accident or Occupational Illness		2-201.2h
LS-215a	24	Notice to Employer and Insurance Carrier That Claim Has Been Filed	Orig: EC cc: Claimant, Claimant's Representative, Case File	2-201.4
LS-216	25	Request for Additional Reports	Orig: EC cc: Case File	3-301.3e(3), 5-300.3
LS-222	26	Carrier's or Self Insurer's Report on Rehabilitation to Deputy Commissioner	Distribute Copies As Shown on Form	3-301.3g
LS-226a	27	Subpoena Duces Tecum	To Any Party	4-400.11
LS-239	28	Compensation Certificate	Orig: To Employer cc: DO Insurance Section	7-500.5
LS-240	29	Compensation Certificate for Self-Insured Employers	Orig: To Self-Insured Employer cc: DO Insurance Section	7-500.5
LS-241	30	Notice to Employees	Orig: To Employer	
LS-242	31	Notice to Employees (for Self-Insured Employers)	Orig: To Employer	
LS-262	32	Claim for Death Benefits		1-400.3, 2-202.3
LS-265	33	Certification of Funeral Expenses		2-202.3, 3-302.8
LS-266	34	Application for Continuation of Death benefit for Student		2-202.3, 3-302.5
LS-267	35	Claimant's Statement	Death Benefit Recipients	6-300.2
LS-274	36	Report of Injury Experience		7-400.8a
LS-280	37	Memorandum of Informal Conference	Orig: Case File cc: All Interested Participants	4-200.8, 4-200.10b
LS-403	38	Employee's Right to File Claim for Disability Compensation	Orig: To Claimant cc: Case File	2-201.2f, 3-301.12b

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FORM NO.	EXHIBIT NO.	TITLE	DISTRIBUTION	PM REFERENCE
LS-426	39	Request to Employee for Wage Earnings Information	Orig: To Claimant cc: EC, Case File	2-201.3b, 3-301.3b
LS-504	40	Letter to Employee Explaining Rights	Orig: To Claimant cc: Case File	1-400.3d, 3-301.12c
LS-512	41	Request to Employer for Form LS-202	Orig: To Employer cc: Case File	8-302.5d
LS-521	42	Annual Adjustment of Award	Orig: EC cc: Claimant, Case File	3-202.5b
LS-526	43	Letter to Employee Explaining Need for Employer's Approval of Third Party Settlement	Orig: To Claimant cc: EC, Claimant's Representative, Case File	3-600.2
LS-535	44	Notice to Guardian of Provision for Benefit Continuation	Orig: To Parent or Guardian cc: EC, Case File	3-302.5a
LS-536	45	Notice to Guardian of Requirement to Complete Form LS-266	Orig: To Parent or Guardian cc: EC, Case File	3-302.5b
LS-537	46	Notice of Recommended Change in Compensation Based on Higher AWW	Orig: EC cc: Claimant, Case File	3-201.8a, 3-301.3b
LS-541	47	Recommendation to EC to Accept Continuation of Death Benefits	Orig: EC cc: Parent or Guardian, Case File	3-302.5c
LS-548	48	Letter Explaining EC's Responsibility to File Timely LS-202	Orig: To Employer cc: Case File	8-302.4b
LS-551	49	Notice Assessing Penalty for Late Filing of Form LS-202	Orig: To Employer cc: Case File	8.302.5d
LS-552	50	Notice to EC of Penalty for Late Filing of Form LS-208	Orig: To Employer	8-301.6d
LS-557	51	Notice to Employee of Compensation Rate Under LHWCA	Orig: To Claimant cc: Case File	2-201.3b
LS-570	52	Card Report of Insurance		7-300.8, 7-500.2
	53 (Reserved)			
AR-10	54	Corrective Action Report	Orig: To Office of Management, Administration, and Planning	9-500.3c, 9-600.4
	55 (Reserved)			
DL 1-301	56	Cash Receipts Register	Orig: Remains in DO	1-200.9e, 8-302.8
DL 1-303	57	Cash Transfer Receipt	Orig: Remains in DO cc: To NO, or Regional Office	1-200.9f, 8-301.8, 8-400.6

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1. Chapter 10-0300, Exhibits

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EXHIBIT NO	TITLE	DISTRIBUTION	PM REFERENCE
1	OWCP Organizational Chart		0-400.2a
2	District Office Directory		0-400.2b
3	LHWCA Bulletin Format		0-500.5
4	LHWCA Circular Format		0-500.5
5	LHWCA Procedure Manual Transmittal Format		0-500.6
6	LHWCA Industry Notice Format		0-500.5e
7	Extract of OWCP Records Disposal Schedule		1-502
8	(Reserved)		
9	Transmittal Letter to OALJ	Orig: To OALJ cc: EC, All Representatives, Case File	4-600.4
10	Notice of Initiation of Debarment Proceedings	Orig: To Health Care Provider or Claims Representative cc: DO File	5-600.5
11	Notice of Debarment	Orig: To Health Care Provider or Claims Representative cc: DO File	5-600.7
12	Form to Transmit Section 8(f) Application for NO Review	Orig: To NO cc: Case File	6-201.7a
13	(Reserved)		
14	Automatic Stay Provisions of Bankruptcy Code		6-202.2f
15	Waiver From Automatic Stay		6-202.2j, 6-202.7b,(5), 6-202.7d(5)
16	Letter to Notify Corporate Officers of Personal Liability for Compensation Payments	Orig: To Corporate Officer cc: Case File	6-202.7a, 6-202.7(b)(1)
17	Letter to Follow-up on Incomplete Form LS-200/267	Orig: To Benefit Recipient cc: Authorized Representative, Case File	6-300.3b
18	Letter to Transmit Form LS-200/267 to EC	Orig: EC cc: Case File	6-300.3c
19	Letter to Follow-up on Non-Receipt of Form LS-200/267	Orig: To Benefit Recipient cc: Authorized Representative, Case File	6-300.3d, 6-300.6a
20	Penalty Log	Orig: Remains in DO	8-301.9, 8-302.9, 8-400.7
21	Workload and Performance Standards Report	Orig: To NO cc: DO	9-400
22	Q.R. & A. Corrective Action Report	Orig: To Office of Management, Administration, and Planning	9-500.3b

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EXHIBIT NO	TITLE	DISTRIBUTION	PM REFERENCE
23	Summary of DO Operations Report	Orig: To Office of Management, Administration, and Planning	9-500.3d
24	24 (Reserved)		
25	Off-Site Accountability Review Report		9-600.3a
26	NAWW, Minimum/Maximum and COLA Rates		2-201.3b(3), 3-301.3b
27	GPRA Log		9-800.5
28	Leaflet "Notice to Claimants Settling Claims"		3-501.12b(2)
29	Cover Letter for Leaflet "Notice to Claimants Settling Claims"		3-501.12b(2)