BCT-FY97

This infobase contains a numerical index of all FECA and OWCP Bulletins, Circulars and Transmittals issued in FY 1997, as well as the text of these issuances.

The BCTINDEX infobase contains a subject index of all FECA and OWCP Bulletins, Circulars and Transmittals issued since FY 1986.

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FECA BULLETINS--TEXT

FECA BULLETIN NO. 97-01

Issue Date: October 1, 1996

Expiration Date: September 30, 1997

Subject: Comp Pay--Direct Deposit

Background: On July 26, 1996 the Treasury Department published interim regulations stating that, in general, Federal agencies are to use electronic funds transfer (direct deposit) when making payments to beneficiaries who first become eligible for benefits after that date. The regulations also note that by January 1, 1999, all federal payments are to be made by electronic funds transfer. This provision would include beneficiaries who were receiving benefits before July 26, 1996.

While we intend to comply with this regulation, we do not believe that payments to claimants who have not signed up for direct deposit should be delayed to obtain such authorization. However, district office staffs should encourage claimants to sign up for direct deposit to receive all payments, whether on the daily or periodic roll. Forms CA-7 and CA-1049 will be modified to request this information.

In August, the National Office advised all check recipients on the periodic roll that direct deposit is available and asked them to adopt this method of receipt, and many beneficiaries did so.

In the near future, we will publish further guidance concerning the effect of this regulation on the bill pay process.

Purpose: To describe the OWCP's policy concerning electronic transfer of funds and the actions needed to implement it more widely

Applicability: Claims Examiners, Senior Claims Examiners, Technical Assistants, Staff Nurses, Rehabilitation Specialists, Fiscal Staff, and Supervisors

Action:

1. When setting up a payment, the Claims Examiner must use the direct deposit address whenever possible. The authorization may already appear in the file, or it may be newly submitted.

2. The forms which may be used to sign up for direct deposit are the Direct Deposit Sign-Up Form (SF-1199A) and the Fast Start Direct Deposit Form (FMS 2231). Either is acceptable, but Form SF-1199A is preferable because the financial institution completes the check routing information, and because this form makes no reference to allotments. Form SF-1199A can be ordered from GPO using stock number 7540-01-058-0224 and control number 1199-207.

Disposition: Retain until the indicated expiration date.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 97-02

Issue Date: October 15, 1996

Expiration Date: October 14, 1997

Subject: ADP - "Reengineered" Coding Scheme and Data Entry for the Quality Case Management (QCM) System.

Background: Commencing in January 1995 the QCM/Time Management Team began developing a plan to streamline the QCM tracking system. During the months since then the team proposed various changes focusing primarily on making QCM data entry more "user-friendly." With considerable group effort, including input from district office management and QCM users, and through discussions with National Office staff, the team put forth its final recommendations this past May. With only a few minor exceptions, the proposed changes have now been incorporated into the QCM system. Associated changes in the QCM reports and in the Disability Tracking system have also been implemented.

Reference: FECA Bulletin 93-10, issued July 28, 1993, FECA Bulletin 94-11, issued November 29, 1993, FECA Bulletin 94-14, issued January 20, 1994, FECA Bulletin 94-24, issued August 5, 1994 and FECA Bulletin 95-13, issued February 28, 1995.

Purpose: To notify all QCM users and DFEC managers of the revised coding scheme and system enhancements for the Quality Case Management and Disability Tracking functions on the Sequent system.

Applicability: Claims Examiners, Senior Claims Examiners, Supervisors, Rehabilitation Specialists, Staff Nurses, Fiscal Personnel, Technical Assistants and Systems Managers.

Action:

1. Under the new scheme there are now 27 mandatory and 46 optional QCM status codes available to users (see Attachment 1). The mandatory codes must be used in all cases, as appropriate, in order to properly track QCM actions and to accurately measure performance. Optional codes will have no significance in the measurement of performance. Also, individual optional codes may be designated "active" or "inactive" within each district office. Optional codes that are designated "inactive" will not be accessible to the users of the system.

2. In the QCM data entry screen (option 35 in the Case Management menu), the mandatory status codes will be listed in the pop-up window (ADD STATUS) under four activity headings. The "active" optional codes, if any, will appear under a fifth heading. The Page Up/Page Down keys may be used to move quickly between the code groups while the Up/Down arrow keys may be used to scroll through the entire list of codes.

3. A new date field (d18_track_date) has been added to the QCM header record. This date will be displayed as the "TRACK DT:" in place of the "DWLB:" in the QCM screens. In most cases this date will reflect the "Disab Date" for the Disability Tracking record associated with the QCM case. However, for cases where the claimant had returned to light duty work prior to the creation of the QCM record the "TRACK DT" will be the same as the QCM Start Date.

QCM performance will now be based on the Track Date rather than the Disab Date (DWLB). Accordingly, where the claimant is already working in a light duty capacity when the case comes under QCM the one-year and two-year tiers for resolving the case will run from the date the case drops into QCM rather than from the date the claimant stopped work.

4. The "QCM CE:" code displayed in the header will now reflect the responsible examiner (RCE) code value associated with each QCM record. The initial value for this field will automatically be copied from the CMF when a QCM record is created. Unless changed manually by the user, this code will remain on the QCM record even if the RCE code is subsequently changed in the CMF. No changes to this field will be permitted on closed QCM

cases.

The QCM header has also been modified to allow for the entry of two lines (160 characters) of text.

5. In addition to the many optional QCM status codes which will not be discussed in detail (see Attachment 1), several mandatory status codes have been added. The current list of mandatory codes, including any changes in their descriptions and defined uses, are detailed below. The nine listed with an asterisk (*) are the "intervention" codes under the new scheme.

CLAIMS EXAMINER ACTIVITY STATUS CODES

OIC* (Other Intervention by CE) This code is significantly re-defined as CE or SrCE contact with the claimant, agency or physician to discuss a return to work date and the availability of limited duty. The following qualifies for use of this code:

a. Telephone contact with the claimant which includes at a minimum, a discussion about the anticipated return to work date (or return to regular work); what the present limitations are and why these limitations preclude any work whatsoever (or preclude return to the regular job), and; whether the employer has been contacted concerning the availability of limited duty. The conversation should be substantive and should serve as a reminder to the claimant of his/her responsibility to return to work.
b. Telephone or written contact with the employer to discuss the availability of limited duty for the injured employee; to discuss the limitations, and; to solicit a job offer. The work restrictions should actually be available on the date of the conversation/letter.

c. Telephone contact with the physician to discuss the reasons for the continuing disability; to request a work release, and; to request the anticipated date of release to regular duty.

A conversation concerning bill payment, compensation payments or other case issues will not qualify for the use of this. Also, if OIC is used based upon a telephone call, the conversation must be fully documented. "OIC" should be pencilled on the corner of the qualifying CA-110, letter or other document for easy identification. This code may be used more than once on a given QCM record.

QAP* (Questions to Attending Physician) This new code applies to the situation where the claims examiner releases a letter to the attending physician posing pointed questions regarding the extent and duration of disability. Simply requesting a current report from the attending physician will not be considered sufficient for use of this code.

CON* (Conference Held) No change.

MSI* (Secop Initiated) The status effective date is now defined as the date of the exam (a future date will be allowed).

MRI* (Referee Exam Initiated) The status effective date is now defined as the date of the exam (a future date will be allowed).

NURSE/REHAB ACTIVITY STATUS CODES

NFN* (Referred to Field Nurse) No change.

NIN (Nurse Interrupt) This code, which was added last January, will be used in situations where the services of

the nurse are interrupted but are expected to resume at a later date. An example of the use of this code is where the claimant undergoes surgery that will require a period of recovery during which nurse services are inappropriate.

RRC* (Referred to Rehab Counselor) This new code will be used to indicate referral of the case to a rehabilitation counselor.

RCL (Rehab Case Closed - No RTW) This new code applies to all cases closed by the rehabilitation specialist without a return to work.

RLT* (Eventual Reduction via Rehab (Ltr Sent by CE)) No change.
RTR* (In Approved OWCP Vocational Training) No change.

WORK STATUS CODES

PLP (Pre-QCM RTW Light Duty/Part Time) This code will apply to all situations where the claimant returns to part-time work prior to the case coming under QCM.

PLF (Pre-QCM RTW Light Duty/Full Time) No change.

NLP (RTW via Nurse; Light Duty/Part Time) This new code applies to all situations where the claimant returns to part-time work via the nurse. (This code may also be entered in cases that already have a PLP code. However, such an entry is proper only if the claimant's work hours are actually increased through the intervention of the nurse.)

NLF (RTW via Nurse; Light Duty/Full Time) No change.

RLP (RTW via Rehab; Light Duty/Part Time) This new code applies to all situations where the claimant returns to part-time work via rehab. (This code may also be entered in cases that already have a PLP code. However, such an entry is proper only if the claimant's work hours are actually increased through the intervention of the rehabilitation counselor.)

RLF (RTW via Rehab; Light Duty/Full Time) No change.

MLP (RTW via CE; Light Duty/Part Time) This new code applies to all situations where the claimant returns to part-time work other than through nurse intervention or rehabilitation services. However, there must be some identifiable intervention by the claims examiner, such as referral of the claimant for a second opinion evaluation, posing pointed questions to the attending physician regarding extent and duration of disability, or other intervention described under OIC above, in order to attribute the return to work to QCM and justify the use of this code. (This code may also be entered in cases that already have a PLP code. However, such an entry is proper only if the claimant's work hours are actually increased through the intervention of the claims examiner.)

MLF (RTW via CE; Light Duty/Full Time) This new code applies to all situations where the claimant returns to light duty work on a full-time basis other than through nurse intervention or rehabilitation services. However, there must be some identifiable intervention by the claims examiner, such as referral of the claimant for a second opinion evaluation, posing pointed questions to the attending physician regarding extent and duration of disability, or other intervention described under OIC above, in order to attribute the return to work to QCM and justify the use of this code.

CLOSURE STATUS CODES

CFF (Closed - RTW (DOI or Pre-established LWEC Job) Used in all cases where the claimant returns to full duty under QCM.

CNL (Closed - RTW (Not DOI Job; 0% LWEC Decision)) No change.

CCO (Closed - Comp Order No Disability) No change.

CSA (Closed - Sanctions Imposed (or Comp Not Claimed)) In addition to designating a sanction decision, this code will now also be used in situations where the claimant elects OPM benefits or otherwise stops claiming compensation benefits. As with cases involving the imposition of sanctions, such cases are subject to reopening at the claimant's choosing.

CSA is the only "successfully resolved" closure code where the case may be reopened by simply entering a later status code into the QCM record. With this "reopen" mechanism in place, QCM activity may continue to be tracked in cases where the sanctions are lifted or the claimant chooses to again receive compensation benefits.

CAE (Closed - LWEC on Actual Earnings) No change.

CLW (Closed - Constructed LWEC) No change.

CRN (Recurrence/New Injury Following RTW Light Duty) This new code will be used in all cases where the claimant sustains a recurrence or a new injury while under QCM.

Cases closed with this code will be scored as "resolved successfully" only where there exists an earlier status for a return to work attributable to QCM intervention (i.e., NLP, NLF, RLP, RLF, MLP, MLF). Where no such code exists the user will be prompted "OK to zero out this QCM record? Y/N:". If the user presses "Y" the CRN code will be added and case will automatically be set to category "0". Otherwise, the code entry will be aborted.

CPN (Closed - Unable to Work (PN memo)) No change.

6. As part of the implementation of the new coding scheme some existing QCM status records have been deleted and others have been converted using new status codes, with revised descriptions, to replace the old code values. For example, existing QCM status records with old code NFC (1st FN Contact w/CE date) or OIC (Initial Call to Claimant) have been deleted from the database. Existing records with status code NCR (Ret'd to CE - Rehab Recommended) or NCS (Ret'd to CE - Second Opinion Recommended), have been converted to the new optional code NCO (Nurse Case Closed - Claimant Cooperative).
Further conversion of existing records has occurred as follows:

PL4 or PL6 (Pre-QCM RTW Light Duty/...) Earliest record updated to new code PLP and any subsequent record deleted.

NL4 or NL6 (RTW via Nurse; Light Duty/...) Earliest record updated to new code NLP and any subsequent record deleted.

RL4 or RL6 (RTW via Rehab; Light Duty/...) Earliest record updated to new code RLP and any subsequent record deleted.

NFF (RTW via Nurse; Full Duty/Full Time) Updated to code CFF.

CRE (Closed - Pre-QCM RTW Light Duty; Recur/New Injury) Updated to new code CRN.

NCW (Recurrence/New Injury Following RTW Light Duty) Updated to new code CRN.

RRS (Referred to Rehab) Updated to new code RRC.

RS1 (RS Closed on Referral) Updated to new code RCL.

RS5 (Closed Other) Updated to new code RCL.

In addition to the deletion and/or conversion of records, four of the old status codes have been made optional: NSN - Referred to Staff Nurse; NCN - Nurse Case Closed - Claimant Not Cooperative; MSC - Secop Exam Completed; MRC - Referee Exam Completed. Existing records with these status codes have not been disturbed.

7. Users of the QCM system will note a number of changes in the data entry edits and screen messages displayed in particular circumstances. For example, the system will prevent the entry of a "resolved" status code (NLP, MLP, RLP, NLF, RLF, MLF, CFF, CNL, CCO, CSA, CAE, CLW, CPN) in a case where no prior "intervention" code exists. The message "Status Not Valid Without Prior Intervention Code" will be displayed in that situation. A similar edit will prevent the deletion of the only remaining "intervention" code if a "resolved" code exists.

8. The data entry edits in the Disability Tracking system (option 36 in the Case Management menu) have also been revised slightly. The edit that prevented users from entering a "D" (Denied) status on a record with an associated RTW code has been removed. Also, for any record that is associated with a QCM record that has been "zero-ed out", the user may not change the status from "A" to another value without deleting the associated QCM record. A prompt "Status change will cause deletion of associated QCM record. Proceed? Y/N" will be displayed and the user may abort the change by pressing "N".

9. Changes have been made to several reports to accommodate the new QCM coding scheme. The changes are as follows:

CASE630 - QCM TRACKING: This report has been dropped from the FECS menu.

CASE633 - QCM NO INTERVENTION: This report has been modified to list QCM cases that do not have one of the nine qualifying "intervention" codes.

CASE611 - QCM QUARTERLY REVIEW AND ANALYSIS: This report has been revised significantly.

- QCM cohorts will now be based upon the "TRACK DT" rather than the "DWLB" (see paragraph 3 above).

- The report will list counts only for the mandatory status codes. Accordingly, several rows have been deleted and others have been added to the report. Cases with only optional status codes will be counted as having "no status."

- For cohorts over one-year old, the upper part of the report will show "0" counts for codes that qualify as a successful resolution only during the first year (RLT, NLP, NLF, MLP, MLF, RLP, RLF). The lower part of the report has been expanded to list the counts for these codes in the over one-year old cohorts. With

this change, the "RESOLVED TOTALS" will actually represent the sum of the individual code counts in the upper part of the report.

10. A new option (UPDATV36 - RE-SET OPTIONAL QCM CODES) has been added to the FECS004 menu under "CASE MANAGEMENT". Accessible by System Managers, this option will enable each office to "activate" or "deactivate" any or all of the optional QCM status codes, as desired. With the initial installation of these revised QCM programs and code tables, certain optional codes were "activated" as requested by the individual district offices.

Disposition: This Bulletin should be retained until the indicated expiration date.

THOMAS M. MARKEY
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Federal Employees' Compensation

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

Attachment 1 to FECA Bulletin 97-02

QCM STATUS CODES

STATUS DESCRIPTION

CLAIMS EXAMINER ACTIVITY STATUS CODES

OIC Other Intervention by CE
QAP Questions to Attending Physician
CON Conference Held
MSI Secop Initiated
MRI Referee Exam Initiated

NURSE/REHAB ACTIVITY STATUS CODES

NFN Referred to Field Nurse
NIN Nurse Interrupt
RRC Referred to Rehab Counselor
RCL Rehab Case Closed - No RTW
RLT Eventual Reduction via Rehab (Ltr Sent by CE)
RTR In Approved OWCP Vocational Training

WORK STATUS CODES

PLP Pre-QCM RTW Light Duty/Part Time
PLF Pre-QCM RTW Light Duty/Full Time
NLP RTW via Nurse; Light Duty/Part Time
NLF RTW via Nurse; Light Duty/Full Time
MLP RTW via CE; Light Duty/Part Time
MLF RTW via CE; Light Duty/Full Time
RLP RTW via Rehab; Light Duty/Part Time
RLF RTW via Rehab; Light Duty/Full Time

CLOSURE STATUS CODES

CFF Closed - RTW (DOI or Pre-established LWEC Job)
CNL Closed - RTW (Not DOI Job; 0% LWEC Decision)
CCO Closed - Comp Order No Disability
CSA Closed - Sanctions Imposed (or Comp Not Claimed)
CAE Closed - LWEC on Actual Earnings
CLW Closed - Constructed LWEC
CRN Recurrence/New Injury Following RTW Light Duty
CPN Closed - Unable to Work (PN memo)

PROCESS STATUS CODES (OPTIONAL)

DEL Delayed Development
IAE Interim Actual Earnings (No Formal LWEC)
NFE Field Nurse Extension Granted
JOL Suitable Job Offer Letter Issued
MIN Medical Interruption of QCM Activity
MRC Referee Exam Completed
MRF Referee Exam Follow-up

MSC Secop Exam Completed
MSF Secop Exam Follow-up
NCE Discussion of Case between CE and Nurse
NCN Nurse Case Closed - Claimant Not Cooperative
NCO Nurse Case Closed - Claimant Cooperative
NRC Referred to CAP Nurse
NSN Referred to Staff Nurse
OPM OPM Elected (Use CSA Code to Close Case)

QCM STATUS CODES

STATUS DESCRIPTION

PROCESS STATUS CODES (OPTIONAL) (continued)

PL4 Pre-QCM RTW Light Duty/4 hrs
PL6 Pre-QCM RTW Light Duty/6 hrs
NL4 RTW via Nurse; Light Duty/4 hrs
NL6 RTW via Nurse; Light Duty/6 hrs
ML4 RTW via CE; Light Duty/4 hrs
ML6 RTW via CE; Light Duty/6 hrs
PRL Pre-reduction Notice Letter Issued
PTL Pre-termination Notice Letter Issued
RHA Initial Interview Held
RHC Returned to Claims Examiner
RHD Plan Development
RHE Employed
RHG Assisted Re-employment Program
RHI Rehab Plan in Place
RHM Medical Rehabilitation
RHN Placement Previous Employer - Without Other Srvcs
RHP Placement New Employer
RHQ Screened
RHR Referred to RS
RHS Self Employment
RHT Training
RHV Employed, Assisted Reemployment Prog; RC Follow Up
RHW Placement Previous Employer - With Other Services
RHX Services Interrupted
RHZ Post Employment Services
RDP Rehab Development Plan in Progress
RWL Rehab Non-cooperation 30-day Warning Ltr
SRE Referred to SrCE for Conference
SUR Surgery Authorized
TTD Continuing Total Disability per Secop/Referee
TML 10-month Letter Issued

FECA BULLETIN NO. 97-03

Issue Date: October 15, 1996

Expiration Date: October 14, 1997

Subject: ADP - New Case Management File (CMF) Data Elements and New "Case Create" and "Case Change" Coding Requirements.

Background: When employing agencies do not to promptly submit injury notices and claim forms to OWCP, it often results in the initial rejection of medical bills and other claims that could otherwise be paid. To better serve claimants and to avoid unnecessary delays in issuing payments, we have been emphasizing to employing agencies the importance of submitting claims involving lost time and/or medical expenses to OWCP in a timely fashion. In order to monitor performance in this area, a new date field has been added to the CMF database. This field will be used during the "case create" process to record the date the employing agency receives the CA-1 or CA-2 claim form.

Other data elements have been added to the CMF to facilitate the identification of potential "dual benefits" cases, especially with respect to claimants employed under the Federal Employees' Retirement System (FERS). In addition, the CMF now includes data elements that will be used to record changes in the adjudication status of a case.

Reference: FECA Bulletin 95-23, issued August 28, 1995.

Purpose: To notify district offices of the new data entry requirements and screen display changes relating to the data elements that have been added to the CMF.

Applicability: Appropriate District Office and National Office personnel.

Action:

1. In the CASE CREATE screen (option 1 of the CASE MANAGEMENT menu) users will note a new data entry field labeled "Agency Received Date". The entry of a valid date in this field is required for any case being created based upon the receipt of form CA-1 or CA-2. A date in this field is optional for other form types.

> **Form CA-1**: For cases being created from form CA-1 the date to be entered as the "Agency Received Date" should be the date listed in item 22 (Date notice received) of the form. If no date is listed in item 22 then, as a last resort, the date listed in item 11 (Date of this notice) should be used. The CA-1 form should be returned to the employing agency for completion if no date is entered in either of these items.
>
> After entering the "Agency Received Date" the screen will display the prompt "ITEM 38 OF CA-1 INDICATES 'NO LOST TIME AND NO MEDICAL EXPENSE:'? Y/N". Depending upon whether this box is checked in item 38 the user should press "Y" or "N", as appropriate. If the user presses "Y" a special code will be entered in the CMF record so that these cases may be excluded from analyses of agency time-lag in submitting CA-1s.
>
> **Form CA-2**: For cases being created from form CA-2 the date to be entered as the "Agency Received Date" should be the later of the date of the employee's signature (item 18) or the date listed in item 26

(Date employee first reported condition to supervisor). The CA-2 form should be returned to the employing agency for completion if no date is entered for either of these items.

2. In addition to the "Agency Received Date", users will note three new data fields in the CASE CHANGE screen (option 2 of the CASE MANAGEMENT menu).

SERVICE COMP DATE: If known, the claimant's Federal "service computation date" should be entered in this field.

OPM RETIREMENT NUMBER and **OPM RETIREMENT DATE**: For a claimant who is retired or is continuing in Federal service as a "reemployed annuitant", the retirement claim number and effective date, if known, should be entered in these fields.

These new data fields display also in the CASE SEARCH screen (option 2 of the QUERY menu.)

3. The STATUS/ACCEPTED COND screen (option 9 of the CASE MANAGEMENT menu) and the CASE STATUS INFORMATION screen (option 15 of the QUERY menu) will now display the "Short Form Reopen Date" for cases where this is applicable. These screens will also display up to three previous adjudication status codes and dates under the heading "Adjudication History". The "Initial", "Prior" and "Post Short Form" adjudication codes and dates will be displayed, as applicable.

The "Initial" adjudication data will be permanently recorded in the CMF only when an adjudication code is entered where none previously existed. This includes cases that are closed "short form" at the time of "case create".

The "Prior" adjudication data will be captured in the CMF record whenever a new adjudication status is entered in place of an existing code. This includes "short form" closure cases that are reopened. The "Prior" adjudication data will be overwritten in the CMF record whenever a new adjudication status is entered.

The "Post Short Form" adjudication data applies only to "short form" closure cases that have been reopened and are adjudicated after the implementation of these system changes. The adjudication code and date entered in such cases will be permanently recorded in the CMF record.

An automatic backfill of the "Initial" adjudication data has been performed for cases that are currently closed "short form" and for reopened "short form" closure cases that are still in "UD" status. Further automated backfill of this data will be accomplished at a later date using information contained in the central database (NCMF).

4. Two new data elements have also been added to the CMF to record the responsible examiner ID associated with the "initial" and "current" adjudication of cases. The "Initial Adj Resp Exam" data will be permanently recorded in the CMF when an adjudication code is entered on a case where none previously existed. This data field will remain blank for cases that are closed "short form". However, if a "short form" closure case is reopened, the "Initial Adj Resp Exam" data will be captured the first time that an adjudication code is entered on the case.

The "Current Adj Resp Exam" data will be recorded automatically in the CMF whenever an adjudication code is entered in a case. This data field will also remain blank for cases that are closed "short form".

Both the STATUS/ACCEPTED COND screen (option 9 of the CASE MANAGEMENT menu) and the CASE STATUS INFORMATION screen (option 15 of the QUERY menu) will display the "Initial Adj Resp Exam" and "Current Adj Resp Exam" codes.

5. The DEPARTMENT CHANGE option has been removed from the CASE MANAGEMENT menu. Changes to

the table of valid agency chargeback codes (v12, Department Master) will be made only by the National Office.

6. In one final system change, the threshold for payment of medical bills in "short form" closure cases has been raised from $1,000 to $1,500. Users will note this new dollar figure in the REOPEN LT/NLT CLOSURE screen (option 10 of the CASE MANAGEMENT menu).

Disposition: This Bulletin should be retained until the indicated expiration date.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 97-04

Issue Date: October 23, 1996

Expiration Date: October 22, 1997

Subject: Comp Pay--Elimination of Short-Term Roll and Code PI
Rehabilitation--Elimination of Code PV

Background: In 1991, the Federal employees' compensation program
began using the short-term roll as part of its case management procedures. It was designed for cases where disability was not expected to exceed one year, to fill the perceived gap between the functions of the daily and periodic rolls.

At that time, the program had not developed the capacity to assign expiration dates in periodic roll cases, and it still required certification of routine daily roll payments, which were processed at several different work stations within the district office.

It was anticipated that use of the short-term roll would make clear to claimants that their disabilities were not expected to continue indefinitely, and that it would reduce the need to move the case among various work stations, thus allowing more rapid referrals for second opinion and referee evaluations. However, neither of these effects was fully realized, and when short-term payments expired, it was sometimes necessary to authorize further payments on an expedited basis.

The changes in daily and periodic roll processing and the problems which have arisen with the short-term roll have essentially rendered the short-term roll unnecessary. It is therefore being eliminated effective October 23. As of that date, cases currently coded PI will be recoded PR, but the expiration dates will remain the same.

This change will affect several letters in the Forms Correspondence System. Forms CA-1650 and CA-1651 are

being removed from the system, and Form CA-1655 is being combined with Form CA-1049, which is being completely revised. Minor revisions are being made to Form CA-1656.

Also effective October 23, cases coded PV will be recoded PR. This change is being made mainly because the Rehabilitation Tracking System provides many other ways to monitor cases where the OWCP is providing vocational rehabilitation services.

The National Office will forward lists of recoded cases to each district office.

Purpose: To advise district office staff of the changes which will accompany elimination of the short-term roll

Applicability: Claims Examiners, Senior Claims Examiners, Hearing Representatives, Supervisors, Technical Assistants, Rehabilitation Specialists, and Staff Nurses

Action:

1. Given the choice between placement on the periodic roll and continued daily roll payments, placement on the periodic roll should almost always be considered preferable.

2. Claims staff should use the periodic roll in place of the short-term roll by entering an expiration date which is carefully selected to reflect the circumstances of the case. It is assumed that expiration dates of at least six months to a year from the date of placement on the periodic roll will be needed in most cases given that it is OWCP's burden to terminate or reduce benefits absent a return to work when injury-related disability has ceased.

3. Claims staff should send Form CA-1049 to all claimants who will receive payments on the periodic roll, regardless of how long those payments are expected to continue.

Disposition: Retain until the indicated expiration date.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 97-05

Issue Date: January 9, 1997

Expiration Date: January 8, 1998

SUBJECT: ADP - Automated Compensation Payment System (ACPS) and Debt Management System (DMS) Report Schedule - 1997.

PURPOSE: To provide the 1997 schedule for processing the periodic disability and death payrolls under the ACPS and the DMS weekly and monthly reports for calendar year 1997.

APPLICABILITY: All appropriate personnel are to be made aware of the periods and "cut-off" dates for the ACPS periodic disability, death, and daily payrolls.

The production schedule for the DMS periodic reports is made available for the appropriate personnel. IT IS IMPERATIVE that this schedule be closely followed.

DISPOSITION: This bulletin should be retained in front of Part 5, Benefit Payments, Federal (FECA) Procedure Manual, until the indicated expiration date.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Attachments

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

FECA BULLETIN NO. 97-06

Issue Date: January 30, 1997

Expiration Date: January 29, 1998

Subject: Fiscal--Updates of Cash Deposits and Cancelled Check Items into the BPS and ACPS History Files

Background: Audits conducted by the Office of the Inspector General show large year-end differences between the chargeback and SF-224, Statement of Transactions, net disbursements. The differences are caused mainly by untimely updates of cash deposits and cancelled check items into the BPS and ACPS History Files. This includes third party transactions.

The National Office is working with the Department of Treasury to develop an automated method for transmitting deposit transactions directly from the Lockbox Depository. The transactions would then be conveyed to each district office for update to the appropriate BPS or ACPS record. Until the automated method is available, however, these transactions will be controlled via the Cash Receipts Register or the Mailroom Cash Receipts Log, Form DL 1-301.

The chargeback year runs from July 1 through June 30, and the target date for all cash receipt transactions is June

15.

Purpose: To describe the steps needed to ensure that cash deposits and cancelled check items are updated in a timely manner

Applicability: Fiscal Staff, All Supervisors, and Technical Assistants

Action:

1. Each district office must develop a plan to ensure that all cash receipts and cancelled checks received through June 15 are entered into the BPS and ACPS History Files by that date, which is the cutoff date for running the chargeback report.

2. Third party refund transactions MUST be included in this process. Entering third party data into the Debt Management System (DMS) is not the same as updating the chargeback file. The DMS transaction simply records the refund amount for the purposes of completing Schedule 9 (report from the Department of Labor to the Department of Treasury).

3. The Cash Receipts Register must be annotated as each transaction is updated in the BPS or ACPS history file. Since cancelled check items are not recorded on Form DL 1-301, the district office must maintain records to verify that history files have been updated. The manner in which the district office maintains these records is discretionary. However, each district office must be able to produce evidence that the history files have been updated, to include the date of the entries.

4. Each office must submit a brief report describing its plan for implementation, including the projected date of implementation, which should be no later than April 1. The report should be sent to Ken Siglin via e-mail (kls@fenix2) no later than April 15.

Disposition: Retain until the indicated expiration date.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Distribution: List No. 4--Folioviews Groups B and D
(Fiscal Officers, Benefit Payroll Clerks and Assistants, All Supervisors, Systems Managers, Technical Assistants)

FECA BULLETIN NO. 97-07

Issue Date: January 6, 1997

Expiration Date: January 5, 1998

Subject: Compensation Pay: Compensation Rate Changes Effective January 1997

Background: In November 1996, the President signed an Executive Order implementing a salary increase of 2.30 percent in the basic pay for the General Schedule. The applicability under 5 U.S.C. 8112 only applies to the 2.30 percent increase in the basic General Schedule. Any additional increase for locality-based pay is excluded. The adjustment is effective the first pay period after January 1, 1997.

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

The new rates will be effective with the first compensation payroll period beginning on or after January 1, 1997. The new maximum compensation rate payable is based on the scheduled salary of a GS-15, Step 10, which is now $92,161 per annum.

The minimum increase specified in this Bulletin is applicable to Postal employees.

The effect on 5 U.S.C. 8112 is as follows:

Effective January 5, 1997	Minimum	Maximum
Monthly	$1,186.92	$5,760.06
Weekly	205.43	1,329.25
Daily(5-day week)	41.09	265.85

The basis for the minimum compensation rates is the salary of $14,243 per annum (GS-2, Step 1) and the basis for the maximum compensation rates is $92,161 per annum (GS-15, Step 10).

The effect on 5 U.S.C. 8133(e) is to increase the minimum monthly pay on which compensation for death is computed to $1,186.92, effective January 5, 1997. The maximum monthly compensation as provided by 5 U.S.C. 8133(e)(2) is increased to $5,760.06 per month.

Applicability: Appropriate National and District Office personnel.

Reference: Memorandum For Directors of Personnel (CPM 96-14), dated November 22, 1996; and the attachment for the 1997 General Schedule.

Action: ACPS will update the periodic disability and death payrolls. Any cases with gross overrides will not have a supplemental record created. Thus, the cases with gross overrides must be reviewed to determine if adjustments are necessary. If adjustment is necessary, a manual calculation will be required.

1. Adjustments Dates.

   a. As the effective date of the adjustment is January 5, 1997, there will be no supplemental payroll necessary for the periodic disability and death payrolls.

   b. The new minimum/maximum compensation rates will be available in ACPS on or about January 24, 1997.

2. Adjustment of Daily Roll Payments. Since the salary adjustments are not retroactive, it is assumed that all Federal agencies will have ample time to receive and report the new pay rates on claims for compensation filed on or after January 1, 1997. Therefore, it will not be necessary to review any daily roll payments unless an inquiry is received. If an inquiry is received, verification of the pay rate must be secured from the employing establishment.

3. Minimum and Maximum Adjustment Listings. Form CA-842, Minimum Compensation Pay Rates, and Form CA-843, Maximum Compensation Rates, should be annotated with the new rate information as follows (these forms will be reproduced after March 1, 1997):

CA-842

1/05/97	41.09-61.64	205.43-308.14	41.09	205.43	1,186.92
	41.09-54.78	205.43-273.90			

CA-843

1/05/97	265.85	1,329.25	(5,317.00)	5,760.06

4. Forms. CP-150, Minimum/Maximum Compensation, will be generated for each case adjusted. Notices to payees receiving an adjustment in their compensation will be sent from the National Office. Form CA-839, Notice of Increase in Compensation Award, will be utilized for this purpose Manual adjustments necessary because of gross overrides should be made on Forms CA-24 or CA-25 with a notice sent to the payee by the District Office.

Disposition: This bulletin is to be retained in Part 5, Benefit Payments, Federal (FECA) Procedure Manual, until the indicated expiration date.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 97-08

Issue Date: March 1, 1997

Expiration Date: February 28, 1998

Subject: Comp Pay/ACPS - Consumer Price Index (CPI) Cost-of-Living Adjustments for March 1, 1997

Purpose: To furnish instructions for implementing the CPI adjustments of March 1, 1997.

1. The new CPI increase, adjusted to the nearest one-tenth of one percent, is 3.3 percent.

2. The increase is effective March 1, 1997, and is applicable where disability or death occurred before March 1, 1996.

3. The new base month is December 1996.

4. The maximum compensation rates which must not be exceeded are the following:

$ 5,760.06 per month
1,329.25 per week
5,317.00 each four weeks
265.85 per day (for a 5-day week)

Applicability: Appropriate National Office and District Office personnel.

Reference: FECA Consumer Price Index (CPI) Amendment, dated January 6, 1981.

Action: On or about February 21, 1997, both the periodic disability and death payrolls will be updated in ACPS. If there are any cases with gross overrides, there will be no supplemental record created. Thus, the cases with gross overrides must be reviewed to determine if CPI adjustments are necessary. If adjustment is necessary, a manual calculation will be required.

1. Adjustment Dates.

a. The periodic disability and death supplemental payrolls for CPI adjustments will cover the period March 1, 1997 only, with the new cycle effective March 2, 1997.

b. The supplemental check date for the periodic disability and death payrolls will be March 18, 1997. Please note: payments of less than $1.00 will not be issued.

2. Adjustments of Daily Roll Payments. Since the CPI will not be in ACPS until February 21, 1997, daily roll payment cases requiring the new CPI should be held for data entry until that date.

3. CPI, Minimum and Maximum Adjustments Listings. Form CA-841, Cost-of-Living Adjustments; Form CA-842, Minimum Compensation Rates; and Form CA-843, Maximum Compensation Rates, should be updated with the new information. (These forms will be reproduced within the next month or so.)

4. Forms.

a. Form CA-837, Notice to Payee, will be sent to the payees on the periodic disability and death payrolls. The notice will be sent to the payees from the National Office. The CA-837 will be addressed using the ACPS Correspondence Address File. PLEASE be sure to maintain the address file as you do with the Payee Address File and the CMF. PLEASE remember that an address change to the CMF DOES NOT automatically change the ACPS check address or correspondence address. ACPS must be accessed and the enter key must be depressed through the address areas. Be watchful for those payments being sent via Direct Deposit.

b. Any manual adjustments necessary because of gross overrides in cases should be made on Form CA-24 or CA-25. A notice to the payee should be sent from the district office.

c. CP-140 will be printed for each case adjusted. These should be drop filed in the case file.

Disposition: This Bulletin is to be retained in Part 5, Benefit Payments, Federal (FECA) Procedure Manual, until further notice or the indicated expiration date.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 97-09

Issue Date: February 3, 1997

Expiration Date: February 2, 1998

Subject: Dual Benefits - Deduction from FECA benefits of Social Security Benefits "Attributable to Federal Service" in FERS cases.

Background: Retirement benefits under the Federal Employees' Retirement System (FERS) are considered dual benefits just like the Civil Service Retirement System (CSRS) benefits. Because FERS benefits include SSA death and old age benefits, however, they are treated differently. While there have been very few Federal employees eligible for retirement under FERS until recently, the number is beginning to grow. This bulletin explains how FERS retirement benefits affect FECA payments and what the CE must do to prevent payment of dual benefits.

WHAT IS THE FERS DUAL BENEFIT?

FERS, which took effect on January 1, 1987, is a mandatory replacement for CSRS and all employees first hired on or after January 1, 1982 are covered under FERS. CSRS employees were offered the opportunity to switch to FERS during an open season in 1987.

The FERS benefit package consists of three basic components, FERS basic benefits paid by OPM, the Thrift Savings Plan, and Social Security. Claimants elect between FECA benefits and the FERS basic benefit from OPM in the same manner as they elect between FECA benefits and CSRS benefits. There is no bar to concurrent receipt of the proceeds of the Thrift Savings Plan and FECA benefits. It is the SSA program which requires the most significant changes by OWCP in how it deals with retirement benefits.

FECA benefits have to be adjusted for the FERS portion of SSA benefits. The portion of the SSA benefit earned as a Federal employee is part of the FERS retirement package, and the receipt of FECA benefits and Federal retirement benefits concurrently is a prohibited dual benefit. 5 USC 8116(d)(2) requires that disability and death benefits paid under the FECA be reduced by the amount of any Social Security (Title II) old age or death benefits paid that are attributable to the Federal service of the employee. Unlike CSRS or FERS OPM benefits, however, this is not an election, but a deduction from FECA benefits payable. The beneficiary continues to receive their full SSA benefit.

There are general exceptions to the dual benefits deduction. The two major ones are: 1) schedule awards, as with CSRS retirement benefits, FERS retirement benefits paid by OPM or SSA can be paid concurrently with a schedule award, without any deduction from FECA benefits; 2) The deduction from FECA benefits does not apply to SSA disability benefits (SSA, not OWCP, makes a deduction from SSA disability benefits for FECA benefits paid).

HOW TO RECOGNIZE POTENTIAL FERS SSA DUAL BENEFIT CASES

In Disability Cases: The possibility of FERS SSA dual benefits exists where:

1. The claimant is at least 62 years old, and

2. The claimant had FERS retirement coverage during any of his or her Federal employment, and

3. The claimant is paid benefits based on age by SSA.

Claimants between 62 and 65 may be eligible for both SSA disability and SSA death benefits. If so, they may elect the more advantageous. If they elect disability, there is no FECA offset. At age 65, SSA disability benefits automatically convert to SSA old age retirement benefits. Therefore, all SSA retirees age 65 or older, who are covered by FERS, are subject to the FERS offset.

In Death Cases: The potential for FERS SSA dual benefits exists where:

1. The deceased employee had FERS retirement coverage during any of his or her Federal employment, and

2. There are dependent children, or

3. There is a spouse who either, 1) has in their care a child under the age of 16, 2) is 50 years old and disabled, or 3) is 60 years old.

Recognizing a FERS dual benefits situation may be difficult. Unlike CSRS retirement, OPM may not be aware of an individual receiving SSA benefits based on Federal employment, since applications for and entitlement to SSA benefits and OPM benefits are not dependent upon one another. OPM is not advised that a FERS employee has or has not applied for SSA benefits. Where a CSA number has been assigned, however, the CSA or CSF number is the easiest way to recognize FERS cases. The CSA number for all FERS retirement cases begins with 8 million. All FERS death cases have a 7 million CSF number.

Forms CA-1, CA-2, CA-5 and CA-5b are currently being revised to ask for the employee's retirement plan and whether a claim has been filed for SSA benefits.

HOW TO CALCULATE THE OFFSET OF SSA BENEFITS "ATTRIBUTABLE TO FEDERAL SERVICE”:

Only that portion of SSA benefit “based on Federal Service” is deducted from the FECA benefits. This section explains how OWCP calculates what that portion is.

SSA benefits are computed based on the number of years of employment and the amount of earnings. To be eligible for SSA benefits, an employee must have a minimum number of quarters of employment (usually 40 quarters or 10 years) during which contributions were made to the Social Security System. OWCP has defined the portion of SSA benefits "ATTRIBUTABLE TO FEDERAL SERVICE", which must therefore be deducted from FECA benefits, as the difference between the beneficiary's actual SSA benefit and a hypothetical SSA benefit computed without the Federal earnings, assuming that the employee had the required number of quarters for SSA benefits.

Where a claimant has received SSA benefits, OWCP will obtain information from SSA on the amount of the claimant's SSA benefits beginning with the date of eligibility to FECA benefits. SSA will provide the actual amount of SSA benefits received by the claimant/beneficiaries. SSA will also provide a hypothetical SSA benefit computed without the FERS covered earnings. OWCP will then deduct the hypothetical benefit from the actual benefit to determine the amount of benefits which are "attributable to Federal Service". That amount is deducted from the FECA benefit to obtain the amount of compensation payable.

EXAMPLE: The claimant is entitled to $900.00 per month in FECA benefits. The actual Social Security benefit is

$500 per month. The “hypothetical” SSA benefit is $300 per month.

$500 - $300 = $200 (the amount deducted from FECA benefits)

$900 - $200 = $700 (FECA benefits payable)

The claimant would be entitled to keep the entire $500 per month from SSA but would have to elect between the $700 per month FECA benefits and the full OPM retirement benefit. (Any Thrift Savings benefit is not considered a dual benefit.)

OTHER ISSUES RELATING TO CALCULATION OF BENEFITS

COLAs: All Social Security beneficiaries receive COLAs effective the 1st of December each year, regardless of when they were put on the rolls. A beneficiary who is first eligible for SSA benefits in November, receives the full COLA in December. Effective December 1 each year, all deductions for FERS SSA dual benefits will be increased by the percentage of the SSA COLA. The FECA CPI, effective March 1, will be added to the total amount of FECA benefits, before the FERS SSA deduction.

There are several issues related to the deduction of the FERS SSA benefit from FECA benefits which apply primarily to death and LWEC cases. In rare instances, they could apply to any claim. Guidelines for handling those issues are outlined in the addendum to this bulletin. The addendum should be kept with the bulletin and used as a reference for all death and LWEC cases.

Purpose: To provide procedures for making proper FERS SSA deductions from FECA benefits in cases which are covered under FERS and are eligible for SSA old age or death benefits.

Applicability: All claims and fiscal staff.

Reference: 5 USC 8116(d); title II of the Social Security Act

Action:

1. When it is determined that FECA benefits are payable, determine if there is a potential for FERS SSA dual benefits, using the criteria outlined in the background.

2. Where the claimant in a disability case is under 62 years old, place a call up on the case for the 62nd birthday.

In a death case, where the spouse is under 60 years old and has no children under 16, place a call-up for the 60th birthday.

Advise these claimants that they must notify OWCP at once upon applying for SSA old age or spousal death benefits.

3. Where there is a possibility of FERS SSA dual benefits, complete the FERS SSA Dual Benefits Form attached to this bulletin. This form should be photocopied in each district office. It will also be emailed to all District Directors for distribution to their staff.

FECA claims examiners complete the header information in all claims. Print your name, phone number and FAX number clearly in the "FROM" section. At the present time, Bill Hilton at SSA is performing the necessary

computations for OWCP. FAX the form "TO" him at (410)966-9214. His phone number is (410)965-2468. The National Office will provide updates of the SSA contact. Check whether you are requesting an initial computation or a recomputation.

OWCP then completes the left side of the form. In Part I, provide the name, SSN, Date of Birth, and Date of Death (if applicable) of the employee. Provide the dates of FERS covered employment. It can be stated in years (e.g. 1981 - 1992). If the date FERS coverage began (either the date FERS covered employment began, or the date of the FERS election) is not available, use 1981. The computation date is the date that FECA benefits are payable.

Complete the name, DOB, SSN (if available) and relationship in item II for all survivors claiming benefits in death cases.

Provide any relevant remarks not covered by this form in item III.

FAX the completed form to SSA at (410) 966-9214, attention: Bill Hilton.

4. When a completed form is returned by SSA indicating that the claimant is not receiving SSA benefits, no further action is necessary at that time. If it is a long term disability case, however, the periodic review should include checking to make sure that SSA benefits have not been initiated since the last review.

When the form indicates that the claimant is in receipt of SSA benefits, subtract the "SSA rate W/O FERS" from the "SSA rate W/FERS" (as indicated on the form). The result is the FERS SSA dual benefit. Subtract the FERS SSA dual benefit from the FECA benefits payable. Perform this computation for each date the benefit amount was revised by either OWCP or SSA, for each beneficiary in the case.

Place a memorandum in the file explaining the claimant's entitlement, and the computation of benefits. A sample memorandum is attached.

5. Where the claimant is entitled to both OPM benefits, including any OPM lump sum death benefit, and FECA benefits, provide the claimant with an election between OPM benefits and FECA benefits, which identifies the full FECA amount, the FERS SSA dual benefit deduction and the amount of FECA benefits payable after the deduction.

With the election, provide the claimant with an explanation of how the FECA benefits were computed. Direct the claimant to address any questions related to Social Security's computations to the local Social Security office. A sample letter is attached for your reference. You may modify this to the circumstances in the case. You could also send the CA-1102 or CA-1103, and include a separate letter of explanation. Make sure that each claimant receives an independent election in a death case.

6. When a claimant elects FECA benefits, coordinate the transfer from OPM benefits and release appropriate correspondence such as Form CA-1049 or CA-180 according to current procedures. These form letters have been revised to advise claimants of the FERS SSA dual benefit deduction.

7. When initiating an ACPS payment in ANY FERS case, answer "Y" to the new system prompt, "FERS SSA Offset? [Y/N], even if there is no current FERS SSA dual benefit. (This will be available in ACPS in late January 1997.)

The following prompt will then appear, "FERS OFFSET AMOUNT". If there is a FERS SSA dual benefit deduction, enter the amount to be deducted from the full FECA benefit. The system will then make the deduction. If there is no current FERS SSA deduction, press "ENTER". This will fill the field with zero.

This will provide a unique identifier for FERS cases and aid in COLA adjustments, tracking and matching.

ACPS will adjust the FERS SSA deduction effective every December 1 with the SSA COLA. In the example provided in the background, the COLA would be added to the $200 deduction.

The FECA CPI will be added to the full FECA benefit, before any deductions, as with current procedures.

8. Some district offices have existing records with an established AR for the FERS off-set. It is necessary for these records to be entered in the new ACPS screen, when available. After entry in the new FERS screen, please be sure the AR is deleted.

9. If there is any adjustment to SSA benefits because of earnings (See addendum. SSA should indicate this in Part III, Remarks, on the form), call up for May 1 to ask SSA to update the computations. Complete and FAX another form. When it is received, adjust ongoing benefits according to the information provided. Provide a letter of explanation to the claimant. A sample is attached.

In addition, follow current procedures for actions appropriate to the receipt of earnings information.

Disposition: This Bulletin is to be retained in Chapter 2-1000, Dual Benefits, of the FECA Procedure Manual, until revised or incorporated into the existing procedures.

Training should be conducted in each District Office on these procedures. Please report to me that the training has been conducted within 60 days of receipt of this bulletin. Any questions regarding these procedures should be addressed to Cecile Moran (202) 219-8461.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

ADDENDUM: FERS SSA DUAL BENEFITS FOR DEATH AND LWEC CASES

WITHHOLDING OF SSA BENEFITS FOR EARNINGS: SSA computes an individual's entitlement as a yearly amount. When an individual under the age of 70 earns more than an amount established by SSA, while otherwise entitled to SSA benefits, SSA will withhold benefits for a period of time. There is no SSA earnings withholding after age 70. Before the start of a calendar year, beneficiaries are required to estimate their earnings for the coming year. Based on that estimate, the entire SSA benefit check is withheld, beginning January 1, until the excess earnings withholding is met. If part of a check is required to complete the withholding, the entire check is withheld.

In the middle of the year, SSA beneficiaries are asked to update the earnings estimate. They are also asked to advise SSA at such time as their earnings exceed their estimate. The SSA withholding period may be adjusted based on the earnings updates. After the year has ended, the beneficiary must report to SSA the actual amount of earnings for the year.

Any balance due the beneficiary by SSA at the end of the year is paid at the end of the year. If, at the end of the year, insufficient funds have been withheld to fully cover the earnings, the balance owed becomes an overpayment, subject to due process overpayment procedures. If, after due process has been followed, entitlement to SSA continues, the overpayment will likely be withheld from continuing benefits.

For example, a beneficiary estimates earnings for 1995, and SSA computes the amount of benefits that must be withheld based on that estimate to be $2,500. The individual is entitled to $500.00 per month in SSA benefits. Monthly payments, beginning January, 1995 are withheld until the amount of excess earnings is withheld. In this case, the total withholding will be met with the May check. The beneficiary will receive nothing from SSA through May. They will receive their full check for June and July. Based on information provided by the beneficiary on the mid-year mailer, SSA, during July, then recomputes the earnings withholding to be $2,900. The entire August check is then withheld to cover the additional $400.00.

By April 15, 1996, the beneficiary must report actual earnings during 1995. If, based on this report, SSA recomputes earnings withholding for 1995 to be $3,300, the beneficiary has an overpayment of $300 (remember the entire $500 was withheld for Aug). If, instead, the final computation of earnings withholding remains $2,900, the extra $100.00 will be paid to the beneficiary.

During months that the claimant is not receiving any SSA benefits due to earnings withholdings, they are entitled to their full FECA benefit. During months that they receive their full SSA check, the full FERS deduction of FECA benefits applies. Where SSA benefits are withheld fully or in part to collect an overpayment, the claimant will have to notify OWCP and request any resulting adjustment to the FERS deduction from FECA benefits.

Where the beneficiary's actual earnings are greater than the estimate, the result would be a decrease in the SSA benefits. A lower amount of SSA benefits results in a smaller deduction from FECA. In these cases, there would be no excess FECA benefits paid. There may by additional retroactive FECA benefits due based on the recomputation of SSA benefits.

SSA will provide pertinent information regarding any withholding for earnings in the comments section when they complete a benefit computation form for FECA. It is important that FECA claims examiners be aware of these SSA procedures so that they can follow up on earnings withholdings and correctly compute the FERS deduction in these cases.

Keep in mind that earnings reported by SSA could also be relevant to the cliamant’s earning capacity in a disability case.

OVERPAYMENTS: Where timely notification of a benefit adjustment is received from SSA or the claimant, an immediate adjustment can be made to FECA benefits. Where OWCP does not learn until after the fact that a claimant's SSA benefits have commenced or increased, an overpayment of FECA benefits will be declared. Usually, prior notification to the claimant to advise OWCP of changes in SSA benefits, and the claimant's failure to provide such advice, will be sufficient to find the claimant "not without fault" in the occurrence of the overpayment.

THE DEDUCTION FROM FECA BENEFITS ONLY APPLIES TO SSA BENEFITS ACTUALLY RECEIVED: OWCP has interpreted the phrase "in the case of benefits received", in 5 USC 8116(d)(2), to mean that only benefits actually received by the claimant from SSA are subject to deduction from FECA benefits. If a claimant is potentially eligible for SSA benefits, but has not received anything, there is no deduction. If SSA benefits are reduced because of earnings or other adjustments, the deduction from FECA benefits is based on the actual SSA benefit received. If benefits are received by one individual on behalf of another, the benefit is considered to be received by the beneficiary, not the individual who receives the check.

MONTHLY MAXIMUM OF SSA BENEFITS IN DEATH CASES: Total SSA survivor benefits are limited by a monthly maximum. In some cases, where there is more than one eligible survivor, each survivor's benefit is reduced so that the total benefit paid does not exceed the monthly maximum. Where there are fewer beneficiaries, each beneficiary receives a larger portion.

WITHDRAWAL OR REFUSAL OF SSA BENEFITS: An individual may either withdraw their application for SSA benefits or decline to apply for benefits. Withdrawal nullifies entitlement. The beneficiary has to repay any benefits paid. If a beneficiary in a death case withdraws their application or declines to apply for benefits, the other eligible survivors will be paid as if that beneficiary does not exist. If a person declines benefits and then applies, the benefits are computed prospectively considering all of the entitled beneficiaries.

A widow with children, for example, could decline to apply for SSA benefits on her own behalf and still collect the same monthly maximum of SSA benefits for her children as if she accepted benefits for herself. Since the widow is not receiving any SSA benefits, OWCP will not make any SSA FERS deduction from her FECA benefits. OWCP will make the FERS SSA deduction for the children's FECA benefits only. The result may be that the widow can collect more from the combined programs than if she accepted SSA benefits on her own behalf. The law does not prohibit this.

ATTACHMENT 1

FERS SSA DUAL BENEFITS CALCULATIONS FAX TRANSMITTAL NO. OF PAGES

FROM:	TO:
OFFICE OF WORKERS' COMPENSATION PROGRAMS	SOCIAL SECURITY ADMINISTRATION
PHONE NUMBER:	PHONE NUMBER:
FAX NUMBER:	FAX NUMBER:
INITIAL	RECOMPUTATION
THIS SIDE TO BE COMPLETED BY OWCP	THIS SIDE TO BE COMPLETED BY SSA

I. EMPLOYEE/ANNUITANT

NAME	SSN	EFF DATE	SSA RATE W/FERS	SSA RATE W/O FERS

DATE OF BIRTH	DATE OF DEATH

FERS $$ PERIOD (FROM - TO)	COMPUTATION DATE (DATE ELIGIBLE FOR FECA)

II. SURVIVORS

1. NAME	DOB	ENTITLED TO SSA?	EFF DATE	SSA RATE W/FERS	SSA RATE W/O FERS
SSN	RELATIONSHIP	YES NO			

2. NAME	DOB	ENTITLED TO SSA?	EFF DATE	SSA RATE W/FERS	SSA RATE W/O FERS
SSN	RELATIONSHIP	YES NO			

3. NAME	DOB	ENTITLED TO SSA?	EFF DATE	SSA RATE W/FERS	SSA RATE W/O FERS
SSN	RELATIONSHIP	YES NO			

II. **REMARKS:**

NAME OF PERSON COMPLETING THE FORM FOR SSA

DATE FORM COMPLETED BY SSA

ATTACHMENT 2

Memorandum to File
JOHN DOE, A00-********

This is a FERS SSA dual benefits case. The Office is required to deduct from FECA benefits that portion of Social Security benefits attributable to Federal Service. The widow has withdrawn her application for SSA benefits. Therefore, she is entitled to the full FECA benefit on her own behalf, with no deduction.

For the children, their SSA benefit is $588.00 per month each effective 9/25/94. Effective 12/1/94, their SSA benefit was increased to $603.00 each per month. In determining that portion of the SSA benefit attributable to Federal Service, SSA computed the amount of SSA benefit to which the children would be entitled, if the deceased never had FERS covered service, assuming that he died fully insured under the SSA system. (They deleted FERS covered earnings from the computation. There was some part time Federal service which was covered by SSA and not covered under any Federal retirement system. Earnings from this service were not deducted.)

The result was that the children would have been entitled to $327.00 each as of 9/25/94, and $336.00 each as of 12/1/94.

	$588.00		$603.00
-	327.00	-	336.00
	$261.00		$267.00

Therefore, effective 9/25/94, the FERS SSA dual benefit deduction for each child from their FECA benefit is $261.00. Effective 12/1/94, the deduction is $267.00.

The FECA benefit for each child at 15% of $2547.25 per month is $382.09.

	$382.09	$382.09
-	261.00	-267.00
	$121.09 FECA as of 9/25/94	$115.09 as of 12/1/94

Effective December 1 of each year, the National Office will increase the FERS SSA dual benefits deduction by the percentage of the SSA COLA. In March, 1996, when the CPI is applied to the FECA benefit, it should be applied to the total FECA benefit ($382.09).

____

CLAIMS EXAMINER
DATE:

ATTACHMENT 3

Mrs. John Doe File Number: A00-000000
****
****

Dear **************,

I deeply regret your loss, and hope that I can be of some assistance in providing you with benefits to which you and your children are entitled on behalf of your husband's death.

Enclosed please find election forms for yourself and your two children, for you to elect between the compensation benefits payable to you as survivors under the Federal Employees' Compensation Act (FECA), and benefits payable to you by the Office of Personnel Management (OPM). Each of you is entitled to an independent election of the benefits you consider most advantageous, and you should complete and submit both originals for each of you to me at:

US Department of Labor, OWCP
District Office Address
****
****

FECA benefits and OPM benefits (including any lump sum death benefit provided under the FERS) are not payable for the same period of time. You are entitled to FECA benefits effective 9/25/93. If you elect FECA benefits, you may receive concurrently benefits from the Thrift Savings Fund and survivor benefits provided by the Social Security Act with the following exception.

5 USC 8116(d)(2) requires that compensation benefits be reduced by the portion of Social Security (SSA) benefits based on age or death that are attributable to Federal Service. Because you are receiving SSA benefits based on the Federal Service of an employee, your compensation benefits are reduced by the amount of Social Security benefits attributable to your husband's Federal service. Any questions related to SSA's computation of benefits should be addressed to your local SSA office.

If you elect compensation benefits, we will calculate the amount of compensation due from 9/25/93 to the present. Any benefits paid to you by OPM will be reimbursed to them from the compensation due, and any remaining balance will be paid to you. If you receive a lump sum death benefit from OPM under FERS, compensation due will be paid to OPM and no benefits will be paid to you until OPM has been fully reimbursed.

Your entitlement to FECA benefits is outlined below. FECA benefits are paid every 4 weeks, but the monthly amount is also shown for ease of comparison. Effective with the first periodic roll period following December 1 of each year, your compensation payment will be adjusted because of the cost of living increase granted to SSA beneficiaries.

EFFECTIVE 9/25/93:

	FECA	SSA DEDUCTION	MONTHLY	4 WEEKLY
Debra:	$1146.26	00	$1146.26	$1058.08
Shannon:	382.09	$261.00	121.09	111.78
Cathy:	382.09	261.00	121.09	111.78
Total:	$1910.44	522.00	$1388.44	$1281.64

EFFECTIVE 12/1/93

	FECA	SSA DEDUCTION	MONTHLY	4 WEEKLY
Debra:	$1146.26	00	$1146.26	$1058.08
Shannon:	382.09	267	115.09	106.24
Cathy:	382.09	267	115.09	106.24
Total :	$1910.44	534	1376.44	1270.56

**** Use the following paragraph in situations where the spouse is not receiving benefits on his or her own behalf, or where the claimant has not yet met the requirements for SSA benefits. ****

(At such time as you apply for Social Security benefits, the appropriate deduction would apply to your FECA benefit. It is your responsibility to advise this office immediately if you should apply for SSA benefits.)

If you have any questions about this election, or if I can be of any assistance, please contact me on (your phone number).

Sincerely,

****
Claims Examiner

cc: Agency

Claimant

****
****

Dear Claimant,

You were advised by letter of 00/00/00 that your FECA benefits had to be reduced by the portion of SSA old age or death benefits attributable to the FERS covered Federal Service of the employee.

Effective 01/01/96 your SSA benefits were adjusted to $550 per month. Your SSA benefits without the FERS covered Federal service would be $325 per month effective 01/01/96. As of 01/01/96, therefore, the amount of FERS SSA dual benefits which must be deducted from your FECA benefits is $225 per month, or $207.69 per 4 weeks. Your FECA benefits will be adjusted accordingly effective with your check dated 03/01/96.

Since OWCP only deducted $200 per month, or $184.62 per 4 weeks for the period January 1, 1996 through March 1, 1996, you have been overpaid in the amount of $50.00. Please remit a check in this amount at your earliest convenience.

If you have any questions about your SSA dual benefits deduction, please do not hesitate to contact me.

Sincerely,

NAME
Claims Examiner
Phone Number

Please note: you must also release the standard overpayment letters

ATTTACHMENT 4

File No. A14-000000
Date of Death: 9/25/93
Employee: ************
Employee SSN: ***-**-****
Employee DOB: 00/00/54
Monthly Pay: $2,547.25

Mrs. **********
****
****

Under the provisions of 5 U.S.C. 8101 et seq. (Federal Employees' Compensation Act), the OWCP makes the following

AWARD OF COMPENSATION

FOUR FOUR HEALTH

FOR WHOM PAID	RELATION	WEEKLY PAY	% OF	WEEKLY PAY	BENEFITS COMP.
DEDUCTION					
Debra	wife	$2351.31	45	1058.08	184.42
Shannon	daughter	2351.31	15	352.70	
Cathy	daughter	2351.31	15	352.70	
				$1763.48	
				-492.92	
				1270.56	

When an employee is covered under the Federal Employees' Retirement System (FERS), Social Security benefits payable to their beneficiaries, which are attributable to the employees' Federal Service, are deducted from FECA benefits (FERS SSA deduction). Each of your daughters are in receipt of Social Security benefits, a portion of which is attributable to the employees' Federal Service. Effective September 25, 1993, the amount of the FERS SSA deduction is $261.00 per month, or $240.92 per 4 weeks, per child. As of December 1, 1993, the FERS SSA deduction is $267.00 per month, or $246.46 per 4 weeks per child. As of December 1, 1993, the FECA benefits payable are $1270.56, minus health benefits of $184.42, for a net of $1086.14.

Your first check and the period covered: $15,361.31 9/25/93 to 10/15/94.

Your continuing four-weekly checks will be: $1,086.14. Effective with the first periodic roll period following December 1 of each year, your compensation payment will be adjusted because of the cost of living increase granted to SSA beneficiaries.

If, at some future time, you apply for Social Security benefits on your own behalf, you must advise this office immediately, so that we may coordinate the appropriate adjustment to your benefits with SSA.

By Order of the Director
Office of Workers' Compensation Programs

Claims Examiner

Enclosures: EN0180-0388, EN0180-0992, ENAPPA-0489/CA0180

cc: Attorney , OPM, Agency, file

FECA BULLETIN NO. 97-10

Issue Date: February 15, 1997

Expiration Date: February 14, 1998

Subject: Case Doubling

Background: The existing procedures for case doubling, found in the Federal (FECA) Procedure Manual at Chapter 2-400.8, state, "Doubling of case files should be avoided if possible." This reluctance to double cases has led to some very difficult situations with respect to cases before the Employees' Compensation Appeals Board, payment of medical bills, correct adjudication of claims, and providing excellent customer service to claimants. In addition, differences in doubling practices among and within the district offices have led to disagreements.

Case doubling is now encouraged where certain criteria are met. In general, the oldest case will be the master case. As of July 5, 1996, the CASE632 report, "Claimant New and Prior Injuries Report," is produced automatically whenever CASE615 (Case Create) is run. All CASE632 reports must be reviewed and appropriate cases doubled.

Reference: Federal (FECA) Procedure Manual, Chapters 1-300.6 and 2-400.8.

Purpose: To describe new guidelines and procedures for case doubling.

Applicability: District Directors, Systems Managers, All Supervisors, Claims, Fiscal, Bill Resolution, Mail Room and ADP staff.

Action:

1. When an employee has sustained more than one injury, it is often necessary to incorporate all of the records in one case folder. The case records are kept separately but travel under one claim number, which is known as the "master file". The subsidiary and master files are cross-referenced in the FECS data base. Each case file is assigned a status code, as follows:

I independent (neither a master or subsidiary file)
M master file
S subsidiary file

2. Cases should be doubled where correct adjudication of the issues depends on cross-reference between files. Cases meeting one of the following tests must be doubled:

a. A new injury case is reported for an employee who has filed a previous injury claim for a similar condition or the same part of the body. An example would be where a claimant has an existing case for a back strain and submits a new claim for a herniated lumbar disc.

b. Two or more separate injuries (not recurrences) have been sustained on the same date.

c. Adjudication or other processing of a case will require frequent reference to another case which is not for a similar condition or the same part of the body. An example would be where an individual who has an existing claim for carpal tunnel syndrome files a new claim for a mental condition which has overlapping disability periods. If only a few such references will be needed, the cases should not be doubled. Cases of this nature include:

1. cases in which problems arise keeping the cases straight for bill pay and/or mail purposes, such as when the same physician is treating the claimant for more than one injury;

2. cases with overlapping periods of disability; and

3. cases which should be handled by a single individual to ensure consistency and fairness.

3. The responsible claims examiner (CE) will be responsible for reviewing newly created cases for potential doubling and making doubling recommendations. The District Director or one or more designees will be responsible for approving case doublings and settling any disputes about whether cases should be doubled and which case file number should be the master file number. Unit claims managers may be designated reviewers.

4. Each day in which cases are created and CASE615 is run, a CASE632, "Claimant New and Prior Injuries Report" will be produced as well. This report shows all cases already existing for a claimant. Each page of the report should be placed in the corresponding newly created case file. If a case contains such a report, it must be forwarded to the responsible CE, even if it is a short-form closure case. The responsible CE will examine the list for each case in which a list appears and determine whether doubling is indicated. If needed, the other cases listed on the report may be pulled for the CE. The CASE632 report should be filed just above the CA-1 or CA-2. If the cases are to be doubled, the responsible CE should forward a request for case doubling to the designated reviewer, along with the cases. If the reviewer approves the case doubling, the cases should then be forwarded to the mail room.

5. If the CE notes, while examining a case file, that there are other injuries that may have bearing on the case at hand, the CE should request the other case file or files by completing Form CA-33. If the cases meet one of the criteria noted above, the CE should request that they be doubled. Such a request, which may be made by informal (handwritten) memo, should show the case file numbers, the master case file number, the reason for doubling, the CE's initials, and the date. The designated reviewer should approve the request before it is sent to the mail room.

6. When cases are forwarded to the mail room for doubling, the mail room should physically combine the cases into the master file jacket. The subsidiary case file numbers should be written on the front top center of the master file jacket. The subsidiary file jackets should be filed in the file room, with an annotation of the master file number. The spindles for the cases should remain separate, even though they are contained within the same jacket. The master file number should be written on the CA-800(s) of the subsidiary case(s). If any subsidiary case is inactive, as defined in item 10(a) below, the CA-800 will be spindled down. If the doubled file is too thick for the folder, it should be divided in accordance with FECA Procedure Manual Chapter 1-500.8. All of the inactive subsidiary cases should be placed in the A part of the file.

7. Once the cases have been physically doubled, the file should be forwarded to the ADP section for doubling on the FEC System. This is accomplished by using the Double/Undouble option under the FECS001 Case Management menu. After the cases have been doubled on the system, the memo which authorized the doubling should be initialed and filed down in the master file.

8. If cases are not doubled, but some cross-reference may be needed, and there is no CASE632 report in the file, related cases should be noted on Form CA-18. Medical and other evidence from other injuries may be copied, annotated to show the source, and added to the file. This would primarily be applicable to cases closed for more than 2 years which were accepted for minor conditions, and "automatic" closures more than 2 years old.

9. Cases should be doubled at the first indication that doubling is needed.

10. The master case file number should generally be the oldest (by file number) case in the office. The claims examiner who is responsible for the master case file will also be responsible for all of the subsidiary files. Changing claims examiners when a new claim is filed should be avoided. Subsequent related cases will be doubled into the existing master case file.

(a) Whether a case is open or closed will have little bearing on the doubling decision. However, a case

that has been closed for at least two years and has not involved medical payments for two years is considered to be inactive, and will generally not be the master case file.

(b) Cases that have to be retrieved from the records center will generally not be the master case file.

(c) Cases that already have a master number will not be undoubled and redoubled under another master case file number. This is true even if compensation payments are being made under a subsidiary case file number, but not under the master case file number.

11. A subsidiary case is not necessarily an inactive case. Subsidiary cases may be in an open status. The status of the case should reflect the situation at hand. If a subsidiary case is open, it should also have appropriate call-ups in place.

12. When case files are doubled, a letter should be sent to the claimant, the employer, the treating physicians, authorized representatives, and other interested parties, informing them of the doubling, and instructing them as to which case file number to use for inquiries, medical bills, and compensation claims.

13. If the accepted conditions in doubled cases are the same, the employing agency is the same, and there is no third party involvement, bills should be paid using the master file number (if that is an open case). However, where accepted conditions among doubled cases are dissimilar, or employers have changed, or third party liability is involved, care should be taken to make bill payments under the appropriate case file number.

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

Training for all personnel affected by these changes should be conducted no later than March 31, 1997. Compliance with these new procedures will be evaluated as part of the accountability review process.

Disposition: Retain until incorporated in the Federal (FECA) Procedure Manual.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Distribution: List No. 3--Folioviews Groups A, B, C, and D (All FECA Employees)

FECA BULLETIN NO. 97-11

Issue Date: February 24,1997

Expiration Date: February 23, 1998

Subject: District Office Use of Nurses Providing Telephonic Services

Background: To enhance the opportunities for the medical recovery and successful return to work of injured Federal workers, OWCP implemented two nurse intervention pilots from 1989 to 1991.

The first pilot, the Early Nurse Intervention Project, was implemented in three district offices and involved face-to-face contact of nurses in the local area (field) under contract to OWCP with claimants, health care providers, and employing agencies. These nurses were managed by designated office staff, usually a senior claims examiner, who served as a liaison between CEs in the office and the nurses. In contrast, the second pilot, Claimant Advocate Project (CAP) was strictly a telephone intervention. Nurses under contract to OWCP came into the district office and contacted claimants, treating physicians, and agency personnel. As in the first pilot, there was a staff member who coordinated the services of these nurses in each district office. Both pilots were effective in reducing compensation costs and enhancing the return to work. In addition, both demonstrated a high degree of satisfaction among participating claimants, agencies, district office staff and medical providers.

The face-to-face nurse intervention served as the model for the nurse intervention process included in the QCM procedures and was implemented nationally in 1993. However, the nurse providing telephonic case management offers several features that expand the district offices' ability to handle workloads. Some of these are: (1) it reduces the need for nurses in rural or geographically isolated areas, (2) it enables each nurse to handle a larger number of cases efficiently, (3) it is a relatively low-cost form of intervention. In implementing this program, district offices must be aware of the guidelines set forth below.

Purpose: This bulletin will provide guidelines and procedures for the use of nurses (telephonic) in the district offices.

Reference: OWCP Bulletin No. 91-2; Federal (FECA) Procedure Manual Chapter 3-200; OWCP Bulletin No. 93-6.

Applicability: Regional Directors, OWCP; District Directors, FEC;
Staff Nurses and Claims Examiners

Action:
District offices implementing this type of intervention need to establish the number of nurses necessary to handle those cases subject to telephone intervention. In addition, district offices need to develop referral and reporting procedures which meet QCM time limits, privacy requirements and a process for the tracking and monitoring of cases by the Staff Nurse (SN). This includes the accurate coding of telephone intervention milestones in the QCM screen for tracking purposes.

Nurses performing telephonic intervention must be certified by OWCP and their recruitment, selection and certification must be in keeping with the process described in FECA PM, Chapter 3-202. Nurses selected for telephonic intervention must sign a Memorandum of Agreement (MOA) unique to telephone intervention. Should one of these nurses, elect to perform face-to-face work as a field nurse (or vice versa) he/she has to sign an appropriate MOA. Further, a nurse cannot perform both types of intervention at the same time. Any cases in an open status have to be transferred to other nurses before the nurse in question can change his/her duties and designation. Irrespective of where the telephonic intervention is conducted, contract nurses must hold valid licenses in the states where their assigned claimants reside.

All nurses providing telephonic services must establish their own work site (e.g. home, office) and cannot work out of the district office. They may come into the office as necessary to obtain or drop off documents and for other administrative purposes. While in the office, the nurse may interact with claims staff. They may also have access to the telephone, computers and copying machines in the office for administrative convenience, but are otherwise responsible for furnishing their own supplies and materials

The duties of the nurses providing telephone services should be identical to those of the field nurse. Both assist the CE in the medical management of compensation cases to bring about the return to work on a full-time, part-time or light duty basis. Nurses may also be asked to review the medical management of long term disability cases for the purpose of coordinating proper medical treatment and reducing residuals. Although nurses may offer medical guidance and input in a case, they cannot perform functions principally performed by a claims examiner such as: preparing statements of accepted facts (SOAF) or questions for a second opinion or referee physician. Further, the nurses' functions are limited to the individual cases assigned to them for medical management, and they may not perform certain duties such as scheduling second opinion examinations and handling medical authorization requests on an office-wide scale.

5. The SN provides general instructions and guidelines to accomplish the return to work goal. However, once a case is assigned, the nurse (telephonic) does not receive direct and continuing supervision. Performance is evaluated on the outcome of cases and on the timeliness and quality of services.
Telephone intervention can have successful outcomes in cases with widely different diagnoses, length of disability, and/or demographic characteristics. However, because of its total dependence on oral communication at a distance, it may not be as efficacious as the face-to-face approach in some instances. To maximize results and to observe QCM time frames, a limit of 60 days should be applied to this intervention. However, in cases where there is a return to work (or return to work is imminent) within the 60 day period the nurse (telephonic) can provide the necessary follow-up. The CE may also allow extensions in special circumstances, such as when there are no available field nurses in the claimant's vicinity or when the nurse(telephonic) possesses language or professional skills that are necessary for the successful management of the case. Absent these circumstances, after 60 days the case should be transferred to a field nurse who will perform face-to-face intervention. An earlier transfer to a field nurse can occur if the nurse identifies factors which may render telephone intervention unsuitable. Some of these are: (a) claimants with problems in oral communication, (b) treating physicians who traditionally support total and prolonged disability for relatively benign conditions, (c) claimants with multiple, severe disabilities or with multiple recurrences of the accepted condition. In non-QCM cases, time limits for telephone intervention are the same as for face-to-face intervention: a total of 120-180 days.

Reimbursement to a nurse providing telephonic services cannot exceed $50,000. Any nurse who reaches this amount must not be assigned further work for the balance of the contract year. This reimbursement excludes all long distance telephone and FAX charges. These services are billed under the NIPTC code. Reimbursement for the services of the nurse (telephone) will follow the same requirements as for the field nurse namely the services provided must be case specific, a brief summary of the contacts made must be included, bills must submitted on the HCFA-1500 form and only the following unique telephonic codes must be used.

NCA00 - Telephonic nurse intervention, administrative - increments of time less than 1 hr.
NCA01 - Telephonic nurse intervention, administrative - 1 hr. increments of time.
NCP00 - Telephonic nurse intervention, professional services increments of time less than 1 hr.
NCP01 - Telephonic nurse intervention, professional services 1 hr.increments of time.

Do not use the field nurse (NIP) codes with the exception of the long distance telephone call code NIPTC for telephonic (CAP) nurse services.

Disposition: Retain until the expiration date or until superseded.

THOMAS M. MARKEY
Director for Federal Employees'
Compensation

Attachments

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

MEMORANDUM OF AGREEMENT

I. Introduction

The functional rehabilitation and return to work of injured workers are primary goals of the Federal Employees' Compensation Program. This agreement provides for early intervention by nurses to affect the extent and duration of disability or to improve medical management in cases where the length of disability is prolonged or uncertain. Examples include: back sprain/strain, neck or shoulder sprain/strain, knee injuries and carpal tunnel syndrome.

II. Services to be Provided

The following services will be performed by the contract nurse: (1) communicate directly with injured workers and their families to explain and monitor medical treatment and progress; (2) identify and pursue as needed more active treatment or more active participation by the injured worker; (3) as requested by the claims examiner, obtain concrete work limitations; (4) when applicable, arrange for on-site visits to the work place; (5) communicate directly with physicians about light duty opportunities and other issues; and (6) initiate return to work programs with the employee, agency and treating physician. All these interventions are conducted telephonically.

III. Reports

For any case referred to the nurse, a written management plan based on the nurse's initial telephone interview with the claimant must be submitted. Additional data elements will also be required in this management plan and will be discussed with the nurse during the training. Brief updates of the claimants medical condition, the goals reached or missed must also be submitted. Each district office will determine the desired frequency of these reports.

IV. Method of Billing and Payment

Reimbursement for the contract nurse's services will be made by charging individual case files worked. These services are considered to be prompt pay bills which will require the use of a separate HCFA-1500 form on each claimant's case.

V. Reimbursement Rate

There is a maximum time limit per case which may be authorized for these services. Duration of nurse services should not exceed sixty (60) days. Any plan for more than this time, must receive authorization by a claims examiner. There is a yearly reimbursement maximum of no more than $50,000 in a given fiscal year.

In those cases when a company will be billing for the nurse's services, the special disclaimer below needs to be signed by the individual nurse.

> I hereby authorize (name of company) to act as my agent to bill and receive payment for any services I render under this contract, and I hereby release the U.S. Department of Labor, and the Employees'Compensation Program from any and all losses which I may suffer as a result of my using (name of company) as my billing and payment agent.

Nurse's signature...

Date ....

VI. Security of Case Files

The contract nurse agrees to maintain the confidentiality of all records, reports, documents and case files developed or generated as part of this intervention effort in accordance with the Privacy Act of 1974 (5 U.S.C. 552a), and regulations promulgated by the Department of Labor to implement that statute (29 CFR Part 70a).

VII. Principles of Ethical Conduct

I understand that, the ethics rules (29 CFR Part O) and laws which apply to government employment may also apply to me. This includes the general prohibition against benefiting, through decision, approval, the recommendation, rendering of advice, or otherwise, in any particular matter in which a spouse, minor child, partner, organization in which you are serving as an officer, director, trustee, partner or employee or any person or organization with whom he is negotiating or has any arrangement concerning prospective employment or has a financial interest.

VIII. Termination

This agreement may be cancelled by either party upon thirty (30) days' written notice.

---------------------------------- ----------------------------------

(FEC district Office Staff (Contract Nurse)

Date --------------------- Date -------------------

Expiration Date of Contract

---------------------------- Address

Employment Identification Number (EIN) or the number under which payments should be reported to the Internal Revenue Service

State(s) in which licensed:

State Board
License Number:

Expiration Date :

FECA BULLETIN NO. 97-12

Issue Date: April 10, 1997

Expiration Date: April 9, 1998

Subject: February 1997 DFEC/OPM Computer Match

Background: Another DFEC/OPM computer match, designed to identify possible occurrences of prohibited concurrent dual benefit payment, was completed last month using the data for the February 1, 1997 periodic roll cycle. The data shared with OPM again included the death roll, and excluded schedule award cases. 110 cases survived the manual and automated screening processes employed by OPM. The last DFEC/OPM Computer Match was conducted in September 1995.

With its advance copy of this bulletin, each District Office will receive a computer printout of the cases under its jurisdiction which should be screened, followed and reported on in accordance with the procedures described in FECA Bulletin 96-4 and again specified below. The presence of a case on the list should indicate that benefits were being paid by both DFEC and OPM on February 1, 1997, in apparent violation of the dual benefit prohibitions.

For this, and future matches, we will continue to follow the procedures used in the past; that is, OPM and the responsible District Offices will directly converse and correspond in order to resolve the hits. The District Offices will continue to have National Office reporting requirements, as detailed below. However, any problems that arise with OPM, or with any other aspect of processing the match hits, should be raised with Alex Senecal (202) 219-8461 for resolution. Telephone inquiries to OPM should be directed to Eugene Wooldridge at (202) 606-0228 (or 606-0232). Written inquiries or other correspondence should be directed to the Office of Personnel Management, Retirement Inspection Branch, P.O. Box 7174, Room 2309, Washington, D.C. 20044-7174, Attention: Eugene Wooldridge.

Purpose: To inform District Offices of the procedures for follow-up review and reporting requirements concerning the "hits" identified in the February 1997 DFEC/OPM match, and to reiterate continuing reporting requirements for the previous OPM matches.

Applicability: District Directors, Assistant District Directors.

Action: Each District Office with one or more cases appearing as hits from this match will receive a copy of a

computer printout detailing the information on those cases, in a combined listing of disability and death cases. (On this printout the OPM Claim Number begins with "A" for disability cases and begins with "F" for death cases. Also, if the first digit of the OPM Claim Number is 7 or 8 then benefits are being paid under FERS rather than CSRS.) In addition, individual "hit sheets" completed by OPM are in the process of being mailed directly to the District Offices by OPM. Please note that the field identified on the printouts as "OWCP Gross" is actually the FECA 28 day payment amount converted to a 30 day equivalent for easy comparison purposes. The "OWCP Net" field is the actual 28-day gross compensation amount paid.

1. Immediately pull and review each disability (OPM "A" prefix) case listed in which the OPM gross payment amount exceeds the FECA gross payment amount. (For these cases the OPM amount is underlined on the printout.) If a review of the case confirms that the claimant is, in fact, in receipt of prohibited dual benefits, then action should be taken immediately to obtain an election from the claimant. If the receipt of dual benefits was discovered as a result of this computer match, the claimant should be advised of this. The claimant should be advised that the benefit not elected will be terminated and that he or she may dispute the dual benefit finding and proposed action. The claimant will be given 30 days to complete and return an election of benefits form. Upon receipt of the completed election form, the benefit not elected is to be terminated as soon as possible. A copy of the election form is to be returned to OPM along with a copy of the supplemental "hit sheet." If the claimant fails to make an election or to dispute the dual benefit finding within the 30 day period, the claimant should be removed from the compensation rolls as soon as possible.

2. Review the remaining disability cases (those where FECA benefits exceed OPM benefits), and the death (OPM "F" prefix) cases (as detailed below). In the disability cases where FECA benefits are greater, OPM will seek the election and return a copy of the election along with a completed OPM "hit sheet" to DFEC.

3. In death/survivor cases (OPM "F" prefix), an informed election must be made before either benefit is terminated. Please remember that split elections can be made. In fact, several *de facto* split elections were discovered during previous matches; that is, there appeared to be dual benefits situations when in fact different beneficiaries were receiving OPM and FECA benefits. In other cases split elections have been made as a result of the matches. It is important that truly informed elections are made in these cases. During the 3rd match you were advised of our revised policy regarding the revocability of elections in death cases. That change was formalized by revision to the regulations. However, OPM maintains that survivor elections are irrevocable; that is, that once an election of FECA benefits is made, the beneficiary may not subsequently elect OPM benefits, unless the FECA entitlement is later determined to have been mistaken, or there is a third-party credit absorption.

Therefore, included in the information provided to a beneficiary in order for him/her to make an informed election should be a statement that an election of OPM benefits can later be changed to elect FECA benefits, but that the reverse is not possible. In addition, an informed election should be based on a comparison of each beneficiary's benefits. Where the total converted gross FECA benefit is greater than the total OPM benefit, OPM will obtain the election of benefits and return a copy of the election along with a copy of the OPM "hit sheet" to DFEC.

Where the total OPM benefit exceeds the total converted gross FECA benefit and the review of the file confirms that the claimant is, in fact, in receipt of prohibited dual benefits, then action should be taken immediately to obtain an election from the claimant. If the receipt of dual benefits was discovered as a result of this computer match, the claimant should be advised of this. The claimant should be advised that the benefit not elected will be terminated and that he or she may dispute the dual benefit finding and proposed action. The claimant will be given 30 days to complete and return an election of benefits form. Upon receipt of the completed election form, the benefit not elected is to be terminated as soon as possible. A copy of the election form is to be returned to OPM along with a copy of the supplemental "hit sheet." If the claimant fails to make an election or to dispute the dual benefit finding within the 30 day period, the claimant should be removed from the compensation rolls as soon as possible.

4. In any case which results in a DFEC overpayment, the District Office should take immediate action in accordance with the overpayment procedures specified in Part 6 of the Procedure Manual.

5. Each DFEC overpayment case should be reviewed in order to determine whether the usual notifications concerning the prohibition against receiving concurrent retirement and compensation payments have been made. If so, the assumption must be made that the claimant is not without fault when such an overpayment occurs. Thus, except where this assumption is overcome by the evidence in the case file, a CA-2201 should be released immediately. Examiners are reminded that the supporting memorandum should explicitly detail the notification made.

6. When the appropriate overpayment letter is released, a 30-day call-up should be placed in the file. As soon as possible after a final decision has been released, administrative offset should be requested from OPM.

7. Initial review of all the listed cases should be completed and a report submitted by May 9, 1997, and quarterly thereafter until each "hit" is resolved. This review should confirm or refute the information supplied, the receipt of dual benefits and, where receipt of dual benefits is confirmed, determine whether or not there is an election of benefits on file. Each report must include, as appropriate:

a. The FECA case number and beneficiary name for each listing.

b. For death cases, the name, date of birth and relationship to the decedent should be listed for each eligible beneficiary.

c. Periods for which FECA benefits have been paid (specify schedule award periods).

d. Was the payment of dual benefits discovered through this match? (yes/no)

e. Is there an election on file? (yes/no) If yes, a copy of the election letter should be attached.

f. Have compensation payments been terminated? If so, effective on what date?

g. Is there an overpayment of compensation? (yes/no)

h. Is DFEC responsible for recovery?

i. What is the amount of the OPM overpayment?

j. What is the amount of the FECA overpayment transferred to the Accounts Receivable ledger?

k. Dates of subsequent due process and collection actions, including issuance of overpayment letters, final decision, release of SF-2805 to OPM requesting offset, etc. (Note: The current version of the SF-2805, Revised October 1988, should be used.)

Follow-up reporting for this match and for unresolved cases from prior matches should continue quarterly (by the 15th day of the first month of each quarter, i.e., 7/15, 10/15, 1/15, 4/15) until final resolution of the matter, until, for example, either the debt has been collected in full, a repayment schedule has been established and met at least once, or the account is otherwise closed. The final report should describe the repayment plan and/or date of payment. For example, the final report should show that a CA-2201 was issued on July 7, 1997; a final decision was issued on August 11, 1997 finding an overpayment of $2000; an SF-2805 was issued on September 22, 1997; the first payment of $200 was received from OPM on December 1, 1997; the debt will be recovered by October 1998.

(Note: For OPM debts, reporting may cease once the OPM overpayment amount has been reported. You no longer need to report any actions on OPM debts beyond this point.)

Disposition: This Bulletin should be retained until all actions have been completed.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Distribution: List No. 6
(Regional Directors, District Directors, Assistant District Directors, Chiefs of Operations, Systems Managers, Technical Assistants and National Office Staff)

FECA BULLETIN NO. 97-13

Issue Date: June 5, 1997

Expiration Date: June 4, 1998

Subject: Contract Observers on Vessels

Background: Public Law 104-297, enacted on October 11, 1996, provides that observers on vessels who are under contract to carry out responsibilities under the Magnuson-Stevens Fishery Conservation and Management Act or the Marine Mammal Protection Act of 1972 shall be deemed to be Federal employees for the purpose of compensation under the Federal Employees' Compensation Act.

Contract observers are employed in private industry to carry out the requirements of these Acts, which are under the jurisdiction of the Department of Commerce. Since these individuals are not Federal employees, the Department of Commerce will not be charged back for these cases, and will not be directly involved in the claims process.

Because we anticipate that these cases will present unusual issues, they must be handled in one location.

Reference: P.L. 104-297, Section 204; Federal (FECA) Procedure Manual, Chapters 1-0100.5 and 2-0802.

Purpose: To alert district offices to the possibility of receiving claims from a new group of individuals.

Applicability: District Directors, Systems Managers, All Supervisors, Claims, Mail Room, and Case Create staff.

Action: All claims from contract observers and their survivors will be forwarded to the National Operations Office (District 25) without jacketing. They will be assigned case file numbers with an OB- prefix, and will be retained in the National Operations Office.

Disposition: Retain until incorporated in the Federal (FECA) Procedure Manual.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Distribution: List No. 3--Folioviews Groups A, B, C, and D

FECA BULLETIN NO. 97-14

Issue Date: July 14, 1997

Expiration Date: July 13, 1998

Subject: Bill Pay--Travel Expenses

Background: Recent changes in travel regulations for federal employees have prompted National Office staff to reevaluate how FECA claimants should be reimbursed in connection with travel to obtain medical examination, treatment, appliances and supplies.

Consistent with the new regulations, claimants will no longer be reimbursed for meals obtained during periods of travel lasting 12 hours or less. Where the period of travel lasts between 12 and 24 hours, the claimant will be authorized actual expenses up to 3/4 of the per diem rate for the locality of travel based on reasonable charges. Where the period of travel is a full 24 hour day, the claimant will be authorized actual expenses up to the entire per diem rate for the locality of travel.

National Office staff will advise employing agencies of these changes through a notice on the Internet and at the next Interagency Meeting.

Reference: FECA Procedure Manual Chapters 3-500.10 and 5-204.8

Purpose: To provide guidance in evaluating claims for reimbursement of travel expenses

Applicability: Claims Examiners, Bill Resolution Staff, Technical Assistants, Staff Nurses, Rehabilitation Specialists, and Supervisors

Action:

1. When authorizing travel, claims staff should advise the claimant of the applicable rule, based on the likely period of travel, as stated above in the second paragraph under "Background".

2. Bill resolution staff should deny payment for meals and incidental expenses for travel lasting less than 12 hours. Ineligible amount code H (disallowed travel expenses) may be used to disallow a portion of a travel claim.

3. Claimants are still required to submit receipts for hotels. Bill resolution staff should reimburse claimants for meals in the same fashion as federal employees are while on official government travel. That is, 3/4 of the per diem rate on the first and last day of travel and full per diem rate for travel on any other days of the trip. With this

there is no requirement for meal receipts.

4. To obtain per diem rates, claims and bill resolution staff may consult "Temporary Duty Guide for Department of Labor Employees", Publication No. 7. This booklet, which is revised each year, is available from OASAM.

5. Claimants must also continue to submit receipts for taxicabs, regardless of the amount, because the use of a taxicab is based on medical need.

6. These provisions are effective for all travel undertaken on or after the date of this bulletin.

7. Form CA-77 has been revised, and a copy is attached.

Disposition: Retain until the indicated expiration date.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Attachment

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

FECA BULLETIN NO. 97-15

Issue Date: September 5, 1997

Expiration Date: September 4, 1998

Subject: Felony Imprisonment Cases—-Reporting Requirements

Background: Public Law 103-333, enacted on September 30, 1994, amended the FECA by adding a new section 5 U.S.C. 8148, which provides for (a) the termination of benefits payable to beneficiaries who have been convicted of defrauding the program, and (b) the suspension of benefits payable to beneficiaries imprisoned as a result of felony conviction.

FECA Bulletin 95-5 originally reported this amendment; it has since been incorporated into the Federal (FECA) Procedure Manual at 2-1400.12. Also provided were instructions for reporting suspensions to Don Frederick of the National Office so that savings from the enactment of this amendment could be monitored. A requirement was not created, however, for reporting when a claimant whose compensation had been suspended under this provision was released from prison and again entitled to compensation. This has resulted in the potential for overstatement of savings.

Purpose: To alert district offices of the requirement that resumption of benefits previously suspended due to felony imprisonment must be immediately reported to the National Office, and to alert district office staff of the new contact person, Sheila Baker.

Applicability: District Directors, Assistant District Directors, Claims staff.

Action: Any claim where compensation has been suspended due to felony imprisonment should continue to be immediately reported to Sheila Baker at the National Office. Ms. Baker should also be promptly notified when the imprisonment ends and compensation resumes.

Disposition: Retain until incorporated in the Federal (FECA) Procedure Manual.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

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FC 97-01 ADP--Access to OWCP Material on the World Wide Web

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FC 97-04 Current Interest Rates for Prompt Payment Bills and Debt Collection

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FC 97-06 Bill Pay--OWCP Liability for Sales Taxes - (0797B)

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FC 97-08 Comp Pay--ACPS Reports (07/97A)

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FECA CIRCULARS--TEXT

FECA Circular No. 97-01 **November 11, 1996**

SUBJECT: ADP--Access to OWCP Material on the World Wide Web

FECA Circular No. 95-10, "Making Folioviews Available Outside OWCP", was published in April 1995. This issuance described how employing agencies and other interested parties could obtain a variety of information about the Federal employees' compensation program through Folio VIEWS software and infobases, and a number of agencies and other parties have done so.

Most of the information available in the Folio VIEWS infobases, and a number of other resources, can now be found on two World Wide Web sites: the OWCP/DFEC Home Page and a Folio web server maintained by a private company. Each of these sites can be accessed directly, and they are also linked together so that the user can access each one from the other.

Material from either the OWCP/DFEC home page or the Folio web server can be downloaded into an ASCII file for translation into a word processing format. Material on the Folio web server can also be downloaded directly into existing Folio VIEWS software using the Folio Web Retriever software (available for $39.95 from the Folio Corporation at 1-800-543-6546).

Given this new means of access to program materials, parties who wish to obtain such materials should be asked if they have access to the World Wide Web. If so, they should be given the addresses (URLs) shown below. Users may still obtain information using the process described in FECA Circular No. 95-10, but they will probably find it more convenient to download material from the Web sites than to send discs to the National Office for copying.

Information Available on the OWCP Home Page. The address of the OWCP Home Page is:

http://www.dol.gov./dol/esa/owcp.htm

From here, the user can link to the DFEC home page, which lists all of the information about the program which is available to the public on line. The list as it appears on the DFEC Home Page is as follows:

- District Office Addresses and Telephone Contacts
- Customer Service Commitment
- FECA Program's Mission

- An Introduction to the FECA Program
- When Injured at Work (CA-11)
- Questions and Answers about the Federal Employees' Compensation Act (Pamphlet CA-550).
- Injury Compensation for Federal Employees (Pamphlet CA-810). Handbook for employing agencies.
- Resource Library in Folio VIEWS. Folio VIEWS gives you the ability to query the system and locate pertinent material.

LAW AND REGULATIONS

Federal Employees' Compensation Act
Regulations under the FECA

PROGRAM PROCEDURES

Overview (FECA Part 0)
Index and Files (FECA Part 1) (not available)
Claims (FECA Part 2)
Medical (FECA Part 3)
Special Case Procedures (FECA Part 4)
Benefit Payments (FECA Part 5)
Overpayments (FECA Part 6)
Vocational Rehabilitation (OWCP Part 3)
FECA Program Memorandums
OWCP Directives (OWCP Part 1)
Planning and Evaluation (OWCP Part 4)

DECISIONS OF THE EMPLOYEES' COMPENSATION APPEALS BOARD (ECAB)

ECAB Headnotes, Volumes 39-44
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INDEXES

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Information Available on the Folio Web Server. The address of the Folio Web Server is:

http://www.fiengroup.com/dol/index.html

The list of infobases shown under "Resource Library in Folio VIEWS" above will appear, along with a short description of each.

"Questions and Answers about the Federal Employees' Compensation Act" and "Injury Compensation for Federal Employees" will be included in the index under the heading "General Information".

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA CIRCULAR NO. 97-02 November 12, 1996

SUBJECT: Cost of Living Increase to SSA Benefits in FERS Cases

The Social Security Administration (SSA) provides a Cost of Living Adjustment (COLA) to beneficiaries effective December 1 of each year. All cases that are in receipt of SSA benefits before December 1, receive the COLA for that year. The SSA check dated January 1 reflects the SSA COLA increase.

In all cases where a deduction is being made from FECA benefits for Social Security (SSA) benefits "attributable to Federal Service", the amount being deducted has to be increased by the SSA COLA effective December 1 each year.

SSA COLAs are as follows:

Effective December 1, 1996	2.9 percent
Effective December 1, 1995	2.6 percent
Effective December 1, 1994	2.8 percent

Please ensure that this adjustment is made in any case to which it applies.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA CIRCULAR NO. 97-03 December 5, 1996

SUBJECT: Selected ECAB Decisions for July - September, 1996

The attached group of summaries of selected ECAB decisions is provided for study and filing by subject.

As usual, decisions on a variety of topics are included. Of special interest are two decisions concerning chiropractic treatment and a decision concerning coverage under section 8191.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

AUTHORIZED REPRESENTATIVES - NOTIFICATION OF SECOND OPINION EVALUATION

Donald J. Knight, Docket No. 94-1931, Issued August 21, 1996

In this case, the Office found that the claimant's work-related disability had ceased as of a certain date, based upon the report of a second opinion physician. No notification of the second opinion evaluation had been sent to the claimant's authorized representative. This omission deprived the claimant of the right to have "a physician designated and paid by him present to participate in the examination" under section 8123(a) of the Act. The Board remanded the case for referral to another second opinion physician and precluded the Office from relying on the existing second opinion evaluation report.

CHIROPRACTIC TREATMENT - DELAY IN TAKING X-RAYS

Marcia A. McGuire, Docket No. 94-2383, Issued August 21, 1996

The claimant in this decision was seven months pregnant when she injured her back at work. She was treated by a chiropractor, who declined to take x-rays because of her pregnancy. The office informed the claimant of the medical information required to establish her case. The Office rejected the claim on the basis that fact of injury was not established. The chiropractor had not taken x-rays due to the pregnancy, and without x-rays to establish the existence of a subluxation, his report was of no probative value.

The claimant requested written review of her case. A report was submitted by the chiropractor which indicated that x-rays were taken two months after the injury (after the baby had been born), which revealed a hypolordotic subluxation, and that taking x-rays earlier would have been a danger to both the mother and child. An office hearing representative found that the claimant had not met her burden of proof because x-ray evidence of subluxation had not been submitted.

The claimant requested reconsideration. Medical reports and x-rays were submitted to the Office. The Office denied modification of the prior decisions, stating that the delay between the injury and the x-rays was too long, and that the chiropractor had indicated that the claimant's condition was exacerbated by pregnancy. The chiropractor

had in fact not so stated, but did state that the pregnancy would impede the claimant's recovery.

The claimant again requested reconsideration, and submitted a report from the chiropractor which stated that knowingly taking x-rays of a child in the womb was forbidden by professional statutes and would be malpractice. He stated that the x-rays clearly showed L5-S1 subluxation with pelvic rotation. The Office denied the request on the basis that the information submitted was repetitious and therefore insufficient to warrant review of the prior decision. The reconsideration examiner stated that the issue was whether the Office could consider any reasons, however justifiable, for not having x-rays at the time of or within a few days of the initial examination. She stated that the claimant's back problems were possibly due to her pregnancy, and that the chiropractor did not explain whether the subluxation found on x-ray was due to the work injury or to the pregnancy and child care which followed.

The Board found that the case was not in posture for a decision. They found that the timing of diagnostic testing alone should not be given dispositive weight to the exclusion of other circumstances. The chiropractor diagnosed a subluxation and submitted x-rays in support of the diagnosis, and must therefore be considered a physician under the Act, even though the x-rays were delayed. There was no medical evidence contradicting the chiropractor's opinion that the work injury caused a subluxation. The evidence was not sufficiently well-rationalized to meet the claimant's burden of proof, but was sufficient to require further development of the record. The case was remanded for a second opinion evaluation.

CHIROPRACTIC TREATMENT - PRESCRIBING PHYSICAL THERAPY

Beverly G. Akins, Docket No. 94-2137, Issued July 8, 1996

The claimant was injured in December of 1991. She was treated by a chiropractor who referred her for physical therapy consisting of soft tissue and deep tissue massage in January of 1992, and who obtained x-rays and diagnosed a subluxation in February of 1992. The claimant requested reimbursement of the physical therapy expenses. The Office denied her request for reimbursement of the physical therapy.

The Board affirmed the Office's decision. They cited section 8103(a) of the FECA, which states, "The United States shall furnish to an employee who is injured while in the performance of duty, the services, appliances, and supplies prescribed or recommended by a qualified physician..." The term "physician" included chiropractors only to the extent that their services consist of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist. Physical examinations, related laboratory tests, and x-rays performed or requested by a chiropractor are also payable. The Act does not provide the authority for a chiropractor to refer a claimant for physical therapy.

It is noted that in other decisions, the Board has found that chiropractic treatment consisting of physical therapy was payable, where it had been prescribed by a qualified physician (M.D. or D.O.). In this instance, however, the chiropractor was
doing the prescribing, and the physical therapy had not been recommended by an M.D. or D.O.

FORFEITURE OF COMPENSATION - UNREPORTED EARNINGS

Carl C. Green, Jr., Docket No. 94-1478, Issued August 26, 1996

An overpayment was declared in this case due to periods of unreported earnings. The alleged unreported earnings were from burglaries for which the claimant had been incarcerated. During the same periods of time, the claimant had other earnings from working in legal jobs which he did report on CA-1032 forms. The Office found that the claimant's compensation for certain periods should be forfeited because he failed to report earnings from self-employment (burglary).

The Board found that the Office incorrectly found that the claimant had forfeited compensation due to unreported earnings. The Office made no finding that the claimant "knowingly" failed to report his work activities, and there was no evidence, such as police reports, statements, or other documents to show that the claimant had any "earnings" from the two burglaries. They distinguished the situation in this case from those found in Cooper (44 ECAB 498), Moon (42 ECAB 947), and Weathersby (Docket No. 94-1087, issued April 2, 1996), where the claimants were involved in criminal employment which resulted in documented earnings.

NON-FEDERAL LAW ENFORCEMENT OFFICER - PREVENTION

Alfred A. Danna, Docket No. 95-1435, Issued September 9, 1995

The Board's decision in this case will be of special interest to the special claims unit in District 25, which adjudicates claims from non-federal law enforcement officers under Section 8191.

The claimant is a Florida state law enforcement officer who was injured as he exited an airplane following an air surveillance assignment. The claimant was participating in a joint Florida state/Federal Bureau of Investigation task force at the time of his injury. The claimant argued that he was not eligible for benefits under either section 8191 or 8101 of the FECA.

The claimant had been deputized as a special federal officer, and was assigned to the task force under Organized Crime Drug Enforcement Task Force (OCDETF) Program Guidelines. The purpose of the particular mission during which he was injured was to conduct surveillance. Arrests were made at a later date. The employer stated that the claimant was a state law enforcement officer, and had not been assigned to the FBI or to an FBI investigation. His deputization by the FBI gave him limited additional authority in working on the joint investigation.

The Office issued a decision, finding that the claim did not fall within the purview of section 8191, and the the claimant was a federal employee (under section 8101). In a subsequent decision, a hearing representative found that the claimant was not an employee under section 8101 and remanded the case for a reasoned decision on the issue of section 8191 coverage.

The Office then issued a decision accepting the claim under section 8191, finding that he was engaged in the prevention of a Federal crime at the time of his injury. The claimant requested a hearing and testified that there was no intent to make any arrests during the mission in which he sustained injury. The hearing representative affirmed the Office's decision, finding that the purpose of the mission was to observe, and that the information gathered as a result of that mission would have eventually been used to apprehend federal criminals, which would result in the prevention of future Federal crimes.

The Board found that the claimant was not entitled to coverage under section 8191. They found that there was no intent to prevent the commission of crimes on the date of injury, and that the “eventual apprehension” was too tenuous to sustain a finding of coverage under the Act.

PERFORMANCE OF DUTY - NOT FOLLOWING DIRECTIONS

Lonnie B. Anderson, Docket No. 94-1842, Issued July 5, 1996

The Board set aside a previous decision in this case, in which the Office found that the claim was barred by the affirmative defense of willful misconduct. The Office had failed to raise this defense in its original adjudication of the case, and was therefore barred from invoking the defense in its later decisions.

On remand, after additional development of the record, the Office denied the claim on the basis that the evidence failed to establish that the injury occurred in the performance of duty. They found that by refusing his supervisor's legitimate order to interrupt his break and move a skid of mail, the claimant removed himself from the performance of duty.

The Board found that the injury arose in the course of employment, stating:

> The Board noted long ago...that disobedience of orders does not necessarily place an employee outside the scope of employment, and that the employer is not entitled under the liberal terms of workers' compensation law to invoke in avoidance of liability any doctrine of added risk or contributory fault, as at common law. The workmen's compensation laws impose liability upon industry to take care of its casualties without regard to the fault or lack of fault of the employer...and similarly give rise to a claim for compensation on the part of the injured employee without regard to the employee’s fault, unless the injury was caused by conduct of the employee amounting to the statutory bar of "willful misconduct."

The Board had found in the previous appeal that the statutory bar based on willful misconduct was no longer available in this instance. They set aside the Office's decision and remanded the case for development of fact of injury.

REFUSAL TO REEOPEN CASE UNDER 8128(A)

Jacquelyn J. Woods, Docket No. 94-1682, Issued August 23, 1996

The claim was initially accepted as a work-related lumbar strain. Ten weeks after the work injury, the claimant was involved in a nonoccupational motor vehicle accident. The Office rejected claims for disability after the motor vehicle accident, and denied medical benefits several months later, on the basis that there was insufficient medical evidence to support that continuing disability was due to the work injury, as opposed to the automobile accident. A hearing representative upheld the decision to reject compensation for disability, but found that the claimant continued to be entitled to medical treatment for her accepted lumbar strain. The claimant requested reconsideration and submitted new medical evidence, but modification of the prior decision was denied.

The claimant continued to submit medical reports over a period of about two years. The Office referred her for a second opinion evaluation. The claimant submitted additional medical evidence, and the Office asked the second opinion physician to clarify his report. At about the same time that the Office requested clarification from the second opinion physician, the claimant again requested reconsideration. The Office denied reconsideration, finding that the request was untimely, and did not constitute clear evidence of error.

The Board found that the Office improperly refused to reopen the case for merit review, and that the Office applied an improper standard in reviewing her request. The Office had already exercised its discretionary authority under 5 U.S.C. 8128 to reopen the claim when they referred her for a second opinion evaluation. The Office could not therefore deny the claimant's request for reconsideration based upon the clear evidence of error standard. The decision was reversed and the case remanded for a merit review.

RESCINDING DECISION BASED ON NEW LEGAL ARGUMENT

James C. Shores, Docket No. 95-2476, Issued September 9, 1996

The claimant in this case was a retired mechanic who was paid a schedule award for 36 percent binaural hearing loss. At the expiration of the award in 1986, the Office began payment for total disability. In December of 1986, the Office reduced his compensation to reflect his actual wages earned in self employment in "odd jobs." Shortly after the LWEC decision was issued, an Office medical advisor reviewed the case and stated that with proper amplification, the claimant’s ability to communicate would not be severely impaired. The evaluating otolaryngologist to whom the claimant had been referred by the Office did not give an opinion on the claimant's ability to work.

In May of 1995, the Office notified the claimant that it proposed to terminate his disability compensation by rescinding the 1986 total disability and loss of wage-earning capacity awards. The Office explained that the medical evidence never showed that the claimant could not perform his work as a mechanic because of the hearing loss, and that the claimant had continued to perform mechanic duties until his position was abolished due to reorganization. They stated that the wage-earning capacity was in error because the claimant was a trained mechanic and should have had a much higher rating. The Office then terminated compensation in June of 1995, and rescinded the wage-loss awards made in 1986.

The Board found that the office properly rescinded acceptance of the claim for employment-related disability and the wage-earning capacity determination. They noted that section 8128(a) gives the Office the authority to reopen a claim at any time on its own motion, but that the power to annul an award is not an arbitrary one. Once the Office accepts a claim, it has the burden of justifying termination or modification. To justify rescission of acceptance, the Office must establish that the prior acceptance was erroneous based upon (1) new or different evidence, or (2) new legal argument and/or rationale.

In this case, the Board found that the Office had made sufficient new legal argument to justify the rescission by arguing that the award for work-related disability was invalid because the medical evidence did not support disability for work. They also found that the Office’s arguments in support of rescinding the wage-earning capacity determination (that a finding of no employment-related disability had the result of showing that there was also no loss of wage-earning capacity, and that the claimant was not limited to the position of "self-employed, odd jobs") were valid.

FECA Circular No. 97-04 — January 15, 1997

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

The interest rate to be assessed for the prompt payment bills is 6 3/8 percent for the period January 1, 1997 through June 30, 1997.

Attached to this Circular is an updated listing of the prompt payment interest rates from January 1, 1985 through current date.

The rate for assessing interest charges on debts due the Government has not changed. The rate of 5 percent continues to be in effect through December 31, 1997.

Attached to this Circular is an updated listing of the DMS interest rates from January 1, 1984 through current date.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Attachments

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

PROMPT PAYMENT INTEREST RATES

1/1/97 - 6/30/97	6 3/8%
7/1/96 - 12/31/96	7.0%
1/1/96 - 6/30/96	5 7/8%
7/1/95 - 12/31/95	6 3/8%
1/1/95 - 6/30/95	8 1/8%
7/1/94 - 12/31/94	7.0%
1/1/94 - 6/30/94	5 1/2%
7/1/93 - 12/31/93	5 5/8%
1/1/93 - 6/30/93	6 1/2%
7/1/92 - 12/31/92	7.0%
1/1/92 - 6/30/92	6 7/8%
7/1/91 - 12/31/91	8 1/2%
1/1/91 - 6/30/91	8 3/8%
7/1/90 - 12/31/90	9.0%
1/1/90 - 6/30/90	8 1/2%
7/1/89 - 12/31/89	9 1/8%
1/1/89 - 6/30/89	9 3/4%
7/1/88 - 12/31/88	9 1/4%
1/1/88 - 6/30/88	9 3/8%
7/1/87 - 12/31/87	8 7/8%
1/1/87 - 6/30/87	7 5/8%
7/1/86 - 12/31/86	8 1/2%
1/1/86 - 6/30/86	9 3/4%
7/1/85 - 12/31/85	10 3/8%
1/1/85 - 6/30/85	12 1/8%

ATTACHMENT TO FECA CIRCULAR NO. 97-04
DMS INTEREST RATES

1/1/97 - 12/31/97	5%

1/1/96 - 12/31/96	5%
7/1/95 - 12/31/95	5%
1/1/95 - 6/30/95	3%
1/1/94 - 12/31/94	3%
1/1/93 - 12/31/93	4%
1/1/92 - 12/31/92	6%
1/1/91 - 12/31/91	8%
1/1/90 - 12/31/90	9%
1/1/89 - 12/31/89	7%
1/1/88 - 12/31/88	6%
1/1/87 - 12/31/87	7%
1/1/86 - 12/31/86	8%
1/1/85 - 12/31/85	9%
Prior to 1/1/84	not applicable

ATTACHMENT TO FECA CIRCULAR NO. 97-04

FECA CIRCULAR NO. 97-05 January 28, 1997

SUBJECT: Code changes for the Departments of Defense, Labor, Agriculture, Education, Interior, State, and Veterans Affairs, and the Corporation for National and Community Service, the Environmental Protection Agency, the Smithsonian Institution, and Other Establishments, Case Management Users' Manual, Appendix 4-7

The Case Management User's Manual is being updated and revised to reflect multiple changes, including the addition of several new codes. For the Department of Agriculture, multiple agencies have been renamed as noted below, and the Packers and Stockyards Admin-istration (chargeback code 8212) has been removed from the User's Manual. For the Department of Defense, a new code has been added for the Defense Polygraphic Institute (chargeback code 3059), and the Defense Nuclear Agency has been re-named the Defense Special Weapons Agency. For the Department of Education, chargeback code 7035 has been removed from the User's Manual, in view of the fact that employees of Gallaudet University are no longer covered under FECA. For the Department of Interior, the National Biological Survey (chargeback code 7118) has been re-named the National Bio-logical Service. For the Department of Labor, chargeback code 1107 has been added to reflect injuries sustained by the Office of the Chief Financial Officer, a separate organization within Labor. For the Department of State, chargeback code 1304 has been added for employees of the Bureau of Finance and Management Policy, and two other organizations reflect name changes. For the Department of Veterans Affairs, 22 new codes have been added to reflect inju-ries reported by employees of Veterans Integrated Service Networks (VISN), and codes have also been added for employees of CHAMPVA and 5 different VA Headquarters organizations. For the Corpora-tion for National and Community Service (the agency formerly known as ACTION), chargeback codes have been added to reflect injuries by AMERICORPS Leaders (chargeback code 1389) and Literacy Corps workers (chargeback code 1393). For the Environmental Protection Agency, chargeback code 1903 is now used for employees of EPA's Headquarters Human Resources Office, replacing a prior entry for the National Enforcement Investigation Center. For the Smithson-ian Institution, chargeback code 1352 has been added to represent employees of the JFK Center for the Performing Arts, formerly part of the National Park Service but no longer part of that agency. Finally, in the Other Establishments category, chargeback code 1464 has been added to reflect a separate code for employees of the Office of Navajo and Hopi Indian Relocation Commission, and two other defunct agencies are being removed from the User's Manual.

Because the procedures for adding new chargeback codes to the Case Management File have changed, ADP Systems Managers no longer need to add the chargeback codes listed below; they will be added by National Office staff. However, changes in the titles for employ-ing agencies which already exist in the agency address field will have to be added to an individual agency address (though not on a case file by case file basis).

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Trans-action type	Code	Dept.	Agency
Add	3059	Defense	Defense Polygraphic Institute
" "	1107	Labor	Office of the Chief Financial Officer
" "	1304	State	Bureau of Finance & Management Policy
" "	4011	VA	Phoenix, AZ VISN
" "	4020	""	San Francisco, CA VISN
" "	4034	""	Long Beach, CA VISN
" "	4041	""	Denver, CO VISN
" "	4056	""	Bay Pines, FL VISN
" "	4068	""	Atlanta, GA VISN
" "	4087	""	Hines, IL VISN
" "	4132	""	Linthicum, MD VISN
" "	4141	""	Boston, MA VISN
" "	4151	""	Ann Arbor, MI VISN
" "	4155	""	Minneapolis, MN VISN
" "	4164	""	Jackson, MS VISN
" "	4170	""	Kansas City, MO VISN
" "	4181	""	Omaha, NE VISN
" "	4203	""	Albany, NY VISN
" "	4207	""	Bronx, NY VISN
" "	4223	""	Durham, NC VISN
" "	4235	""	Cincinnati, OH VISN
" "	4253	""	Portland, OR VISN
" "	4266	""	Pittsburgh, PA VISN
" "	4295	""	Nashville, TN VISN
" "	4307	""	Dallas, TX VISN
" "	4503	""	Office of General Counsel
" "	4504	""	Board of Contract Appeals
" "	4509	""	DAS for Acquisition & Material Mgmt
" "	4518	""	Asst Sectry for Public & Intergov Affrs
" "	4519	""	Asst Sectry for Congressional Affrs
" "	4525	""	CHAMPVA

" "	1389	CNCS	AMERICORPS Leaders
" "	1393	" "	Literacy Corps
" "	1352	Smithsn	JFK Center for the Performing Arts
" "	1464	Other Est	Ofc of Navajo & Hopi Indian Relocation
Change	8310	Agricltre	from: Federal Grain Inspection Service to: Grain Inspection, Packers & Stock-yards Administration
" "	8409	" "	from: Cooperative State Research Svce to: Cooperative State Research, Educaion-and Extension Service
" "	8504	" "	from: Agricultural Stabilization and Conservation Service and Committees to: Farm Service Agency
" "	8601	" "	from: Farmers' Home Administration to: Rural Housing Service
" "	8606	" "	from: Soil Conservation Service to: Natural Resources Conservation Svce
" "	8705	" "	from: Food and Nutrition Service to: Food and Consumer Service
" "	3004	Defense	from: Defense Nuclear Agency to: Defense Special Weapons Agency
" "	7118	Interior	from: National Biological Survey to: National Biological Service
" "	1328	State	from: Bureau of Human Rights & Human-itarian Affairs to: Bureau of Democracy, Human Rights and Labor
" "	1334	" "	from: Bureau of Refugee Programs to: Bureau of Population, Refugees and Immigration
" "	1903	EPA	from: Nat'l Enforcement Investigtn Cntr to: HQ, Human Resources Office
Delete	8212	Agricltre	Packers & Stockyards Administration
" "	7035	Education	Gallaudet University
" "	1410	Other Est	Comm on the Bicentennl of Constitution
" "	1426	" "	Interstate Commerce Commission

Distribution: List No. 5 - Folioviews Groups C and D
(All Supervisors, Index and Files Personnel,
Systems Managers and Technical Assistants)
Note: Immediate distribution to chargeback coding personnel is essential.

FECA CIRCULAR NO. 97-06 **July 25, 1997**

SUBJECT: Bill Pay--OWCP Liability for Sales Taxes

Periodically the question arises as to whether the FECA program must pay state and local sales taxes on purchases for which payment is made from the Employees' Compensation Fund.

The federal government is exempt from paying state and local taxes on purchases made and used by agencies in their "governmental capacities". However, purchases made from the Compensation Fund for individual employees are not exempt, even when the district office pays for the purchases directly. This is because the party using the service, appliance or supply is the claimant, not the federal government.

The Supreme Court has spoken to this issue in a number of decisions. For instance, in *South Carolina v. Baker*, 485 U.S. 505, 523 (1988), the Court wrote that:

> under current intergovernmental tax immunity doctrine the States can never tax the United States directly but can tax any private parties with whom it does business, even though the financial burden falls on the United states, as long as the tax does not discriminate against the United States or those with whom it deals.

Therefore, OWCP is liable for payment of state and local sales taxes, except where the state or local government has specifically exempted the federal government from such payment.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA CIRCULAR NO. 97-07 **July 21, 1997**

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

The interest rate to be assessed for the prompt payment bills is
6 3/4 percent for the period July 1, 1997 through December 31, 1997.

Attached to this Circular is an updated listing of the prompt payment interest rates from January 1, 1985 through current date.

The rate for assessing interest charges on debts due the Government has not changed. The rate of 5 percent continues to be in effect through December 31, 1997.

Attached to this Circular is an updated listing of the DMS interest rates from January 1, 1984 through current date.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Attachments

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

PROMPT PAYMENT INTEREST RATES

7/1/97 - 12/31/97	6 3/4%
1/1/97 - 6/30/97	6 3/8%
7/1/96 - 12/31/96	7.0%
1/1/96 - 6/30/96	5 7/8%
7/1/95 - 12/31/95	6 3/8%
1/1/95 - 6/30/95	8 1/8%
7/1/94 - 12/31/94	7.0%
1/1/94 - 6/30/94	5 1/2%
7/1/93 - 12/31/93	5 5/8%
1/1/93 - 6/30/93	6 1/2%
7/1/92 - 12/31/92	7.0%
1/1/92 - 6/30/92	6 7/8%

7/1/91 - 12/31/91	8 1/2%
1/1/91 - 6/30/91	8 3/8%
7/1/90 - 12/31/90	9.0%
1/1/90 - 6/30/90	8 1/2%
7/1/89 - 12/31/89	9 1/8%
1/1/89 - 6/30/89	9 3/4%
7/1/88 - 12/31/88	9 1/4%
1/1/88 - 6/30/88	9 3/8%
7/1/87 - 12/31/87	8 7/8%
1/1/87 - 6/30/87	7 5/8%
7/1/86 - 12/31/86	8 1/2%
1/1/86 - 6/30/86	9 3/4%
7/1/85 - 12/31/85	10 3/8%
1/1/85 - 6/30/85	12 1/8%

ATTACHMENT TO FECA CIRCULAR NO. 97-07

DMS INTEREST RATES

1/1/97 - 12/31/97	5%
1/1/96 - 12/31/96	5%
7/1/95 - 12/31/95	5%
1/1/95 - 6/30/95	3%
1/1/94 - 12/31/94	3%
1/1/93 - 12/31/93	4%
1/1/92 - 12/31/92	6%
1/1/91 - 12/31/91	8%
1/1/90 - 12/31/90	9%
1/1/89 - 12/31/89	7%
1/1/88 - 12/31/88	6%
1/1/87 - 12/31/87	7%
1/1/86 - 12/31/86	8%
1/1/85 - 12/31/85	9%
Prior to 1/1/84	not applicable

ATTACHMENT TO FECA CIRCULAR NO. 97-07

FECA CIRCULAR NO. 97-08 July 31, 1997

SUBJECT: Comp Pay--ACPS Reports

The National Office is currently preparing and releasing a series of change controls to permit printing of certain ACPS reports on 8 1/2" by 11" paper. These reports include the CP030, CP040, CP045, and CP285, but not the CP295 or BPS reports.

Effective August 18, all district offices will have the capacity to print these reports on letter-size paper, and should begin to do so. The reports will be produced on the laser printer. For easy identification, yellow paper may be used

for printing (other colors are not to be used, however).

The Jacksonville District Office recently piloted this method of printing the reports and found that good-quality photocopies, faxes, and machine images resulted.

The reports should be filed with the left side on the spindle so that the total amount of the payment will not be obscured.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA CIRCULAR NO. 97-09 August 25, 1997

SUBJECT: Revised Forms OWCP-5a, OWCP-5b, OWCP-5c

Attached please find copies of the above referenced forms which were recently revised. Please use the revised forms for all future requests for work tolerance limitations.

Please discard all copies of the former versions of the forms. Their use is prohibited because they are not currently cleared by the Office of Management and Budget under the Paperwork Reduction Act.

Thank you for your assistance.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA TRANSMITTALS (FT)--INDEX

FT 97-01	**Revision to Chapter 2-0900, Determining Pay Rates, and Chapter 2-1000, Dual Benefits (11/96A)**
FT 97-02	**Revision To Chapter 2-0700, Death Claims, Chapter 2-0806, Occupational Illness, and Chapter 2-0811, Early Management of Disability Claims Part 2 - Claims, Federal (FECA) Procedure Manual (11/96B)**
FT 97-03	Revision To Chapter 2-0810 - Developing and Evaluating Medical Evidence, and Chapter 2-0813, Reemployment: Vocational Rehabilitation Services , Part 2 - Claims, Federal (FECA) Procedure Manual (11/96A)
FT 97-04	Revision To Chapter 2-0600, Case Management, Part 2 - Claims, Federal (FECA) Procedure Manual (01/97A)
FT 97-05	**Checklist, Federal (FECA) Procedure Manual (01/97A)**
FT 97-06	**Not Published**
FT 97-07	**Revision To Chapter 2-0804, Performance of Duty, and Chapter 2-0813, Reemployment: Vocational Rehabilitation Services, and Chapter 2-0814, Reemployment: Determining Wage-Earning Capacity, Part 2 - Claims, Federal (FECA) Procedure Manual**
FT 97-08	Revisions to Chapter 2-1000, Dual Benefits, and Chapter 2-1602, Reconsiderations (07/97A)
FT 97-09	Revision to Chapter 2-1400, Disallowances (03/97A)
FT 97-10	Revisions to Chapter 2-0814, Reemployment: Determining Wage-Earning Capacity, and Chapter 2-1500, Recurrences, Part 2 - Claims, Federal (FECA) Procedure Manual (05/97A)
FT 97-12	**Revisions to Chapter 2-1600, Review Process; Chapter 2-1601, Hearings and Reviews of the Written Record; Chapter 2-1602, Reconsiderations; and 2-1603, Appeals; Part 2 - Claims, Federal (FECA) Procedure Manual (05/97A)**
FT 97-13	**Revision to Chapter 2-0900, Determining Pay Rates, and Chapter 2-0901,**

	Computing Compensation, Part 2 - Claims, Federal (FECA) Procedure Manual (06/97A)
FT 97-14	**Revision to Chapter 6-0200, Initial Overpayment Actions, Part 6 - Debt Management, Federal (FECA) Procedure Manual (07/97A)**
FT 97-16	**Revisions to Chapter 2-600, Case Management, Chapter 2-807, Continutation of Pay and Initial Payments, Part 2 - Claims, Federal (FECA) Procedure Manual (09/97A)**
FT 97-17	**Revisions to Chapter 2-811, Early Management of Disability Claims, Chapter 2-812, Periodic review of Disability Cases, and Chapter 2-0814, Reemployment: Determining Wage-Earning capacity, part 2 - Claims, Federal (FECA) Procedure Manual (07/97A)**
FT 97-19	**Revisions to Chapter 2-0500, Conferencing; Chapter 2-0700, Death Claims, and Chapter 2-0804, Performance of Duty, Part 2 - Claims, Federal (FECA) Procedure Manual (07/97B)**
FT 97-20	Revisions to Chapter 2-0810, Developing and Evaluating Medical Evidence; Chapter 2-1100, Subrogation; and Chapter 2-1200, Fees for Representatives' Services, Part 2 - Claims, Federal (FECA) Procedure Manual (07/97B)

FECA TRANSMITTALS--TEXT

FECA TRANSMITTAL NO. 97-01 **October 30, 1996**

RELEASE - REVISION TO CHAPTER 2-0900, DETERMINING PAY RATES, AND CHAPTER 2-1000, DUAL BENEFITS, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 97-01 October 30, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

In PM 2-0900, paragraph 4a(2) has been modified to state that concurrent employment may be used to demonstrate the ability to perform full-time work. This statement appeared in the previous version of this chapter, but it was dropped in error when the chapter was revised.

Beginning in 1982, the number of hours which make up the work year for most Federal employees (that is, those whose status and rules of work are governed by the Office of Personnel Management and its regulations) was changed by statute from 2080 to 2087. However, the number of hours which make up the work year has remained 2080 for employees of the U.S. Postal Service. Paragraph 10b is modified to reflect this difference.

The last line of paragraph 12f is modified to state that the pay rate should be determined in accordance with section 8114(d) (that is, the reference to subparagraph (3) has been removed).

In PM 2-1000, paragraph 13b has been revised to state that cases from the Mine Safety and Health Administration (MSHA) are handled in the Kansas City District Office. The lettering of the first subparagraph on the following page has also been corrected.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0900	i, 5-6 23-26	2	2-0900	i, 5-6 23-26
	2-1000	i, 25-26		2-1000	i, 25-26

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

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

Nurses)

FECA TRANSMITTAL NO. 97-02 **November 20, 1996**

RELEASE - REVISION TO CHAPTER 2-0700, DEATH CLAIMS, CHAPTER 2-0806, OCCUPATIONAL ILLNESS, AND CHAPTER 2-0811, EARLY MANAGEMENT OF DISABILITY CLAIMS PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 97-02 November 20, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

FECA Transmittal No. 96-26 removed the requirement that copies of certificates submitted to support payment of death benefits bear the raised seal of the custodian of records. The three chapters titled above are being revised to remove this requirement for birth, marriage, divorce, and adoption certificates as well.
The specific references changed are paragraphs 5f, 7 and 9 of PM 2-0700; Exhibit 2 of PM 2-0806; and paragraph 10d of PM 2-0811.

However, the Claims Examiner may still request a certificate bearing a raised seal if he or she has any doubt as to whether a document presented to support a claim for benefits is authentic. If this is done, the certificate should be photocopied for the file and the certified copy should be returned to the sender.

PM 2-0700 is also revised to add a new paragraph 20 addressing the gratuity recently authorized by Public Law 104-208 for survivors of employees who died in the line of duty on or after August 2, 1990. This gratuity, in an amount not to exceed $10,000, is paid by the employing agency, not the OWCP. However, burial and administrative expenses paid by OWCP are subtracted from the entitlement, so employing agencies will need to contact claims staff for this information in individual claims.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0700	i, 5-8 15-16 27-28	2	2-0700	i, 5-8 15-16 27-28
	2-0806	i, Ex. 2, p. 2		2-0806	i, Ex. 2, p. 2
	2-0811	i, 13-14		2-0811	i, 13-14

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

FECA TRANSMITTAL NO. 97-03 November 11, 1996

RELEASE - REVISION TO CHAPTER 2-0810 - DEVELOPING AND EVALUATING MEDICAL EVIDENCE, AND CHAPTER 2-0813, REEMPLOYMENT: VOCATIONAL REHABILITATION SERVICES, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 97-03 November 11, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

In Chapter 2-0810, a new paragraph 20 is added to address the material about Functional Capacity Evaluations (FCEs) which was first published in FECA Bulletin No. 96-12.

In Chapter 2-0813, paragraph 5c modifies the criteria for referring claimants for vocational rehabilitation services. Ordinarily, claimants are to have stable, well-defined work limitations which allow them to work eight hours per day before such referral is made. Where this is not the case, the Claims Examiner (CE) is expected to work toward establishing the claimant's ability to work full-time through a variety of case management methods. The CE will be required to document any inability to establish work limitations of eight hours a day by a Memorandum to

the File.

However, where an occupational rehabilitation program (ORP) may be of benefit, the requirement that the claimant be able to work eight hours per day need not be met. Also, where it appears that the employing agency can offer work to an employee who can work at least four hours per day, the case may be referred for rehabilitation services on this basis. However, if the offer does not materialize, and the Rehabilitation Specialist cannot proceed further with the employing agency, the CE must attempt to establish the claimant's ability to work eight hours per day, as described above.

Paragraph 5d is modified to remove the specific reference to the RH-4 report, which is seldom used, and to remove the requirement for a "full" description of work limitations before referral.

Paragraph 5e is modified to state that, when referring cases for vocational rehabilitation services, Claims Examiners should not authorize Rehabilitation Counselors to contact attending physicians when work tolerance limitations have been established by a second opinion or referee examination. Form OWCP-14 has been revised to make the options clearer. (Paragraph 6 has been edited slightly to conserve space on the page.)

Paragraph 11a is expanded to include failure to begin or continue pre-vocational training and failure to appear for a functional capacity evaluation (FCE) in the definition of non-cooperation with early vocational rehabilitation efforts.

Paragraph 11c is modified to state that the 90 days of placement assistance is computed from the date of the Form OWCP-3.

Paragraph 12b is changed to state that where compensation is suspended or reduced due to non-cooperation with vocational rehabilitation efforts, the case status should remain PR, since an LWEC decision has not been issued. The example of multiple sanctions in paragraph 12c is modified to show that compensation is reduced (rather than suspended) for the second and third instances of non-cooperation, though when cooperation resumes, compensation is restored at the rate for total disability.

Finally, a new paragraph 13, Occupational Rehabilitation Programs, has been added. It addresses material first published in FECA Bulletin No. 96-09.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0810	i-ii 39-40	2	2-0810	i-ii 39-40
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File this transmittal sheet behind the checklist in front of the Federal (FECA) Procedure Manual.

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

FECA TRANSMITTAL NO. 97-04 **November 11, 1996**

RELEASE - REVISION TO CHAPTER 2-0600, CASE MANAGEMENT, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 97-04 November 11, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

Paragraphs 5, 6e and 6g have been revised to incorporate the material concerning the role of registered nurses in QCM cases which was first published in FECA Bulletin No. 96-06. (A similar revision is being made to PM 3-0201). The attachments to that bulletin have also been added as Exhibits 4 and 5.

Former paragraph 7, "Return to Work with Previous Employer", has been divided into two paragraphs. New paragraph 7 addresses referrals for vocational rehabilitation services, while new paragraph 8 addresses returns to work with the previous employer.

Paragraph 7a modifies the criteria for referring claimants for vocational rehabilitation services. Ordinarily, claimants are to have stable, well-defined work limitations which allow them to work eight hours per day before such referral is made. Where this is not the case, the Claims Examiner (CE) is expected to work toward establishing the claimant's ability to work full-time through a variety of case management methods. The CE will be required to document any inability to establish work limitations of eight hours a day by a Memorandum to the File.

However, where an occupational rehabilitation program (ORP) may be of benefit, the requirement that the claimant be able to work eight hours per day need not be met. Also, where it appears that the employing agency can offer work to an employee who can work at least four hours per day, the case may be referred for rehabilitation services on this basis. However, if the offer does not materialize, and the Rehabilitation Specialist cannot proceed further with the employing agency, the CE must attempt to establish the claimant's ability to work eight hours per day, as described above.

Paragraph 7b is modified to state explicitly that, when referring cases for vocational rehabilitation services, Claims Examiners should not authorize Rehabilitation Counselors to contact attending physicians when work tolerance limitations have been established by a second opinion or referee examination. Form OWCP-14 has been revised to make these options clearer. Also, Form OWCP-14 should contain the gross amount of compensation.

Various other changes have been made to paragraphs 7 and 8 to clarify and update the material found there.

Former paragraph 8, "Return to Work with New Employer", has been divided into three paragraphs. New paragraph 9 addresses the 10-month letter, new paragraph 10 addresses development of vocational rehabilitation plans, and new paragraph 11 addresses returns to work with new employers.

Paragraph 10c(1) is expanded to clarify the Claims Examiner's role in reviewing vocational rehabilitation plans, and paragraph 10c(2) is expanded to address the claimant's motivation in the context of vocational training programs.

Paragraph 11a is modified to state that the Rehabilitation Specialist has the authority to approve an extension of 90 days in Placement New Employer/Short-Term Assisted Reemployment status when the claimant is cooperating with vocational rehabilitation efforts.

Here again, a number of other changes have been made to paragraphs 9-11 to clarify and update the material found there.

Former paragraph 9 has been renumbered paragraph 12. Also, paragraph 2a is modified to

reflect the increase in the number of paragraphs in this chapter from 9 to 12.

The chapter as a whole has been reviewed and edited in light of the program's experience with nurse intervention. References to telephone interventions have been added, and a reference to Staff Nurses serving in the capacity of Field Nurses has been removed. Other changes have been made for clarity and consistency.

Finally, the balance of the chapter has been repaginated.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0600	i, 1-26 Ex. 3	2	2-0600	i, 1-28 Exs. 3-5

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

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

FECA TRANSMITTAL NO. 97-05 **November 20, 1996**

RELEASE - CHECKLIST, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 97-05 November 20, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

This release transmits the current checklist for the Federal (FECA) Procedure Manual. The checklist is a comprehensive accounting of all Procedure Manual pages issued as of August 2, 1996. The previous checklist, issued September 28, 1995, and all transmittal sheets through No. 96-26 may be discarded. The current checklist should be retained at the front of the Pro- cedure Manual, with transmittal sheets subsequent to No. 96-26.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
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Previous checklist and FECA transmittal sheets through No. 96-26				Current checklist	

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

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

FECA TRANSMITTAL NO. 97-07 January 1,1997

RELEASE - REVISION TO CHAPTER 2-0804, PERFORMANCE OF DUTY, AND CHAPTER 2-0813, REEMPLOYMENT: VOCATIONAL REHABILITATION SERVICES, AND CHAPTER 2-0814, REEMPLOYMENT: DETERMINING WAGE-EARNING CAPACITY, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 97-07 January 1,1997

EXPLANATION OF MATERIAL TRANSMITTED:

In Chapter 2-0804, references to several ECAB decisions in paragraphs 12 and 17 have been updated to show citations to the published volumes.

In Chapter 2-0813, one reference to an ECAB decision in paragraph 11 has also been updated. Also, Exhibit 2 has been revised to make it clear that in the training stage, compensation is reduced to the LWEC rate (a suspension of the rate for total disability). References to "penalty decision" have been removed, since this phrase is usually used only with respect to terminations under
5 U.S.C. 8106(c) and some confusion has resulted from using the phrase in the context of non-cooperation with vocational rehabilitation efforts.

In Chapter 2-0814, the discussion in paragraph 7a of the kinds of appointments and tours of duty which may be considered suitable has been expanded.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0804	i 21-22 37-44 47-48	2	2-0804	i 21-22 37-44 47-48
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	2-0814	i, 11-12		2-0814	i, 11-12

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

FECA TRANSMITTAL NO. 97-08 **July 9, 1997**

RELEASE - REVISIONS TO CHAPTER 2-1000, DUAL BENEFITS, A ND CHAPTER 2-1602, RECONSIDERATIONS, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 97-08 July 9, 1997

EXPLANATION OF MATERIAL TRANSMITTED:

Paragraph 4a of PM 2-1000 is modified to state that the rules for electing between OPM benefits and FECA benefits also apply to reemployed annuitants.

Exhibit 4 of PM 2-1602 is modified to correct the ZIP code shown in the address for the ECAB.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages

2	2-1000	i, 1-2	2	2-1000	i, 1-2
	2-1602	i, Ex. 4		2-1602	i, Ex. 4

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

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

FECA TRANSMITTAL NO. 97-09 March 1, 1997

RELEASE - REVISION TO CHAPTER 2-1400, DISALLOWANCES

FECA TRANSMITTAL NO. 97-09 March 1, 1997

EXPLANATION OF MATERIAL TRANSMITTED:

For the past two years, an OWCP/FECA reinvention team has been examining various aspects of formal decisions. After authoring FECA Bulletin No. 95-16, "Compensation Orders--Delegation of Signature Authority", the team turned to streamlining the process of issuing formal decisions.

The product of this effort is a series of decision formats for initial disallowances of cases which do not meet one of the five basic requirements, with the exception that the format for performance of duty denials is not designed to address emotional stress cases. Using these formats, the Claims Examiner can deny a case on the basis that the requested information has not been received, or that the requested information is not sufficient to accept the claim. The formats are being added to the Letter Generator system and will be listed under "Formal Decisions" on the Letter Generator index page, as follows:

Time:

Evidence Received Not Sufficient
Additional Evidence Not Received

Civil Employee:

Evidence Received Not Sufficient
Additional Evidence Not Received

Fact of Injury:

Factual Evidence Received Not Sufficient
Additional Factual Evidence Not Received
Medical Evidence Received Not Sufficient
Additional Medical Evidence Not Received

Performance of Duty:

Evidence Received Not Sufficient
Additional Evidence Not Received

Causal Relationship:

Evidence Received Not Sufficient
Additional Evidence Not Received

In some of these letters, the Claims Examiner must choose among two or more options so that the decision will fit the circumstances of the case. For instance, the decision addressing timeliness requires choices between "The CLAIMED INJURY or LAST EXPOSURE..." and between "You WERE AWARE or REASONABLY SHOULD HAVE BEEN AWARE...."

When decisions are issued using these formats, or a similar approach, neither the compensation order (the "Findings of Fact" page) nor the cover letter (usually Form CA-1042) will be required. However, the Claims Examiner must still make findings of fact specific to the case in question in the body of the decision. The standards set by the ECAB for the contents and quality of formal decisions must be met, whether the decision is issued using these formats or another approach.

The reinvention team most recently focused on Memorandums to the Director and compensation orders. While many offices have streamlined the decision-making process somewhat by incorporating Memoranda to the Director in decisions, there continued to be concern that the use of two documents where one would suffice is rather cumbersome. The following specific problems with the format of the Memorandum to the Director and the compensation order were identified:

Memorandum to Director. While the apparent audience of the Memorandum to the Director is the Director of the OWCP, the real audience is the reviewer of the memorandum, the claimant, and employing agency personnel. Similarly, while the decision-making process apparently includes the Director of the OWCP, this process in fact almost always occurs entirely within the district office. The current format of the Memorandum to the Director thus unintentionally obscures the true nature of the decision-making process.

Compensation Order. The layout of this document, which is legal in origin, is not

user-friendly. When the Memorandum to the Director is included by reference, the findings basically repeat information and conclusions which are stated in the narrative. The phrase "By Order of the Director, OWCP" in the signature block suggests that the Director has a role in the decision-making process, which is misleading, as noted above.

To address these concerns, a new Notice of Decision has been designed for all disallowances which cannot be addressed using pre-formatted text. The Notice of Decision will consolidate the functions of the compensation order and the Memorandum to the Director. Each decision will include the following elements: Statement of Issue, Requirements for Entitlement, Background, 260 Discussion of Evidence, Basis for Decision, and Conclusion.

Use of a standardized format should result in decisions which are more uniform in the kinds of information conveyed and easier to write and to understand.

The Notice of Decision will be directed to the claimant and signed by the Claims Examiner or Senior Claims Examiner who makes the decision. It will not refer to the Director of the OWCP.

This revision contains several other changes. It removes the requirement to list the elements of the claim which are established before addressing the issue at hand, and it removes the requirement to prepare a memorandum which recommends continuation of compensation when evidence submitted in response to a pre-reduction or pre-termination notice overcomes the evidence of record on which the proposed action was based.

Other material removed from this chapter includes the following:

Paragraph 3, Fatal Cases. This material appears in PM 2-0700.

Paragraph 4, Continuation of Pay. This material appears in PM 2-0807.

Paragraph 5d, Failure to Report for an Office-Directed Medical Exam. This topic is covered in PM 2-0810.14.

All offices should provide training on this transmittal within 30 days of receipt.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
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File this transmittal sheet behind the checklist in front of the Federal (FECA) Procedure Manual.

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

FECA TRANSMITTAL NO. 97-10 May 29, 1997

RELEASE - REVISIONS TO CHAPTER 2-0814, REEMPLOYMENT: DETERMINING WAGE-EARNING CAPACITY, AND CHAPTER 2-1500, RECURRENCES, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 97-10 May 29, 1997

EXPLANATION OF MATERIAL TRANSMITTED:

Paragraph 3b of PM 2-1500 defines recurrences of disability.
A statement at the end of current subparagraph (2) refers readers to paragraph 2-1500.9 with respect to terminations of employment. This statement has been read as applying to subparagraph (1) as well, though such a reading is not intended. As a result, in several cases which have come to our attention, denials have been issued in error.

The scenario which has occurred in these cases is as follows: the claimant was rated for loss of wage-earning capacity (LWEC) based on actual earnings with the employing agency for 60 days. The employing agency eliminated the light duty job, and the claimant applied for compensation based on temporary total disability. OWCP then denied modification of the LWEC, instead of treating the claim as a recurrence of disability. In accordance with Hedman, the withdrawal of light duty does in fact meet the definition of a recurrence, and the claim should be developed for recurrence.

To stem confusion over this matter, the statement referring readers to the paragraph concerning terminations of employment has been moved to the beginning of subparagraph 3b(2). Paragrpah 7 has also been modified to reflect this change by removing the distinction between cases rated for LWEC and those not rated.

It also appears that the paragraph 2-1500.9 itself is more properly included in PM 2-0814, as it addresses recurrences only in passing. Therefore, this paragraph has been removed from PM 2-1500 and added (with slight modifications) to PM 2-0814 as new paragraph 12. A reference to this paragraph in paragraph 7e has been modified, and current paragraph 12 has been renumbered paragraph 13.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0814	i, 15-16 27	2	2-0814	i, 15-16 27-29
	2-1500	i, 1-4 7-12		2-1500	i, 1-4 7-10

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

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

FECA TRANSMITTAL NO. 97-12 **June 27, 1997**

RELEASE - REVISIONS TO CHAPTER 2-1600, REVIEW PROCESS; CHAPTER 2-1601, HEARINGS AND REVIEWS OF THE WRITTEN RECORD; CHAPTER 2-1602, RECONSIDERATIONS; AND 2-1603, APPEALS; PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 97-12 June 27, 1997

EXPLANATION OF MATERIAL TRANSMITTED:

Chapters 2-1601, 2-1602, 2-1603 are modified to state that Form CA-1009, Now That Your Claim Has been Accepted..., should be released when benefits are payable following a reconsideration, hearing, or appeal. Paragraph 8e of PM 2-1601, paragraph 8c of PM 2-1602, and paragraph 5d of PM 2-1603 have been changed.

Also, PM 2-1602, paragraphs 7b(1), 8c(1), and 8c(3) are modified to allow for use of a Notice of Decision instead of a memorandum to the Director and compensation order when issuing a reconsideration decision.

Finally, the term "compensation order" has been replaced with "formal decision" in PM 2-1601.4b(2), and "notice of decision" has been included with "compensation order" in PM 2-1600.3c. Also in PM 2-1600, the term "formal decision" has replaced "final decision" throughout, and references to "the Office" have been changed to "OWCP".

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

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Part	Chapter	Pages	Part	Chapter	Pages
2	2-1600	i, 1-3	2	2-1600	i, 1-4
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2-1602	i, 5-8	2-1602	i, 5-8
2-1603	i, 3-5	2-1603	i, 3-5

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

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

FECA TRANSMITTAL NO. 97-13 June 18, 1997

RELEASE - REVISION TO CHAPTER 2-0900, DETERMINING PAY RATES, AND CHAPTER 2-0901, COMPUTING COMPENSATION, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 97-13 June 18, 1997

EXPLANATION OF MATERIAL TRANSMITTED:

PM 2-0900 is modified as follow:

1. A new subparagraph 7b(22) adds dive pay to the increments which may be included in the pay rate. This form of pay is granted to wage system workers for the specific hours they actually perform diving duties.

2. Paragraph 10 is reorganized and expanded to provide a fuller discussion of computing pay rates for regular Federal employees who are paid by the hour.

3. A new paragraph 12f addresses the compensation entitlement of Special Census workers. Current paragraph 12f is relettered paragraph 12g.

PM 2-0901 is modified as follows:

1. References to the short-term roll have been removed from paragraphs 3b(3), 6b(2), and 7b. All of paragraph 2a(2) has been removed, and the following subparagraphs have been renumbered.

2. Exhibits 1, 2, and 3 are updated to show the recent increases in the CPI and the minimum and maximum rates of compensation.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0900	i 19-20 23-26	2	2-0900	i 19-20 23-27
	2-0901	i 1-4 7-10 Exs. 1-4		2-0901	i 1-4 7-10 Exs. 1-4

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

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

FECA TRANSMITTAL NO. 97-14 July 1, 1997

RELEASE - REVISION TO CHAPTER 6-0200, INITIAL OVERPAYMENT ACTIONS, PART 6 - DEBT MANAGEMENT, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 97-14 July 1, 1997

EXPLANATION OF MATERIAL TRANSMITTED:

Some uncertainty has arisen on accountability reviews as to what action, if any, should be taken if the claimant submits payment after receiving the preliminary decision. Paragraph 4a is

modified to state that a brief acknowledgment letter should be sent to the claimant in this situation.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
6	6-0200	i, 3-4	6	6-0200	i, 3-4

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

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

FECA TRANSMITTAL NO. 97-16 **September 1, 1997**

RELEASE - REVISIONS TO CHAPTER 2-0500, CONFERENCING; CHAPTER 2-0700, DEATH CLAIMS, AND CHAPTER 2-0804, PERFORMANCE OF DUTY, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 97-16 September 1, 1997

EXPLANATION OF MATERIAL TRANSMITTED:

References to the short-term roll have been removed from these chapters in accordance with

FECA Bulletin 97-04. Specifically, PM 2-600.4b, PM 2-806.8a, and PM 2-807.17d have been modified.

Also, in light of the recent revisions to PM 2-1400, the term "formal decision" has replaced "compensation order" in PM 2-600, paragraphs 7c(4) and 12a, and in PM 2-807, paragraphs 16b(2)(b) and 16b(4).

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

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Part	Chapter	Pages	Part	Chapter	Pages
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	2-0807	i, 19-22		2-0807 i,	19-22

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

FECA TRANSMITTAL NO. 97-17 **July 1, 1997**

RELEASE - REVISIONS TO CHAPTER 2-811, EARLY MANAGEMENT OF DISABILITY CLAIMS, CHAPTER 2-812, PERIODIC REVIEW OF DISABILITY CASES, AND CHAPTER

2-0814, REEMPLOYMENT: DETERMINING WAGE-EARNING CAPACITY, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 97-17 July 1, 1997

EXPLANATION OF MATERIAL TRANSMITTED:

References to the short-term roll and code PV have been removed from these chapters in accordance with FECA Bulletin 97-04:

> In PM 2-811, paragraph 3 has been modified; paragraph 7a has been modified and paragraph 7a(2) has been removed, with paragraph 7a(3) renumbered (2); and paragraph 9 has been rewritten to reflect use of the periodic roll in early disability cases.
>
> In PM 2-812, paragraph 6b has been removed and subsequent paragraphs have been relettered. Paragraph 8c(2) has been modified.
>
> In PM 2-814, paragraphs 7b(1) and 12b(3) have been modified.

Also, references to "compensation orders" have been changed to "formal decisions" in PM 2-812.10c(2) [first paragraph and subparagraph (b)] and in PM 2-814.4d(2), 5d(1) and 10b(2)) in light of the recent revisions to PM 2-1400.

Finally, in response to a question which has arisen from several district offices and at least one employing agency, a sentence is being added to PM 2-814.6a stating that it is not proper to authorize relocation expenses for an employee who has been offered a temporary job which is not expected to lead to a permanent assignment. This is so even if the original job was temporary and the offered job would otherwise be suitable.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
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	2-0812	i, 5-6 9-10 17-20		2-0812 i,	5-6 9-10 17-20
	2-0814	i 5-8 11-12 23-24 27-28		2-0814	i-ii 5-8 11-12 23-24 27-28

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

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

FECA TRANSMITTAL NO. 97-19 **July 25, 1997**

RELEASE - REVISIONS TO CHAPTER 2-0500, CONFERENCING; CHAPTER 2-0700, DEATH CLAIMS, AND CHAPTER 2-0804, PERFORMANCE OF DUTY, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 97-19 July 25, 1997

EXPLANATION OF MATERIAL TRANSMITTED:

In PM 2-0500, a sentence has been added to the end of paragraph 7 to describe the elements of a Memorandum of Conference. Exhibit 1 is being removed as unnecessary.

Paragraph 8 has been rearranged to clarify two points. Specifically, paragraph 8a is modified to state that when the outcome of the conference will be favorable to the claimant, it is not necessary to obtain comments from any party to the conference before issuing the decision. Also, paragraph 8b is modified to state that the issue for resolution need not be addressed in a separate memorandum.

Also, in light of the recent revisions to PM 2-1400, references to "compensation orders" have been changed to "formal decisions" in paragraph 6a of PM 2-0700 and in paragraphs 16e and 17k (at end) of PM 2-0804.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0500	i, 5-6 Ex. 1	2	2-0500	i, 5-6
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	2-0804	i, 35-36 53-54		2-0804	i, 35-36 53-54

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

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

RELEASE - REVISIONS TO CHAPTER 2-0810, DEVELOPING AND EVALUATING MEDICAL EVIDENCE; CHAPTER 2-1100, SUBROGATION; AND CHAPTER 2-1200, FEES FOR REPRESENTATIVES' SERVICES, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 97-20 July 25, 1997

EXPLANATION OF MATERIAL TRANSMITTED:

In light of the recent revisions to PM 2-1400, references to compensation orders have been expanded to include formal decisions in general in paragraphs 10f and 13b of PM 2-0810; in paragraph 27 of PM 2-1100; and in paragraph 10 of PM 2-1200.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0810	i, 23-24 27-28	2	2-0810	i, 23-24 27-28
	2-1100	i-ii 19-20		2-1100	i-ii 19-20
	2-1200	i, 9-10		2-1200	i, 9-10

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

Distribution: List No. 1--Folioviews Groups A and D

(Claims Examiners, All Supervisors, District Medical Advisers, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

OWCP BULLETINS (OB)--INDEX

OB 97-01	Measuring Rehabilitation Resolutions for the Program Plan.
OB 97-02	Selection of Rehabilitation Counselors (RCs) during Option Years.
OB 97-03	Additional Codes for Nurse Rehabilitation Tracking System (N/RTS)
OB 97-04	**Selection of Contract Field Nurses during Option Years.**
OB 97-05	**Management Review of Vocational Rehabilitation**
OB 97-06	**Vocational Rehabilitation Counselor (RC) Notification of Performance during Option Years.**

OWCP BULLETINS--TEXT

OWCP BULLETIN NO. 97-01

Issue Date: February 14, 1997

Expiration Date: February 13, 1998

Subject: Measuring Rehabilitation Resolutions for the Program Plan.

Background: For the Fiscal Year 1997, OWCP has adopted "percent of cases successfully resolved" as a measure of the success of the vocational rehabilitation program. According to the Operational Planning memorandum issued on September 30, 1996, resolution is defined as:

a. reemployment with a new or the previous employer (status codes 2, 4,v,3).

b. demonstration of a wage-earning capacity or presumed earning capacity following completion of a rehabilitation program. This may occur in one of the following ways:

- On closing the case, the rehabilitation counselor completes a sound OWCP-66 certifying that two jobs are reasonably available and medically and vocationally suitable, in accordance with OWCP procedures. For FECA, if the jobs are other than those originally considered by the CE in reviewing the vocational plan, the CE must initial the OWCP-66 signifying agreement (status code 5, reason code j).

- A Longshore case is settled based on representations of OWCP-sponsored vocational rehabilitation and after significant services over and above a labor market survey were provided (status code 5, reason code s).

- A medically and vocationally appropriate job is formally offered to the injured worker but the worker does not return to work (retires or refuses employment)(status code 5, reason code r).

Refusal to cooperate with the vocational program before its completion is not considered to demonstrate an earning capacity. Partial or total completion of a training program is also not considered a positive outcome in and of itself. Two jobs must be suitable and available and at least 30 days of placement services must have been offered to the injured worker.

The provisional goal for FY 1997 is that 70% of closures during the Fiscal Year shall have one of these outcomes.

Purpose: To give instructions for recording cases which satisfy the definition of "resolution" for program plan purposes.

Applicability: FECA and LHWCA Rehabilitation Specialists and Supervisors; FECA and LHWCA Claims Staff.

Action:

1. New closure reason codes have been added to the Nurse/Rehabilitation Tracking System to reflect resolutions which meet the standards as follows:

r - Refused suitable job.
s - Settled case based on OWCP rehabilitation.

The provisional "resolution" standard will be measured as follows:

The sum of closures during the period which were Closed, Reemployed (codes 2, 4, and either V or 3 with reemployment occurring within the reporting period) plus the closures without reemployment listed above, taken as a percent of total closures within that period.

A percentage "score" for each office and each program will be computed quarterly and reported on the Vocational Rehabilitation Performance Report, which accompanies the RH reports. At the end of the Fiscal Year, an annual score will be tabulated.

3. To make sure that resolutions are coded accurately and consistently, you should use the reason codes in a way that indicates whether suitable and available jobs leading to a wage-earning capacity determination were identified at closure. For example, you should use reason code j if two jobs were identified (and, in FECA cases, approved by the CE) and the injured worker elected to retire rather than return to work. Use reason code r if a job offer was refused and the injured worker's compensation was terminated as a result.

The accuracy of resolution coding will be examined on accountability reviews. The selection of two jobs should be documented in the file with Form OWCP-66, and for FECA Quality Case Management cases there should be indication that the CE had an opportunity to review the job or job goals for suitability either when a plan was approved or at closure.

Disposition: This Bulletin should be retained until incorporated in the OWCP Procedure Manual.

DIANE B. SVENONIUS
Director, Division of
Planning, Policy and Standards

Distribution: List No. 5
(All FECA and LHWCA Claims Examiner, Supervisors, Rehabilitation Specialists, Systems Manager, and Technical Advisors)

OWCP BULLETIN NO. 97-02

Issue Date: March 10, 1997

Expiration Date: March 9, 1998

Subject: Selection of Rehabilitation Counselors (RCs) during Option Years.

Background: The current certification procedures call for a one-year certification period of Rehabilitation Counselors (RCs) followed by four one-year option periods. For the purpose of these procedures, the certification year is defined as a twelve month period beginning on the date of the local workshop. For this reason, the certification year will expire on difference dates across district offices. Each district office should use the procedures described in this bulletin to implement the first and succeeding option years.

References: OWCP Bulletin No. 96-2

Purpose: To provide directions for the selection of RCs during the option years.

Action:

1. Review of the office's needs.

a. Geographic clusters. The RS examines the distribution of injured workers (IWs) and the location of RCs in the geographic clusters under his or her jurisdiction. To do so, the RS studies the rotation of RCs within each cluster, posing questions such as: Are the number and/or size of the clusters commensurate with the number and location of the IWs in the region? Do the number and size of the clusters expedite or, conversely, impede the rotation and the management or RCs? Are the travel costs submitted by the RCs in the cluster reasonable in terms of duration and frequency?

If, as a result of this review, the RS identifies areas where the number or the geographic makeup of the clusters is not appropriate, he or she may consider actions such as the merging of clusters, or altering the size and borders of clusters to arrive at an adequate configuration. After this stage is completed, the RS continues the review, taking into account the results of any changes in the configuration of the region's clusters.

b. Number of Counselors per cluster.

(1) The RS examines the number of RCs per cluster, and based on the available reports determines whether the number is adequate or whether there are a significant number of counselors in a cluster that have more or less than an optimal number of active cases/year. In a large urban cluster, we believe that the optimal number of active cases/RC/year ranges from a minimum of four (one per

quarter) to a maximum of 10. A case load of less than four cases is not generally sufficient to successfully acquaint the RC with the OWCP programs and procedures. In contrast, too many cases may lead to delays, inefficiency, or uneven quality. These limits do not apply to clusters composed of rural areas and/or small cities or towns. In these instances, the program needs to maintain the presence of some RCs per cluster even though some of these RCs may receive one or no cases per year. In such clusters, the RS studies additional factors to arrive at a determination of the appropriateness of the number of RCs per cluster. The factors include the results of the RC evaluation process, historical rates of attrition, availability of RCs in neighboring clusters, etc.

(2) The RS establishes the appropriate number of RCs per cluster as well as the number to be subtracted, if any. He or she documents the results of this review and continues the process.

c. RC evaluation.

(1) The RS should conduct the evaluation of the RCs under his or her jurisdiction in accordance with the OWCP Bulletin 96-2. If the cluster distribution and the number of RCs per cluster are deemed appropriate, the RS can go to the next step and determine whether there are any RCs who have at least two cases and who rank significantly below others in the cluster in the RC Detail Evaluation Report and/or the RC Ranking Report. (The counselor's ranking on the planning score and the overall case quality score should be considered individually. The combined ranking tends to disfavor RCs who close cases in the previous employer period.) These RCs should not be selected for the option year unless there are clear and major attenuating circumstances including precipitating a shortage of counselor by
subtracting their number from the current complement of RCs in the cluster.

(2) The RS lists the names of the RCs who will not be asked to come back during the option year and documents all findings and decisions.

2. Communications.

a. District office management. The RS should share the option year procedures, the results of the review, and the time frames for completion of the process with the office management. This should be done prior to the release of the RC letters.

b. Other staff. The RS consults with other RSs in the district office and/or in adjacent jurisdictions and makes them aware of any potential effects on their case load. In addition, the RS informs CEs that they will no longer work with the RCs who are

discontinued and that their cases will be reassigned.

c. Counselors. The RS should release appropriate option year letters to all RCs under his or her jurisdiction. The letter to counselors who are not continued should state that the initial agreement year has expired, and that "in the best interest of the government, OWCP has reviewed its use of counselor services, and has decided not to exercise its option to continue using this counselor's services." There are no appeal rights from this determination.

Disposition: Retain until superseded.

DIANE SVENONIUS
Director, Division of Planning,
Policy and Standards

Distribution: List No. 5
(All FECA and LHWCA Claims Examiners, Supervisors, Rehabilitation Specialists, Systems Managers, and Technical Advisers)

OWCP BULLETIN 97-03

Issue Date: February 24,1997

Expiration Date: February 23,1998

Subject: Additional Codes for Nurse Rehabilitation Tracking System (N/RTS)

Background: OWCP Bulletin No.94-3 clarified the coding and reporting of nurse accomplishments under Quality Case Management in the Federal Employees' Compensation Program. This directive addressed basic coding sequences (B,H,7 etc.) initiated by the staff nurse (SN) during the intervention and return to work (RTW) follow-up activities of the field nurse(FN). As the nurse intervention program expanded, additional actions by claims examiners (CEs) and staff nurses to facilitate case resolution were identified. For example, when the complexity of a case warrants it (surgery, second opinion), FN services are either extended or interrupted for a finite time period. District offices also relate that by assigning FNs to claimants who are already in a light duty capacity, progression to full duty status is often

expedited.

Since the coding and reporting of these case actions impacts on evaluating intervention time frames and outcomes, a standardized approach to code and track these actions on the Nurse Rehabilitation Tracking System (N/RTS) needs to be made available.

Purpose: This bulletin defines the new “interrupt” (Y) and “light duty” status” (L) codes and clarifies their use in the N/RTS. Code U is replaced by code O.

Applicability: FECA supervisors and claims examiners; staff nurses; rehabilitation specialists; systems managers.

Reference: OWCP Procedure Manual Chapter 3-400.15; OWCP Bulletins : 92-7, 94-3, and FECA Bulletin 96-6.

Action:

1. To capture the new codes and track case progression, a STATUS HISTORY screen for nurse cases has been added to the N/RTS. The screen is accessed by selecting “Status” from the update case screen or selecting “maintain status” from the CASE drop down menu. Once the code has been entered on the status history screen, the current status block on the case screen will automatically reflect this entry.

2. Use of the “Y” or “interrupt” code will now permit the SN to track extensions of FN services for specific medical reasons (surgery, second opinions) and for a finite time period. When FN services need to be interrupted (a decision that is coordinated with the claims examiner), the SN enters a “Y” code on the status history screen. While the case is in “Y” status, Progress Flags will not be updated. The tickler code and date will be used instead. The tickler code for “report due” (RD)is already available for use. When the case is removed from the “Y” status, the nurse may enter an “L” code on the status screen, update the H status date on the case screen or enter a closure on the case screen. Once the case moves out of the “Y” status, the next progress report flag update will be calculated systematically (e.g. if the report was due 15 days after it entered the “Y” status, it will now be due 15 days after it leaves the “Y” status). Note: if the worker has not returned to work when leaving the “Y” status, you may reflect this on the status screen by entering “L” with 0 hours.

3. Code “L” has now been added to track cases where the claimant is: (1) already working light duty when the FN is assigned and/or (2) the FN successfully gets the injured worker (IW) back to light duty. If the SN wants to record return to work status at the time the IW returns to light duty, the “H” status code should be entered with a status date one day after the “L” code. At the

time the “L” is entered on the status screen, the system will prompt for entry of the number of hours (Exhibit #1).

4. Coding reflecting such events as light duty (“L”) or interrupt (“Y”) status will be reflected in this manner:

Case Action	Code	Screen
a. case open in lt. dty (4 hr.) status or no work	B L 4	Case screen Status history
b. surgery required history	Y	Status
c. out of interrupt but no RTW history	L 0	Status
d. RTW lt. dty (6 hrs) history	L 6	Status
60 day FN follow up begins	H	Case Screen
e. remains at work for 60 days may/may not have increased lt. dty hours	7	Case Screen

5. The “O” code now replaces the former closure code of “U” and signifies “Closed, no work limitations on file”. Cases previously closed in “U” status have been converted to “O”. Additional codes reflecting FN activity resulting in non-RTW (medically unfeasible, refer to ORP, etc. will be added to the system at a later date.

6. The addition of the above three new codes will be reflected on your monthly NI reports.

7. An “H” Code tracking report is now available to all SNs at their local level and provides at a glance, FN caseload and length of time FN is following claimant’s RTW .

Disposition: This bulletin should be retained until superseded or until incorporated into OWCP Procedure Manual.

DIANE SVENONIUS
Director, Division of
Planning, Policy and Standards

Distribution: List No.5
(All FECA Claims Examiners, Supervisors, Staff Nurses, Rehabilitation Specialists, Systems Managers and Technical Advisers)

OWCP BULLETIN NO. 97-04

Issue Date: February 24, 1997

Expiration Date: February 23, 1998

Subject: Selection of Contract Field Nurses during Option Years.

Background: The current certification procedures outlined in FECA PM Chapter 3-200 detail the soliciting, recruiting, selecting and contracting with registered nurses to work with FECA injured workers. The certification occurs at five year intervals. Nurses sign a Memorandum of Agreement (MOA) that is valid for two (2) years. After the initial two year agreement, the FN services may be renewed yearly for three (3) option years. Guidance and direction for the renewal of contracts during the option years are detailed below:

Reference: FECA Procedure Manual Chapter 3-200

Purpose: To provide direction for the selection of contract nurses during the option years.

Action:

1. Review Office's Needs.

   a. Geographic Clusters. The SN examines the distribution of injured workers (IW) and the location of field nurses in these geographic clusters. The SN also needs to take into account the number of cases which the telephonic nurse can handle. In performing this needs assessment, the SN studies the rotation of the FNs within each cluster, posing such questions as: Are the number and/or size of the clusters commensurate with the number

and location of the IWs in the region? Do the number and size of the clusters expedite or conversely impede the rotation and management of the FNs? Are travel costs submitted by the FNs in the cluster reasonable in terms of duration and frequency?

If as a result of the review, the SN identifies areas where the number or the geographic make-up of the clusters is not appropriate, she may consider actionssuch as merging clusters or altering the size and borders of clusters to arrive at an adequate configuration. After this stage is completed, the SN continues the review taking into account the results of any changes in the configuration of the region's clusters.

b. Number of FNs per cluster. The SN examines the number of FNs per cluster and based on the available data determines whether the number of FNs per cluster is adequate or whether the nurses in the cluster have too few or too many cases per year. In a large urban cluster, we believe that the optimal number of active cases/FN/year ranges from a minimum of 5 to a maximum of 10. A case load of less than 4 cases is generally not sufficient to successfully acquaint the FN with OWCP policies and procedures. In contrast, too many cases may lead to delays, inefficiency or uneven quality. These limits do not apply to clusters in rural areas and/or small cities or towns. In these instances, the SN needs to maintain the presence of some FNs per cluster even though some of these FNs may receive one or even no cases per year. In such clusters, the SN needs to study additional factors to arrive at a determination of the appropriateness of the number of FNs per cluster. These factors include: evaluating FN performance, historical rates of attrition and availability of FNs in neighboring clusters.

c. The SN establishes the appropriate number of FNs
per cluster as well as the number to be subtracted if applicable. SN documents the results of this review and continues the process.

2. Field Nurse Evaluation:

a. The SN reviews the FN performance in terms of timeliness, quality, billing characteristics, intervention successes, complaints or compliments received from employing agencies, claimants, FEC staff and whether there was a need for verbal or written warnings. The suggested evaluation factors to be used when considering option year renewal are detailed in Exhibit # 1. A notification letter advising the FN of the option year assessment is detailed in Exhibit #2. This evaluation is a cumulative review of the FNs performance. The SN must support a "no" response on the evaluation factors by documentation (case number, delayed report, no CE contact etc.) If the answer is "no" in 50% or more of the factors, the option year should not be renewed.

b. If the cluster distribution and the number of FNs per cluster are deemed appropriate, the SN can go to the next step and determine whether there are any FNs who

have at least two (2) cases and rank significantly below the others in the cluster. These FNs should not be selected for option year renewal unless there are clear and major extenuating circumstances including precipitating a shortage of FNs when subtracting their number from the current complement of FNs in the cluster.

c. The SN lists the names of the FNs who will not be renewed for the option year and documents all findings and decisions. The FN is made aware via letter that the option year was not renewed. A sample of this non renewal letter is attached (Exhibit #3)

3. Communication:

a. District Office Management. The SN should share the option year procedures, results of the review and the time frames for completion of the process with the office management.

b. Other staff. The SN advises CEs and other SNs in the adjacent region of those FNS who have not been renewed by the program.

c. Inform FNs. The SN releases letters to those FNs who have been renewed for the option year. (Exhibit #4)

Disposition: This Bulletin is to be retained until the expiration date.

DIANE SVENONIUS
Director, Division of
Planning, Policy and Standards

Distribution: List No. 5
(All FECA Claims Examiners, Supervisors, Staff Nurses, Rehabilitation Specialists, Systems Managers and Technical Assistants)

Attachment 1

OPTION YEAR ASSESSMENT NOTIFICATION LETTER

Dear M :

At present the Office of Workers' Compensation Programs (OWCP) is reviewing the status of contract nurses who provide services to injured workers under our program. This review will determine whether you are approved to continue working for OWCP for the next year.

Your assessment will be based on how you have fulfilled the terms of your contract with OWCP, your overall comprehension of the OWCP nurse intervention process and how you compare with other contract nurses serving this office in terms of quality and outcomes.

You will be notified by------------- of our decision.

Sincerely,

Staff Nurse
Region ________

cc: contract nurse file

Attachment 2

OPTION YEAR DENIAL LETTER

Dear M :

Your two-year agreement with the Office of Workers' Compensation Programs(OWCP) to provide direct services to injured workers has expired. We have determined that in the government's interest, OWCP will not exercise its option to refer additional cases to you.

To be selected during an option year, OWCP requires adherence to our standards as presented in the contract, compliance with our reporting requirements, and importantly, excellence in the quality of services provided. A review assessed your performance on work you have completed during the past year as well as cases that are now in progress. As a result of the review, OWCP will not renew your option for another year. Specifically, the decision is based on
----

You should now close all your open cases. To this end, you may contact each injured worker and active party (for instance the employing agency) once, by telephone for a brief call, notifying them that you will no longer be providing intervention services for OWCP. All materials pertinent to your cases should be forwarded to my attention as soon as possible.

Please acknowledge receipt of this notice.

Sincerely,

Staff Nurse
Region ____________

Attachment 3

OPTION YEAR RENEWAL LETTER

Dear M :

The Office of Workers' Compensation Programs(OWCP) has reviewed your performance as a contract nurse providing services to injured workers who receive benefits under our program.

Your performance was assessed on work you have completed during the past twelve months, as well as on cases that are now in progress. Based on the overall quality of your performance, OWCP has determined to exercise its option to extend your agreement for another year, pending continuing good performance.

We appreciate your efforts on behalf of injured workers and your interest in our program.

Sincerely,

Staff Nurse
Region ____

cc: Contract Nurse File

Attachment 4

CONTRACT FIELD NURSE EVALUATION FORM

Instructions: This evaluation form should be completed when the FN option year renewal is being considered. These factors should be graded equally and are based on a cumulative review of the FNs case outcomes and performance.

Did the FN:	Yes	No
1. Respond timely to the request for case Referral?		
2. Communicate timely & effectively with IW, AP EA, SN,CE and other parties?		
3. Identify problems which could affect the RTW promptly and accurately?		
4. Offer good problem solving techniques and/or viable recommendations to OWCP?		
5. Only make commitments based on the written approval and authorization of FEC staff (CE,SN)?		
6. Provide and coordinate necessary services (e.g. 2 option examinations) without delay?		
7. Follow the directions of the SN and CE?		
8. Submit reports and bills timely and accurately?		

Issue Date: March 19, 1997

Expiration Date: March 18, 1998

Subject: Management Review of Vocational Rehabilitation

Background: Each OWCP Regional Director is required to supplement the OWCP accountability review process with an internal management review of vocational rehabilitation quality in any year in which there is no national review. The rehabilitation review is modeled on the national office accountability review, and uses the same standards and sampling techniques to examine Longshore and FECA cases. The results in summary form must be submitted to the National Office, Division of Planning, Policy and Standards.

Purpose: To revise and reissue procedural requirements for conducting management review of the vocational rehabilitation program in OWCP district offices.

Applicability: Regional Directors, District Directors for FECA and LHWCA Rehabilitation Specialists, and their supervisors in each FECA and Longshore district office.

Action:

1. A management review of the district office rehabilitation program will be conducted, usually bi-annually by randomly sampling vocational rehabilitation cases. A review should be done one year after the National Office review in each program, and at annual intervals until the next National Office review.

2. The timeliness and quality of rehabilitation services, equitable use of available counselors, and quality of management of counselors by the RS will be measured using standards 4a-e of the FECA accountability review manual. (the same standards are used for both FECA and Longshore reviews by the National Office, except that reference to Quality Case Management and loss of earning capacity are deleted from the Longshore standards).

3. Worksheets for each management review item are attached and should be copied in sufficient numbers for the sample to be reviewed.

4. The size of the universe of cases for a particular item and the sample size which is adequate for a statistically valid sample should be determined from the attachments. The most recent month's automated reports, RH-1, RH-7, LS-1 and RTS reports should be used according to the instructions in the attachment. If the office has more than one RS, each RS's work is sampled in

proportion to his or her share of the workload (however it is not necessary to pull a statistically valid sample for each RS). A counselor Referral Log must be run from the RTS to review standard 8c.

5. The reviewer should prepare a summary report for the District Director and Regional Director which includes, for each standard, the size of the universe of cases, the statistically valid sample size, the number of cases reviewed, the error rate, and a discussion of the types of errors and other significant findings noted. A copy of the report should be submitted to the Director, Division of Planning, Policy and Standards, Room S3522, Frances Perkins Building.

6. The designated reviewer should prepare by reading the OWCP Procedure Manual Part 3, particularly Chapters 3-201, 3-300, 3-400 and 3-700. Counselor certification guidelines (Red Book, revised December 1996) are an important supplement to this material. The Procedure Manual can be found in Folioviews; the current Red Book may be obtained by calling the Branch of Medical Standards and Rehabilitation, (202) 329-6808. Questions about the application of the standards can also be directed to the Branch.

7. Office management should address problems identified through appropriate corrective actions.

Disposition: Retain until expiration date.

DIANE B. SVENONIUS
Director, Division of
Planning, Policy and Standards

Distribution: List No. 6
(All Supervisors, Rehabilitation Specialists, Systems Managers and Technical Advisers).

Attachments: (1) Accountability Review Standards for FECA and Longshore, FY 1997; definitions of universe and sample with special instructions; (2)sample size chart; (3) worksheets.

OWCP BULLETIN NO. 97 - 5, Attachment 1.

Standard 4 a.

Is the RS following procedures for selecting and monitoring Rehabilitation Counselors (RCs)?

Standard: The RS follows procedures for selection, use, evaluation and termination of private RCs. The RS documents exceptions to geographic counselor rotation. The RS follows up with RCs when reports are not timely, RCs do not follow instructions or do not submit required documentation or when other violations of the contract occur. (Reference: OWCP Procedure Manual Chapters 3-600 and 3-700; OWCP Bulletin 92-3).

Special instructions:

Rotation is not reviewed by sampling, but from a list of case openings since the last review. A Counselor Referral Log should be printed for each RS to show for each zip code cluster the number of cases assigned to each counselor in that cluster. Each RC in the cluster should have received a roughly equal number of referrals. If referrals appear skewed, the RS should have documented exceptions to geographic referral in the "notes" section of the RTS or in the counselor files maintained in the office. Acceptable deviations for cases needing special skills or for counselors assigned by agency are covered in Rehabilitation PM Ch. 3-400.4 (b)(1) and 3-700.6.

Warnings and terminations can be reviewed in conjunction with item 4c, using the same sample. Warnings should be issued when there is a violation of one of the standards in the RC's agreement (Form OWCP-36, Exhibit 21, OWCP Rehabilitation PM 3-800, page 37). Reviewers should particularly note occasions when the RC did not comply with the RS's instructions; knowingly submitted incorrect bills; provided services beyond the authorization on OWCP-35, OWCP-16, or OWCP-24 without requesting and receiving additional authorization; failed to submit reports, tests, etc. on time; failed to notify the RS when the injured worker was uncooperative, and so on.

Standard 4 b

Does the RS direct the provision of services, including rehabilitation planning, and intervene to ensure that timely cost-effective services are provided to reemploy the injured worker? Does the RS or RC-S conduct the initial interview, explaining the responsibilities and essential points of the vocational rehabilitation program? Are vocational plans well-developed and reasonable? Does the RS keep parties informed of rehabilitation progress?

Standard: The RS gives appropriate guidance to the RC, responds to requests and recommendations, and intervenes when problems and delays occur. [FECA only: FECA Quality Case Management (QCM) referrals are opened promptly and managed in accordance with QCM procedures.] Planning is initiated immediately if the previous employer does not respond promptly to the RC. Testing by a qualified examiner, other than the RC or an associate of the RC's unless otherwise documented by the RS, is conducted immediately with specific recommendations from the examiner.

Approved plans are based on adequate evaluation of worker characteristics and job availability, have clear achievable goals, and are supported by required documentation. Training plans are requested when likely to significantly improve earning capacity or employability; (FECA only: Assisted Reemployment Plans are requested when they could reasonably be expected to improve the likelihood or quality of placements).

Time limits for Planning/Placement Previous Employer, Placement New Employer, Medical Rehabilitation and Interrupted Status are observed or reasonable extensions are granted in writing where justified. Individual Placement Plans are prepared for Placement, New Employer. OWCP-3s are used to keep parties informed of major events, and the CE is promptly advised when intervention is needed. (Reference: OWCP PM Chapters 3-201, and 3-400).

Source: Sample files opened for rehabilitation or active in rehabilitation during the preceding 12 months or since the last accountability review, whichever is less.

Special Instructions:

Universe and sample:

The universe is the total number of open cases for the RSs at the time of the most recently monthly RH-1 or LSRH-1. Add the number of cases on each RS's section of the report for which the status is N (Placement Previous Employer, No Other Services); W (Placement Previous Employer with Other Services; D (Plan Development); T (Training): P (Placement, New Employer); E (Employed); S (Self-Employment Program); and G (Assisted Reemployment

Placement Program).

The sample size should be selected from the chart (Attachment 2) and halved. The resulting number should be divided into the universe number (N) to yield N. Every nth item should be selected from the RH-1 listing for the RSs of open cases to form half of the sample. (This will automatically yield a proportionate sample for each RS if their workloads are approximately equal. If not, the review should draw a proportionate share of the total sample from each listing. It is not necessary to draw a valid sample for each RS separately). An equal number, the other half of the sample, should be drawn from a "code I" report generated from RTS for the cohort which was last scored for QR&A.

Standard 4c

Does the case file contain a properly executed authorization covering time and cost for all services provided? Does the file contain executed authorizations for services not covered by the OWCP-35, including authorization above the RS level where required?

Standard: All services being provided are covered by the appropriate authorization (RS or above). Plans have appropriate justifications.

Source: Sample cases active in the last 12 months. Review OWCP-16s and 24s for appropriate signatures.

Special instructions:

Universe and Sample:

For FECA cases the universe consists of the number of cases with costs exceeding $8,000 on the most recent RH-7s for all of the RSs in the office. Although DD approval is only required when services are authorized which will bring total costs over $20,000 (not including the OWCP-35 authorization), the lower figure is used to identify cases in which expenses of this magnitude have been or should have been authorized, even thought they may not have been spent. Since the universe is generally small, it is often necessary to review a 100% sample; otherwise use the nth item technique described above.

For Longshore cases, examine the disbursement sheets maintained by the bill examiner who authorizes Longshore rehabilitation bills to identify cases in which authorizations reach or exceed $8,000. Consult the Branch of Medical Services and rehabilitation if assistance is needed.

Guidance:

All expenses in a rehabilitation case require prior authorization by the RS. Initially, this is in the form of OWCP-35, which authorizes RC services, including sub-contracted testing, up to $5,000 and two years. RC services beyond that, and any additional services such as tuition, vocational evaluation, and so on, must be authorized on OWCP-15 with OWCP-24 issued to the service vendor if the vendor is not the RC. If an authorization will bring the total dollar amount of authorized services to more than $20,000, that authorization and each additional $5,000 worth of authorizations require DD or designated approval.

A case would contain an error if for example:

DD approval is lacking on the OWCP-16 which brings total authorization $20,000 not including the original OWCP-35;

Services by the RC had exceeded the original $5,000 or two years and no OWCP-16 covering counselor services had been approved by the RS;

A school provided services and no OWCP-16 and OWCP-24 had been approved by the RS.

The RC may subcontract for testing under the initial OWCP-35 authority without preparing and submitting an OWCP-16.

If the case was previously opened and closed, only those costs occurring in the same or prior Fiscal year are counted in determining whether a higher level of authorization is needed.

Standard 4d

Are reemployment closures and closures without reemployment made in accordance with procedures? Are they documented in the case file and RTS?

Standard: Reemployment case closures meet the criteria for each type. Cases are properly documented in each case file and on the Rehabilitation Tracking System. Injured workers are followed in employment for sixty days before closure. (FECA ONLY: If an injured FEC worker was not placed the CE received appropriate documentation concerning refusal to participate or to accept employment or documentation of suitable jobs. Medical issues impeding rehabilitation are reviewed with the FECA CE). (Reference: OWCP Procedure Manual Chapter 3-400).

Source: Cases closed within the preceding 12 months (status 2, 4, 5, 7, V) are sampled for conformance with requirements.

Universe and sample:

The universe consists of the number of cases in status 2, 4, 7, V and 5 in the last year or since the last review. It may be necessary to use the two RH or LS reports to determine this, since the closures accumulate during the fiscal year and drop off the report at the end of September. The RTS Case Query Capability can be sued to produce a listing of closed cases within a six month period from each RS's PC. Combine the listing and sample consecutively from each.

Determine the sample size from Attachment 2, divide into the universe (N) to determine n and choose each nth item from the list(s). Use each RH-1 in turn so that the sample is drawn from each RS.

Code 7s (nurse service requirements) may be incorporated into the claims management review, depending on district office structure.

This portion of the review may identify cases for which wage-earning capacity determinations should have been performed but were not. If so, better procedures should be instituted for tracking and following up on Code 5 closures with two jobs identified.

See PM 3-400.16.

Note on Standard 4 e

Does the RS maintain current and complete records in the rehabilitation Tracking System?

Review of this standard is **optional but recommended**. The worksheets are designed to collect coding information without drawing a separate sample. The usefulness of the extensive RH and N/RTS management reports is wholly reliant on the accuracy of coding.

Standard: Case record information and plan status changes are entered into RTS within five working days of the event being recorded. Code I is entered when a plan for training, placement or medical rehabilitation is approved by the RS, as documented by referral to the FECA CE or notification to the counselor. Codes and dates are present and accurate for 90 percent of the sample.

Source: Sample N/RTS case status history, and compare with RH reports or with documents in case file.

Inaccurately coded "rehabilitations" could count as errors when selected under standard 4e as well as 4f.

OWCP BULLETIN NO. 97-05, ATTACHMENT 2

ACCOUNTABILITY REVIEW SAMPLE SIZES:

If Universe <33 then Sample Size = Universe

If Universe >33 then Sample Size = 34

If Universe >199 then Sample Size = 35

If Universe >224 then Sample Size = 36

If Universe >249 then Sample Size = 37

If Universe >324 then Sample Size = 38

If Universe >399 then Sample Size = 39

If Universe >599 then Sample Size = 40

If Universe >799 then Sample Size = 41

If Universe >1499 then Sample Size = 42

OWCP BULLETIN 97-06

Pending

OWCP CIRCULARS (OC)--INDEX

OWCP CIRCULARS--TEXT

OWCP CIRCULAR NO. 97-01 **May 7, 1997**

Subject: Reporting Estimated Savings to the Office of Inspector General.

We have agreed to provide estimates to the Office of Inspector General which will be used to represent the probable savings resulting from their cases which lead to terminations and adjustments of benefits.

A statistical study done in the Division of Planning Policy and Standards will be used to project the estimated time an injured worker would remain on the rolls based on the worker's date of birth, period in receipt of compensation, nature of injury, and other basic information. Because of certain limitations of this study, the estimate will be based on either the expected duration of the case on the periodic roll or the projected life expectancy based on an actuarial table, and will not be projected longer than ten years.

The attached form will be used to obtain the data. The investigator should complete the Claimant Information portion of the form and give it to the district office. The form should be forwarded to: Diane Svenonius, Director, Division of Planning, Policy and Standards, Office of Workers' Compensation Programs, U.S. Department of Labor, 200 Constitution Avenue NW, Room S-3524, Washington, D.C. 20210. The response will be returned to the Regional Inspector General through your office.

DIANE SVENONIUS
Director, Division of
Planning, Policy and Standards

Attachment:

Distribution: List No. 3 - Regional Directors, District

Directors, Assistant District
Directors, and National Office
Staff

Memorandum For: Diane Svenonius
Director, Division of
Planning, Policy and Standards
Office of Workers' Compensation
Programs

Thru: ____

District Director
District _____
Office of Workers' Compensation
Programs

____

____

From: ____

Regional Inspector General
for Investigations

____

Subject: Determining FECA Savings as a
Result of OIG Investigations

In accordance with a procedure recently approved by the national Office of Workers' Compensation Programs (OWCP), it is requested that you provide this office with the projected savings to be realized after an Office of Inspector General (OIG) investigation resulted in the conviction of the individual listed below for violations of the Federal Employees' Compensation Act (FECA) or related statutes. It is understood that the savings realized will be based on an OWCP automated data base program developed from historical information concerning FECA claimants on the periodic rolls during the 10-year period from 1981-1991.

Claimant Information

Claimant's Name:

Claimant's Date of Birth:

Sex:

Date of Injury:

Period in Receipt of Compensation (Years, Months):

Accepted Condition (Use OWCP NOI Code):

Date of Termination:

Current Monthly Compensation Payment:

The projected savings reported, calculated for a maximum of ten years, or a lesser amount based on statistical data showing an expected duration in compensation status of less than ten years, will be utilized by OIG to more accurately portray the impact of our investigative efforts when a claimant is removed from the FECA rolls and more realistically report cost efficiencies claims as a result of these investigations.

In order that we may timely enter the projected savings in our case management information system, it would be appreciated if you could notify this office of the projected savings within 30 days of receipt of this request. Should you have questions or need additional information please contact me at __________________________.

Your cooperation and assistance in this matter is appreciated.

OWCP TRANSMITTALS (OT)--INDEX

OWCP TRANSMITTALS--TEXT