BCT-FY96

This infobase contains a numerical index of all FECA and OWCP Bulletins, Circulars and Transmittals issued in FY 1996, 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.

FECA BULLETINS INDEX

FECA BULLETINS TEXT

FECA BULLETIN NO. 96-01

FB 96-01 Codes--Nature of Injury Codes in Cases for Occupational Illness

Issue Date: October 5, 1995

Expiration Date: October 4, 1996

Subject:Codes--Nature of Injury Codes in Cases for Occupational Illness

Background: Until now, the Office of Workers' Compensation Programs (OWCP) has had one set of time frames for adjudicating claims for occupational illness. After some study, it has become clear that certain kinds of occupational illness cases can be adjudicated in much less time than is currently allowed.

Therefore, a second standard for occupational illness cases has been developed. Some groups of cases should now be routinely adjudicated within 90 days, whereas other groups should continue to be adjudicated within 180 days.

So that claims examiners will know which cases are to be adjudicated within 90 days and which cases are to be adjudicated within 180 days, each case must now have a Nature of Injury code which shows exactly what kind of injury is involved. For this reason, code "D9" can no longer be used.

Also, new codes were needed since certain diseases, such as eye strain, inguinal hernia, Lyme disease, and dental problems were not included in the previous list of codes. Such codes have

been developed, and a list of all codes to be used effective the date of this bulletin is attached.

Purpose: To instruct Case Create Clerks in proper coding of nature of injury in occupational illness claims

Applicability: All Supervisors, Mail and File Personnel

Action:

1. When coding incoming cases, Case Create Clerks should use the attached list to identify the nature of injury. The code "D9" should no longer be used.

2. If the nature of injury does not appear on the list, or if it is not clear what code should be used, the Case Create Clerk should consult the claims staff member designated by district office management for guidance.

Disposition: Retain until the indicated expiration date.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Attachment

Distribution:List No. 5--Folioviews Groups C and D
(All Supervisors, Index and Files Personnel, Systems Managers, and Technical Assistants)

Attachment to FECA Bulletin 96-01

NATURE OF INJURY CODES

CODE	DEFINITION
TA	Amputation
TB	Back strain
TC	Contusion; bruise; abrasion
TD	Dislocation

TE	Exposure (including frostbite, heat stroke/exhaustion)
TF	Fracture
TH	Hernia (inguinal)
TJ	Crush injury
TK	Concussion
TL	Laceration; cut
TP	Puncture (not insect bite)
TS	Strain (not back)
TT	Tooth injury
TU	Burn, scald, sunburn
TV	Foreign body in eye
TY	Insect bite
TI	Traumatic skin diseases/conditions, including dermatitis
TR	Traumatic respiratory disease
TQ	Traumatic food poisoning
TW	Traumatic tuberculosis
TX	Traumatic virological/infective/parasitic diseases
T1	Traumatic cerebral vascular condition; stroke
T2	Traumatic hearing loss
T3	Traumatic heart condition
T4	Traumatic mental disorder; stress; nervous condition
T8	Traumatic injury - unclass. (except disease, illness)
(G)	Gastrointestinal
GH	Hiatal, umbilical or ventral hernia
GU	Ulcer
G9	Gastrointestinal, not otherwise classified
(S)	Skin Disease or Condition
SB	Biological (including poison ivy, poison oak)
SC	Chemical
SL	Skin lesion (including blister, bunion, callus and corn)
S9	Dermatitis, not otherwise classified
(M)	Musculoskeletal and Connective Tissue
MA	Arthritis
MB	Back or neck strain, sprain
MC	Carpal Tunnel Syndrome
MD	Degenerative Disc Disease; spondylosis; spondylitis
MI	Inflammatory Disease (including bursitis, tendinitis)

MK	Chondromalacia
M9	Musculoskeletal condition, not otherwise classified

* Injury or condition must be caused by a specific incident or event which occurred during a single work day or shift.

CODE	DEFINITION
(R)	Respiratory Disease
RA	Asbestosis
RB	Bronchitis, asthma
RE	Emphysema
RP	Pneumoconiosis (Black Lung)
RR	Reaction to smoke, fumes, chemicals
RS	Silicosis
R9	Respiratory disease, not otherwise classified
(V)	Virological, Infective and Parasitic Diseases
VA	Acquired Immune Deficiency Syndrome (AIDS) and HIV
VB	Brucellosis
VC	Valley Fever (Coccidioidomycosis)
VH	Hepatitis
VL	Lyme Disease
VM	Malaria
VP	Parasitic Diseases
VR	Rocky Mountain Spotted Fever
VS	Staphylococcus
VT	Tuberculosis
V9	Virological/Infective/Parasitic, not otherwise classified
(C)	Cardiovascular/Circulatory
CA	Angina
CB	Blood Disorder
CH	Hypertension
CM	Myocardial Infarction (Heart Attack)
CP	Phlebitis; varicose veins
CS	Stroke; cerebral vascular condition
C9	Cardiovascular/circulatory, not otherwise classified
(O)	Occupational disease, non-complex

OF	Food poisoning
OG	Tooth and gum-related problems
OL	Inguinal Hernia
OP	Pregnancy (Peace Corps only)
(D)	Other Disability, Occupational
DH	Hearing loss
DI	Vision/sight loss
DM	Mental disorder; emotional condition; nervous condition
DN	Nerve injury, incl. paralysis, after exposure to toxins
DR	Radiation
DT	Tumors and other cancer-related conditions

FECA BULLETIN NO. 96-02

FB 96-02 Dual Benefits--Severance and Separation Pay

Issue Date: November 5, 1995

Expiration Date: November 4, 1996

Subject: Dual Benefits--Severance and Separation Pay

Background: Employing agencies may grant severance pay to employees who are involuntarily separated as part of a reduction in force (RIF). Severance pay represents a certain number of weeks worth of salary or wages, and it is usually computed as a lump sum.

Employing agencies may also offer separation pay ("buyouts") to encourage employees to leave Federal employment voluntarily. For example, the U.S. Postal Service offered a six-month lump-sum payment as part of its Special Retirement Option, as described in FECA Bulletin No. 93-1.

We have received many questions about entitlement to compensation during periods covered by severance or separation pay. The purpose of this bulletin is to explain which payments constitute dual benefits under the FECA and the actions which district office staff should take when a claimant receives one of these forms of payment. (Determining loss of wage-earning capacity (LWEC) under these circumstances is addressed in FECA Procedure Manual Chapter 2-1500.9.)

Severance pay was first authorized by the Federal Employees' Salary Act of 1965 (Pub. Law 89-301, since codified at 5 U.S.C. 5595). Under this statute, severance pay could not be paid "concurrently with salary or on account of the death of another person." FECA Program

Memorandum 55, dated January 24, 1968, interpreted the phrase "concurrently with salary" to allow payment of severance pay to claimants receiving benefits for LWEC, since the severance pay is calculated on the basis of the salary only, and does not take claimants' LWEC payments into consideration. Also, a schedule award may be paid concurrently.

Health benefits and optional life insurance coverage may continue during the period of severance pay as long as the OWCP eventually makes appropriate payments for the time period covered by the severance pay to the Office of Personnel Management (OPM).

Separation pay is offered in different forms by different agencies. Sometimes it is defined as a number of weeks of pay, and other times as a specific amount of money. How separation pay is defined is determined by the law governing the operations of the agency in question. For example, in 1992 the Postal Service calculated its payments as six months of the employee's base pay, while the Department of Defense, beginning in 1993, used the amount of severance pay to which the individual would have been entitled, or $25,000, whichever was less. The method of offset differs somewhat according to how the separation pay is defined (see below).

Reference: 5 U.S.C. 8116; FECA Program Memorandum 55

Purpose: To provide instructions for payment of compensation, deductions for health benefits and optional life insurance, and later claims for compensation in cases involving severance and separation pay.

Applicability: Claims Examiners, Senior Claims Examiners, All Supervisors, Technical Assistants, Staff Nurses, Rehabilitation Specialists, and Fiscal Officers in the district offices; and Hearing Representatives

Action:

1. Nature of Payment. Before attempting to address entitlement to benefits, it will be necessary to determine whether severance pay or separation pay is at issue. The employing agency should provide this information. If there is any doubt, request a copy of the pertinent law (or at least a citation to it). If the nature of the payment remains unclear after correspondence or discussion with the employing agency, the Supervisory Claims Examiner or higher-level manager should contact the National Office for further guidance.

The employing agency should also submit a copy of the claimant's acceptance of the offer of separation pay and severance pay (if applicable) and the separation or retirement papers themselves.

Some employees may be entitled to both severance and separation pay. If the separation pay is based on a specific sum of money, address separation pay first (see item 3 below). Otherwise, the two types of payment may be addressed in either order.

2. Severance Pay.

a. Section 5 U.S.C. 5595(c), which governs severance pay, states as follows:

(c) Severance pay consists of--

(1) a basic severance allowance computed on the basis of 1 week's basic pay at the rate received immediately before separation for each year of civilian service up to and including 10 years for which severance pay has not been received under this or any other authority and 2 weeks' basic pay at that rate for each year of civilian service beyond 10 years for which severance pay has not been received under this or any other authority; and

(2) an age adjustment allowance computed on the basis of 10 percent of the total basic severance allowance for each year by which the age of the recipient exceeds 40 years at the time of separation.

Total severance pay under this section may not exceed 1 year's pay at the rate received immediately before separation. For the purpose of this subsection, "basic pay" includes premium pay under section 5545(c)(1) of this title.

b. Claimants are not entitled to compensation payments for temporary total disability (TTD) during the period covered by the severance pay. For example, if a claimant receives 13 weeks worth of severance pay, compensation is not payable until the fourteenth week.

The employing agency will need to advise the OWCP of the total dollar amount of severance pay and the date of separation or retirement.

c. Compensation payments should be suspended for the period in question, effective the date of separation or retirement, by 100% offset for the number of weeks (not the amount of money) which the severance pay represents. The total amount of the severance pay should be divided by the salary used to compute it to determine the number of weeks for which compensation payments should be suspended. The employee will not be entitled to compensation payments at least through the end of that period.

d. Where the OWCP finds out after the fact that severance payments were made to a claimant for the same period that compensation was paid, an overpayment must be declared and the usual due process rights provided.

e. Compensation for a schedule award may be paid concurrently with severance pay. Also, medical benefits continue to be payable.

f. Severance pay may also be paid concurrently with compensation for LWEC. The basis for allowing concurrent payment for LWEC is that the amount of severance pay is based on the employee's reduced salary, not OWCP's payments for LWEC. If an employee who is receiving compensation for LWEC receives severance pay and then retires, an election of benefits will be required at the time of retirement.

3. Separation Pay Based on Period of Time.

a. The entitlement to benefits is as described for those entitled to severance pay (items 1a-1c above). That is, the claimant may not receive compensation for TTD, but may receive compensation for a schedule award or LWEC based on a given number of weeks of compensation at the current rate of salary (i.e., the salary as reduced to reflect the claimant's LWEC) concurrently with separation pay.

b. Provisions for offset and overpayments are also as noted above for severance pay. A claimant who was receiving compensation for TTD should be advised that payment of these benefits will cease immediately because he or she has elected to receive separation pay and severance pay (if applicable).

4. Separation Pay Based on Amount of Money.

a. The entitlement to benefits is as follows: a claimant may not concurrently receive payment for TTD or LWEC, but may receive payment for a schedule award. The reason for the difference in policy with respect to payments for LWEC is that, under 5 U.S.C. 8116 (a), lump-sum separation payments are not included in the categories of payments which may be made concurrently with compensation payments (except, of course, for schedule awards). As with other kinds of severance and separation payments, medical benefits continue to be payable.

b. The employing agency should advise the OWCP of the total dollar amount of separation pay and the date of separation or retirement. This amount should be applied to the amount of compensation for wage loss on a dollar-for-dollar basis. The claimant should be advised of the approximate time the offset will end; the estimate may be affected by application of cost-of-living increases, etc.

5. Health Benefits and Optional Life Insurance.

a. For claimants with health benefits and/or optional life insurance coverage, compensation should be suspended at the net rather than the gross amount to allow OWCP to collect

the appropriate deduction(s) and forward them to OPM. Form CA-25 should be

completed so that only the amounts of deductions for health benefits and/or optional life insurance are payable. The amounts are payable to OPM. If compensation payments are suspended at the gross rate, it will be necessary to contact the claimant to arrange for payment of the premiums for the period in question.

b. The agency will transfer the health benefits enrollment to OWCP effective the date that employment ceases. The claimant is responsible only for his or her own share of the premiums.

c. Claims and Fiscal personnel may receive inquiries concerning entitlement to continuation of health benefits coverage under the Temporary Continuation of Coverage (TCC) program. This program allows employees who have been involuntarily separated to continue their coverage for a short period of time. The TCC program will not allow the enrollment of an individual who is entitled to compensation, and it will terminate any existing enrollment of a person entitled to either of these benefits.

6. Claims for Additional Compensation.

a. If a schedule award ends during the period covered by the separation or severance payment, the employee may claim additional compensation for disability (see subparagraph b below). If the claimant was not receiving compensation for disability before the schedule award, he or she would not be entitled to receive compensation afterwards unless it could be shown that the medical condition had worsened to the point that it disabled him or her from the regular or limited duty job performed before separation. Should entitlement to additional compensation be established, the employee will need to elect between OWCP and retirement benefits (if eligible).

b. A separated employee who was not receiving compensation at the time of separation because of placement in a modified job with no loss of pay will not be entitled to further compensation at the end of the period covered by separation or severance pay solely because the modified job is no longer available. A claimant who has returned to duty, whether regular or light, has the burden of proof to show that injury-related disability had worsened to the point that he or she is now disabled for the limited duty position (see Terry L. Hedman, 38 ECAB 222).

c. Benefits will not necessarily be reinstated in cases where the employee shows that the condition has worsened, since he or she might have been able to continue performing the modified job even if the condition worsened. Therefore, where a formal LWEC decision has not been issued, the employing agency should be asked to submit a description of the employee's job duties, including the physical requirements, at the time of separation. With this evidence, it will be possible to determine if the employee has any further entitlement to compensation.

d. An employee who establishes that his or her accepted condition worsened to the point of being unable to perform a modified job will be required to make an election of benefits, if eligible for retirement, since he or she has been formally separated. An employee who elects OWCP benefits should receive compensation for TTD and be considered for referral for vocational rehabilitation services to explore reemployment in another job.

e. Employees working part time, or working full time but at lower rates of pay, will be entitled to continue receiving compensation at the end of the period covered by separation or severance pay at the LWEC rate, if injury-related disability continues and they elect OWCP benefits in favor of retirement benefits. Should a recurrence be claimed, it will be their burden to show that injury-related disability has worsened (see question 6 above).

f. An employee who was performing regular duty at the time of separation would be entitled to receive compensation only if a true recurrence of disability were established (see subparagraph b above).

g. An employee who accepts separation pay and then changes his or her mind may not receive compensation for the duration of entitlement to separation pay or severance pay (if applicable). After that time, a claimant who remains entitled to benefits on the basis of total disability or LWEC when separated, and who contacts OWCP seeking compensation, will be offered an election of benefits.

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. 96-03

FB 96-03 Excluded Provider Changes

Issue Date: November 30, 1995

Expiration Date: November 29, 1996

Subject: Excluded Provider Changes

Background: The National Office has in the past maintained a data file of medical providers which were excluded under the FECA program. The source of most of these exclusions was the Department of Health and Human Services, Office of the Inspector General (HHS OIG). These exclusions make up most of the so-called automatic exclusions. In addition, district offices have regulatory authority to exclude medical providers for a variety of reasons. These inhouse exclusions comprise most of the so-called non-automatic exclusions.

Formerly, all updates to the National Office excluded provider file were made manually. Periodically, updated reports of excluded providers were sent to district offices and were also made available to Federal employers for their use in authorizing medical treatment. When updates were made to the National Office data file, the geographically appropriate district offices were also informed, so that the provider payment flag on the local Sequent provider file (v46) could be set to N for "no".

Major changes have been made to the ADP systems portion of the excluded provider process. A new excluded provider data file has been created at National Office (m41). This file has a different format from the previous data files. The m41 file will be updated automatically from data provided by the HHS OIG. The m41 file can also be updated manually, to allow for exclusions from other sources, including the inhouse non-automatic exclusions.

A new data file at the district office Sequents (v41) is an extract of the m41 file. The v41 file will be updated periodically. Whenever the v41 file is updated, the records in that file will be compared to the records on the office's existing v46 file (provider file), using the tax identification numbers. If a match is found, the v46 file record will be flagged as an excluded provider (the excluded provider flag will be Y for "yes"). In addition, whenever a new provider is added to the provider file, the provider update program checks tax identification number against the v41 file to determine whether that provider has been excluded, and if a match is found, the v46 exclusion flag is set to Y. A message concerning the exclusion status of the provider appears at the top of the provider update screen.

The new excluded provider flag is in addition to and does not replace the existing v46 payment flag, which is set by the district office, and is Y for "yes" if the provider is payable. District offices also have the ability to query the v41 (excluded provider) file, using either a tax identification number or a last name. Within a short time, district offices will also be able to run reports of the records in the v41 file.

A new edit has been added to the BILL552 process which is based on the provider exclusion flag in v46.

Reference: 20 C.F.R. Chapter 10, Subpart F; Federal (FECA) Procedure Manual Chapter 3-800, Exclusion of Medical Providers.

Purpose: To inform offices of changes to the excluded provider process, and provide revised procedures.

Applicability: Regional Directors, District Directors, Systems Managers, District Medical Advisors, Claims and Bill Resolution staff, and individuals responsible for secure provider file updates in the district offices.

Action:

1. Updates to the v41 file (excluded providers) will be performed promptly by the operations staff. Whenever v41 updates are done, a new excluded provider report (BILL610) will be run and be made available to district office staff. (Note that the report is not yet available, but will be shortly.)

2. When providers are added to the provider file (v46) by the authorized individual(s) responsible for security input, a check against the v41 file (using the tax identification number) will be made automatically by the system. A message appears on the BILL005 (provider master file update) screen stating whether the provider is excluded or not, based upon the v41 data. In addition to the automated check, an on-line excluded provider query must be performed, using the provider's last name, to determine whether the provider is excluded. Excluded provider query is option 19 on the FECS001 bill payment menu and option 24 under the FECS001 query menu. A copy of the screen is shown as Attachment 1. This action is necessary because providers may use different tax identification numbers, and the information from the HHS OIG contains Social Security Numbers, rather than Employer Identification Numbers. For organizations, the first word of the organization should be used to query. A flow may be set up between FECS001 bill payment menu options 19 (excluded provider query) and 5 (provider update). In place of the on-line query, once it is available, the latest excluded provider report may be checked to determine whether the name of the provider appears on the report, and has been excluded. If the provider is present in the on-line query or on the excluded provider report, but was not identified as an excluded provider in the provider update screen, the district office payment flag should be set to N for "no" when the provider is added to v46 (provider file), and the National Office notified.

3. Offices will continue to flag a v46 provider record for non-payment when an inhouse or non-automatic exclusion is made. The Director for FEC will also be informed, preferably by memorandum. The National Office will then add the provider to the m41 table, and the local v41 exclusion flag should be set to Y automatically the next time a v41 update is done. After the

v41 flag has been set to Y, the district office may change the v46 payment flag to Y.

4. A new bill processing system edit 201 is based upon the new v46 exclusion flag. If the exclusion flag is Y for a provider, and a bill from that provider is data entered and edited by the BILL552 process, edit 201 will fail. Edit 201 failure results in suspension of the bill for manual review. The resolver should check the excluded provider query (or report) to ensure that the excluded provider's name matches the name on the bill. Complete instructions for resolving edit 201 failures are contained in Attachment 2. This attachment should be inserted in the thick BPS edit by edit resolution job aid.

5. The description and resolution instructions for BPS edit 202 have been modified slightly to reflect the differences between edits 201 and 202. The modified information is contained in Attachment 3. This modified sheet should be substituted for the existing edit 202 sheet in the thick BPS edit by edit resolution job aid.

6. E-mail containing Attachments 2 and 3, as well as an updated condensed edit listing, and EOB listing has been sent to each office.

7. Each office should continue to keep a written file of actions taken with respect to non-automatic exclusion of providers.

8. Any problems or inaccuracies noted with respect to the v46 exclusion flags or v41 records should be brought to the attention of the Director for FEC. An example of such a problem would be if a provider was shown as excluded on the system, but provided documentation that the exclusion had been rescinded or was in error.

9. It should be noted that the excluded provider file includes a large number of providers for whom no tax identification number was provided. These providers, which include organizations as well as individuals, are being placed on the excluded provider file and may be viewed through a name query. Because of variances in name formats, the entire name for these providers is placed in the last name field.

10. Excluded provider information is also used by Federal agencies when they authorize medical treatment for injuries covered under the FECA. The excluded provider report should be made available to employing agencies upon request. The National Office also provides excluded provider information to employing agencies on a periodic basis, either by report or diskette.

Training for all personnel affected by these changes should be conducted no later than November 30, 1995.

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)

EXCLUDED PROVIDER QUERY SCREEN

```
PAYEE NO: 123456789       LAST NAME: JONES

PAYEE NAME:
LAST: JONES                    FIRST: JOHN      MI: J

ADDR: 123 MAIN STREET

CITY: ANYWHERE          ST: DC  ZIP: 20210

SANCTION DATE: 09/21/1995    NOTIFY DATE: 09/01/1995

SOURCE OF EXCLUSION: H - HHS


NEXT RECORD [Y/N]
```

This is what the screen would look like if a query were performed using the last name of Jones. The user is able to view all of the records which contain "JONES" in the last name field by responding "Y" for "yes" to the NEXT RECORD prompt.

MEDICAL BILL SYSTEM
EDITS

EDIT NO. 201H

ERROR DESCRIPTION: PROVIDER EXCLUDED UNDER FECA

EDIT DESCRIPTION:BILL TIN MATCHES THAT OF A RECORD ON THE PROVIDER FILE WITH V46_EXCLUDE_FLAG OF Y (FOR YES).

SUSPEND/DENY: S

OVERRIDE: Y

EOB: Payments to this provider are excluded under Federal Regulations 20 C.F.R. Part 10, Subpart F.

PRIORITY: 1

BILL RESOLUTION:

1. Verify that the TIN (tax identification number) was keyed correctly. Correct any errors.

2. If the TIN was keyed correctly, verify that this particular provider has been excluded by querying provider exclusions, preferably on-line, and matching the name of the provider. This flag is activated by the national office. The flag is set to Y when the provider has been excluded automatically from participation in FECA. These flags are updated periodically.

3. If the provider has been formally excluded from participation in FECA, deny bill with EOB 201 (above), unless a CA-16 authorization was issued to the excluded provider. If a CA-16 authorization was issued, the bill should be paid by overriding the edit. The CE is responsible for rescinding the CA-16 authorization. If this particular provider has not been excluded, but shares a tax identification number with an excluded provider, the edit failure may be overridden.

4. If it appears that the exclusion flag is in error, national office should be contacted.

EDIT NO. 202H

ERROR DESCRIPTION: PROVIDER SUSPENDED OR UNDER REVIEW

EDIT DESCRIPTION:BILL TIN MATCHES THAT OF A RECORD ON THE PROVIDER FILE WITH V46_PAYMENT_FLAG OF N (FOR NO).

SUSPEND/DENY: S

OVERRIDE: Y

EOB: Payments to this provider are excluded under Federal Regulations 20 C.F.R. Part 10, Subpart F.

PRIORITY: 1

BILL RESOLUTION:

1. Verify that the TIN (tax identification number) was keyed correctly. Correct any errors.

2. If the TIN was keyed correctly, determine why the provider file payment flag has been set to no. This flag is activated by the district office. The flag may have been set because of a non-automatic exclusion, or a need to review all of this provider's bills. The systems manager or other office manager should maintain information on these providers.

3. If the provider has been formally excluded from participation in FECA, deny bill with EOB 202 (above), unless a CA-16 authorization was issued to the excluded provider. If a CA-16 authorization was issued, the bill should be paid by overriding the edit. The CE is responsible for rescinding the CA-16 authorization.

4. If the flag has been activated with the purpose of reviewing services rendered by the particular provider, the bills should be reviewed by the CE. If the services are approved for payment the edit is overridden. Non-reimbursable services are denied with an appropriate EOB.

FECA BULLETIN NO. 96-04

FB 96-04 September 1995 DFEC/OPM Computer Match

Issue Date: January 25, 1996

Expiration Date: January 24, 1997

Subject: September 1995 DFEC/OPM Computer Match

Background: Another DFEC/OPM computer match, designed to identify possible occurrences of prohibited concurrent dual benefit payment, was completed in September using the data for the August 19, 1995 periodic roll cycle. The data shared with OPM again included the death roll, and excluded schedule award cases. 55 cases survived the manual and automated screening processes employed by OPM.

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 95-22 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 August 19, 1995, in apparent violation of the dual benefit prohibitions. (Note: The Boston, Philadelphia and Kansas City District Offices had no "hits" from this match.)

For this, and future matches, we will continue the procedures used for the past few years; 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 Jim Najjar at (202) 606-0235 (or 0232). Written inquiries or other correspondence should be directed to the Office of Personnel Management, Program Integrity Section, P.O. Box 7174, Room 2309, Washington, D.C. 20044, Attention: Jim Najjar.

Purpose: To inform District Offices of the procedures for follow-up review and reporting requirements concerning the "hits" identified in the September 1995 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, "hit sheets" completed by OPM should have already been 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.

FB 96-04 September 1995 DFEC/OPM Computer Match

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 January 15, 1995, 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., 4/15, 7/15, 10/15, 1/15) 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 March 6, 1996; a final decision was issued on April 10, 1996 finding an overpayment of $2000; an SF-2805 was issued on May 20, 1996; the first payment of $200 was received from OPM on August 1, 1996; the debt will be recovered by June 1997. (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, Systems Managers, Technical Assistants and National Office Staff)

FECA BULLETIN NO. 96-05

FB 96-05 ADP - Automated Compensation Payment System (ACPS)

Issue Date: December 15, 1995

Expiration Date: January 4, 1997

SUBJECT: ADP - Automated Compensation Payment System (ACPS) and Debt Management System (DMS) Report Schedule - 1996.

PURPOSE: To provide the 1996 schedule for processing the periodic disability and death payrolls under the ACPS and the DMS weekly and monthly reports for calendar year 1996.

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)

AUTOMATED COMPENSATION PAYMENTS SYSTEM (ACPS) - 1996

FECA DISABILITY PAYROLL - EACH 28 DAYS
FECA DEATH PAYROLL - EACH 28 DAYS

CHECK CYCLE	PERIOD ENTITLEMENT FROM TO*	BI-WEEKLY PAY PERIODS FOR HEALTH AND LIFE iNSURANCE PURPOSES	DISTRICT OFFICE CUT-OFF DATE TO ENTER ROLL DATA	N.O. CHK OF TAPE TO TREASURY
1	01/07/96-02/03/96	01/07/96 - 01/20/96 01/21/96 - 02/03/96	01/24/96	01/26/96
2	02/04/96-03/02/96	02/04/96 - 02/17/96 02/18/96 - 03/02/96	02/21/96	02/23/95
3	03/03/96-03/30/96	03/03/96 - 03/16/96 03/17/96 - 03/30/96	03/20/96	03/22/96
4	03/31/96-04/27/96	03/31/96 - 04/13/96 04/14/96 - 04/27/96	04/17/96	04/19/96
5	04/28/96-05/25/96	04/28/96 - 05/11/96 05/12/96 - 05/25/96	05/15/96	05/17/96
6	05/26/96-06/22/96	O5/26/96 - 06/08/96 06/09/96 - 06/22/96	06/12/96	06/14/96
7	06/23/96-07/20/96	06/23/96 - 07/06/96 07/07/96 - 07/20/96	07/10/96	07/12/96
8	07/21/96-08/17/96	07/21/96 - 08/03/96 08/04/96 - 08/17/96	08/07/96	08/09/96
9	08/18/96-09/14/96	08/18/96 - 08/31/96 09/01/96 - 09/14/96	09/04/96	09/06/96
10	09/15/96-10/12/96	09/15/96 - 09/28/96 09/29/96 - 10/12/96	10/02/96	10/04/96
11	10/13/96-11/09/96	10/13/96 - 10/26/96 10/27/96 - 11/09/96	10/30/96	11/01/96
12	11/10/96-12/07/96	11/10/96 - 11/23/96 11/24/96 - 12/07/96	11/27/96	11/29/96
13	12/08/96-01/04/97	12/08/96 - 12/21/96 12/22/96 - 01/04/97	12/24/96	12/27/96

*ENDING PERIOD IS THE CHECK DATE
FOR EFT PAYMENTS, THE DAY BEFORE

******FECA DAILY ROLL SCHEDULE (ONCE WEEKLY)******

DATE OF CHECK	DISTRICT OFFICE CUT-OFF DATE TO ENTER DATA INTO ACPS	N.O. CHECK TAPE TO TREASURY
EACH FRIDAY**	PREVIOUS TUESDAY	PREVIOUS WEDNESDAY

**FOR EFT PAYMENTS, EACH FRIDAY

DEBT MANAGEMENT REPORT SCHEDULE 1996

12/22/1995	EEKLY CASH RECEIPTS/INTEREST REPORT (12/16/1995 -12/22/1995)
12/29/1995	WEEKLY CASH RECEIPTS/INTEREST REPORT (12/23/1995 -12/29/1995)

01/02/1996	MONTH END PROCESSING (12/31/1995)
O1/05/1996	ACPS/DMS DEBT NUMBER MATCH
01/08/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (12/30/1995 -01/05/1996)
01/16/1996	WEERLY CASH RECEIPTS/INTEREST REPORT (01/06/1996 -01/12/1996)
01/22/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (01/13/1996 -01/19/1996)
01/29/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (01/20/1996 -01/26/1996)
01/31/1996	MONTH END PROCESSING (01/31/1996)
02/05/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (01/27/1996 -02/02/1996)
02/05/1996	ACPS/DMS DEBT NUMBER MATCH
02/12/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (02/03/1996 -02/09/1996)
02/20/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (02/10/1996 -02/16/1996)
02/26/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (02/17/1996 -02/23/1996)
02/29/1996	MONTH END PROCESSING (02/29/1996)
03/04/1996	ACPS/DMS DEBT NUMBER MATCH
03/04/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (02/24/1996 -03/01/1996)
03/11/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (03/02/1996 -03/08/1996)
03/18/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (03/09/1996 -03/15/1996)
03/25/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (03/16/1996 -03/22/1996)
03/27/1996****	SPECIAL ACPS/DMS DEBT NUMBER MATCH****
03/31/1996	MONTH END PROCESSING (03/31/1996)
04/01/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (03/23/1996 -03/29/1996)
04/08/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (03/30/1996 -04/05/1996)
04/15/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (04/06/1996 -04/12/1996)
04/22/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (04/13/1996 -04/19/1996)
04/26/1996	ACPS/DMS DEBT NUMBER MATCH
04/29/1996	WEERLY CASH RECEIPTS/INTEREST REPORT (04/20/1996 -04/26/1996)
04/30/1996	MONTH END PROCESSING (04/30/1996)
05/06/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (04/27/1996 -05/03/1996)
05/13/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (05/04/1996 -05/10/1996)
05/20/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (05/11/1996 -05/17/1996)
05/24/1996	ACPS/DMS DEBT NUMBER MATCH
05/28/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (05/18/1996 -05/24/1996)
05/31/1996	MONTH END PROCESSING (05/31/1996)

06/03/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (05/25/1996 -05/31/1996)

06/10/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (06/01/1996 -06/07/1996)

06/17/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (06/08/1996 -06/14/1996)

06/21/1996 ACPS/DMS DEBT NUMBER MATCH

06/24/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (06/15/1996 -06/21/1996)

06/28/1996 MONTH END PROCESSING (06/30/1996)

07/01/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (06/22/1995 -06/28/1996)

07/08/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (06/29/1996 -07/05/1996)

07/15/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (07/06/1996 -07/12/1996)

07/19/1996 ACPS/DMS DEBT NUMBER MATCH

07/22/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (07/13/1996 -07/19/1996)

07/29/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (07/20/1996 -07/26/1996)

07/31/1996 MONTH END PROCESSING (07/31/1996)

08/05/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (07/27/1996 -08/02/1996)

08/12/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (08/03/1996 -08/09/1996)

08/16/1996 ACPS/DMS DEBT NUMBER MATCH

08/19/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (08/10/1996 -08/16/1996)

08/26/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (08/17/1996 -08/23/1996)

08/30/1996 MONTH END PROCESSING (08/31/1996)

09/03/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (08/24/1996 -08/30/1996)

09/09/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (08/31/1996 -09/06/1996)

09/13/1996 ACPS/DMS DEBT NUMBER MATCH

09/16/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (09/07/1996 -09/13/1996)

09/23/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (09/14/1996 -09/20/1996)

09/30/1996 MONTH END PROCESSING (09/30/1995)

10/01/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (09/21/1996 -09/27/1996)

10/07/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (09/28/1996 -10/04/1996)

10/11/1996 ACPS/DMS DEBT NUMBER MATCH

10/15/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (10/05/1996 -10/11/1996)

10/21/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (10/12/1996 -10/18/1996)

10/28/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (10/19/1996 -10/25/1996)

10/31/1996 MONTH END PROCESSING (10/31/1996)

11/04/1996 WEEKLY CASH RECEIPTS/INTEREST REPORT (10/26/1996 -11/01/1996)

11/08/1996	ACPS/DMS DEBT NUMBER MATCH
11/12/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (11/02/1996 -11/08/1996)
11/18/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (11/09/1996 -11/15/1996)
11/25/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (11/16/1996 -11/22/1996)
11/29/1996	MONTH END PROCESSING (11/30/1996)
12/02/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (11/23/1996 -11/29/1996)
12/06/1996	ACPS/DMS DEBT NUMBER MATCH
12/09/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (11/30/1996 -12/06/1996)
12/16/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (12/07/1996 -12/13/1996)
12/23/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (12/14/1996 -12/20/1996)
12/30/1996	WEEKLY CASH RECEIPTS/INTEREST REPORT (12/21/1996 -12/27/1996)
12/31/1996	MONTH END PROCESSING (12/31/1996)
01/03/1997	ACPS/DMS DEBT NUMBER MATCH
01/06/1997	WEEKLY CASH RECEIPTS/INTEREST REPORT (12/28/1996 -01/03/1997)
01/13/1997	WEEKLY CASH RECEIPTS/INTEREST REPORT (01/04/1997 -01/10/1997)
01/21/1997	WEEKLY CASH RECEIPTS/INTEREST REPORT (01/11/1997 -01/17/1997)
01/27/1997	WEEKLY CASH RECEIPTS/INTEREST REPORT (01/18/1997 -01/24/1997)
01/31/1997	MONTH END PROCESSING (01/31/1997)
02/03/1997	WEEKLY CASH RECEIPTS/INTEREST REPORT (01/25/1996 -01/31/1997)

FECA BULLETIN NO. 96-06

FB 96-06 Case Management--Role of Registered Nurses in QCM Cases

Issue Date: January 29, 1996

Expiration Date: January 27, 1997

Subject: Case Management--Role of Registered Nurses in QCM Cases

Background: The Federal Employees' Compensation program has had two years of experience in using the services of registered nurses to assist in medical management of disability claims and help claimants return to work. Staff Nurses and Field Nurses have identified several policies which affect their ability to bring claimants back to work at their fullest potential. Also, district office and national office staff have been discussing the nurses' role during the 60-day period after the claimants' return to work, especially in light of the downsizing of the Federal

government. Among the foremost issues raised are follow-up by the nurse after return to light duty, the effects of surgery, and other kinds of medical situations which may develop.

Until now, the focus of the 60-day return-to-work period has been to ensure that the claimant remains on the job. Where the job is other than full-time full duty, we have not emphasized the need to increase the number of hours of work, or to help the claimant progress from light to full duty. In the period just after return to work, the nurse should remain involved to help the claimant reach higher levels of physical capacity, resulting wherever possible in return to full-time full duty. Toward this end, Claims Examiners (CEs) will now be able to extend the nurses' time beyond the usual 60-day follow up when return to full(er) duty is imminent.

At the same time, it is also clear that delays in returning to work or problems in remaining at work may be caused by other medical conditions, either work-related or not. Nurses sometimes continue working on such cases, but by the time the claimant has recovered from the concurrent condition or surgery and return to work has again become a viable goal, the nurses have often exceeded their allotted 120 days. To remedy this situation, we are instituting an interrupted status for nurse services.

References: FECA PM Chapters 2-600 and 3-201; OWCP Bulletin Nos. 91-2 and 93-6; MEDGUIDE Chapter 1

Purpose: To describe when extensions and interruptions of the Field Nurse's time may be warranted, and the actions which Staff Nurses, Field Nurses and Claims Examiners should take

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

Action: Nurse intervention can result in various outcomes. If the intervention progresses along the normal course, the expected result is that the claimant returns to work within 120-180 days. Action items have been grouped by topic for ease of reference.

LIGHT/PART-TIME DUTY

1. Field Nurses (FNs) should stress to claimants the need to return to maximum functioning and work potential. Return to light duty should be considered just the first step in helping claimants reach their maximum abilities. After the claimant has returned to work, the FN should continue to pursue increases in work tolerance limitations and obtain descriptions of them on Form OWCP-5 at periodic intervals if the claimant does not return to full-time full duty. These attempts should be made at approximately two to three week intervals unless the facts of the case suggest a different plan.

2. After the 60-day follow-up period ends, the FN may continue to work toward full-time full duty if the medical evidence shows that such an outcome is likely. The FN and the Staff Nurse

(SN) should recommend additional time in increments of no more than 30 days each, up to a total of 60 days. The Claims Examiner (CE) must authorize each increment.

3. In authorizing the extension, the CE must note on the Form CA-110 (or other form; see Attachment 1 for a sample) the goals of continued intervention, the steps the CE has directed the FN to take, and the time frame for performing the work. The goals should be consistent with the medical evidence of record, and they must be specific, i.e., framed as a stated number of hours within a stated time frame. The CE should also advise the SN of the extension. See Attachment 2 for a sample tracking sheet, which should be maintained in the case file.

SURGERY AND OTHER MEDICAL ISSUES

4. Return to work may be delayed by the need to obtain a second opinion evaluation. The FN may help the CE or Medical Management Assistant to identify physicians who can perform such examinations on an expedited basis.

5. Return to work may be delayed or interrupted by other medical conditions (work-related or not), by pregnancy, or by surgery. The chart below lists some common surgical procedures and their usual recovery times. As with the medical matrices contained in MEDGUIDE, this information is meant to serve as guidance, not the last word in determining a return to work date.

FB 96-06 Case Management--Role of Registered Nurses in QCM Cases

TTT	TYPE OF SURGERY	PROCEDURE	EXTENSION
A.	Simple, uncomplicated	Endoscopies, diagnostic arthroscopy, herniorrhaphy	30 day extension, for a maximum of 150 days
B.	Moderately complex	Discectomies	60 day extension, for a maximum of 180 days
C.	Very complex surgery or surgery with serious complications	Multiple fusions, open heart surgery, amputation of limb	Work with claimant until stable, then refer for rehabilitation services

In general, the simple procedures should require no more than 8-10 hours of professional nurse services within the 30-day period. The moderately complex procedures will require about 12-16 hours of services within the 60-day period. Since the complex procedures will typically result in work limitations which may warrant referral for vocational rehabilitation services, the FN should

work toward stabilizing the claimant's condition and obtaining Form OWCP-5 in these cases.

6. For a concurrent non-work-related condition, or surgery (whether work-related or not), the SN should determine whether continued FN services will likely be needed within six months.

If so, and the CE concurs, the SN should place the case in interrupted status until the time of expected recovery. (Interrupted status, rather than an extension, is appropriate since the claimant would require little or no active involvement by the FN during this time.)

The FN may not unilaterally interrupt services, and the CE's approval is necessary because any interruption will affect the one-year time frame for resolving the case. Interrupted status should not continue longer than six months. The status code "NIN" (Nurse Interrupt) has been added to the QCM tracking system and is available for immediate use. The Nurse/Rehabilitation Tracking System (N/RTS) will also be modified to accommodate entry of an interrupt status code.

7. During the interruption, the FN should stay in touch with the claimant to monitor medical issues and maintain a focus on return to work. If surgery is involved, the FN will typically review the attending physician's orders with the claimant after surgery and monitor the claimant's course at home. Also, the FN may discuss the post-operative plan with the physician by telephone and monitor the claimant's compliance with these orders. The RN may perform these services up to five hours per month.

MANAGEMENT BY CLAIMS EXAMINERS

8. The CE must assess the medical evidence carefully and use judgment to determine the continuing benefit of the FN's services. For instance, if the medical evidence states that the claimant will be able to work eight hours per day within a month, the situation is straightforward, and the CE may authorize another 30 days of FN services. However, if the claimant has reached a plateau and is unlikely to improve, nurse services should be terminated.

9. Timely responses to telephone calls from FNs are crucial to successful case management. Interventions, whether by telephone or in writing, do not necessarily need to be long and involved. Brief but timely inquiries and reminders to physicians, employing agencies, and RNs are often very effective.

10. The claimant may progress from light to full duty or from four to six or eight hours of work a day, then claim a recurrence of total disability or a relapse which returns the claimant to light duty status or fewer hours of work per day. In addition to developing the claim for recurrence, the CE will need to decide whether the FN should continue to work with the claimant, or whether referral for vocational rehabilitation services is needed. This decision should be based on whether return to work with the Federal employing agency remains feasible, the length of time since the original injury, and the degree of disability.

REFERRAL FOR VOCATIONAL REHABILITATION SERVICES

11. In cases where at 120 days (or sooner) the FN cannot identify any potential for return to the previous employment, the FN must obtain a good description of work tolerance limitations using Form OWCP-5 and then recommend referral for vocational rehabilitation services if there is any ability to work. The FN may also recommend a second opinion examination. The SN may complete Form OWCP-14 to refer the case for vocational rehabilitation services, but may not sign the form. The actual referral remains the CE's responsibility.

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)

REQUEST FOR EXTENSION OF FIELD RN SERVICES

CLAIMANT NAME:_____

FILE NUMBER:_____

NO. OF DAYS REQUESTED:_____

REASON FOR EXTENSION:_____

Change of attending physician
Released to light duty
Monitor RTW full time full duty

FIELD RN INTENDS TO ACCOMPLISH:

CE AUTHORIZATION:_____

DATE:_____

FIELD RN:_____

TELEPHONE NO:_____

FAX NO:_____

Attachment 1

PLANNING CHART FOR QCM CASES

Claimant Name	DOB	DOI	File Number
Accepted Condition(s)			ICD-9 Codes
Date Wage Loss Began	10 Month Letter/ VR Referral Due		Reinstatement Rights Expire
Date RN Assigned	Status at 120 Days		
RN Services	Date/How Long	Reason	Interrupted
	Date/How Long	Reason	
	Date/How Long	Reason	

RN Services Extended	Date/How Long	Reason
	Date/How Long	Reason
	Date/How Long	Reason

For interruptions and extensions which will exceed the date of the 10 month letter, the SCE must initial concurrence with the time frame

Attachment 2

FECA BULLETIN NO. 96-07

FB 96-07 Compensation Pay: Compenation Rate Changes Effective

Issue Date: January 7, 1996

Expiration Date: January 4, 1997

Subject: Compensation Pay: Compensation Rate Changes Effective January 1996.

Background: In December 1995, the President signed an Executive Order implementing a salary increase of two percent in the basic pay for the General Schedule. The applicability under 5 U.S.C. 8112 only applies to the two 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, 1996.

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, 1996. The new maximum compensation rate payable is based on the scheduled salary

of a GS-15, Step 10, which is now $90,090 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 7, 1996	Minimum	Maximum
Monthly	$1,160.25	$5,630.63
Weekly	200.81	1,299.38
Daily(5-day week)	40.16	259.88

The basis for the minimum compensation rates is the salary of $13,923 per annum (GS-2, Step 1) and the basis for the maximum compensation rates is $90,090 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 $1,160.25, effective January 7, 1996. The maximum monthly compensation as provided by 5 U.S.C. 8133(e)(2) is increased to $5,630.63 per month.

Applicability: Appropriate National and District Office personnel.

Reference: Memorandum For Directors of Personnel (CPM 95-10), dated December 29, 1995; and the attachment for the 1996 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 7, 1996, 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 26, 1996.

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, 1996. 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 (later this year these forms will be reproduced):

CA-842

1/07/96	40.16-60.24 40.16-53.55	200.81-301.22 200.81-267.75	40.16	200.81	1,160.25

CA-843

1/07/96	259.88	1,299.38	(5,197.52)	5,630.63

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. 96-08

FB 96-08 Comp Pay/ACPS - Consumer Price Index (CPI) Cost-of-Living

Issue Date: March 1, 1996

Expiration Date: February 28, 1997

Subject: Comp Pay/ACPS - Consumer Price Index (CPI) Cost-of-Living Adjustments for March 1, 1996.

Purpose: To furnish instructions for implementing the CPI adjustments of March 1, 1996.

1. The new CPI increase, adjusted to the nearest one-tenth of one percent, is 2.5 percent.

2. The increase is effective March 1, 1996, and is applicable where disability or death occurred before March 1, 1995.

3. The new base month is December 1995.

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

$ 5,630.63 per month
1,299.38 per week
5,197.52 each four weeks
259.88 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 23, 1996, 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 through March 2, 1996, with the new cycle effective March 3, 1996.

b. The supplemental check date for the periodic disability and death payrolls will be March 19, 1996.

2. Adjustments of Daily Roll Payments. Since the CPI will not be in ACPS until February 23, 1996, 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.

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. 96-09

FB 96-09 Occupational Rehabilitation Programs (ORPS)

Issue Date: June 17, 1996

Expiration Date: June 17, 1997

Subject: Occupational Rehabilitation Programs (ORPs)

Background: There are a great variety of rehabilitation services available to help the injured worker return to work, and to expedite that process through the use of abbreviated workdays or altered job duties. As a group, these services, which were previously known as work hardening or work conditioning, are now defined as Occupational Rehabilitation Programs (ORPs). Although some report significant successes, professionals in rehabilitation concur that the lack of standards in this area make it difficult to identify programs with positive outcomes and reasonable cost.

The substantial increase in the length and cost of such services over the past year has prompted inquiry about their quality, appropriateness, and outcomes. Moreover, these services constitute a workload for district offices. The lack of a coding scheme often results in inappropriate denials, suspensions and fee reductions. Conversely, the lack of codes prevents the application of cost controls. To encourage the use of effective services and to prevent abuse, OWCP has developed guidelines for the authorization and reimbursement of occupational rehabilitation services. These guidelines are intended to aid as a resource for: (1) the selection of claimants who would benefit from these services, (2) the identification of programs that are effective and cost efficient, (3) setting limitations on the length and cost of ORPs, (4) providing methods for monitoring ORPs, and (5) establishing a means to measure program outcomes.

Purpose: To transmit guidelines for the authorization and reimbursement of Occupational Rehabilitation Programs (ORPs).

Applicability: Claims Examiners, Senior Claims Examiners, Hearing Representatives, Supervisors, Technical Assistants, Rehabilitation Specialists, Staff Nurses, Bill Resolution Staff.

Action:

1. Identification of cases which could benefit from these services may arise from various sources:

(a) CEs refer the following cases to the Rehabilitation Specialist for an ORP assessment:

i. cases in which a health care provider has recommended rehabilitation, unless the claimant has already returned to full regular duty,

ii. QCM cases in which the Field Nurse (FN) period has been exhausted but the claimant has not returned to work, and has been determined to have moderate to high physical limitations/deconditioning, or has not had an assessment of physical limitations.

(b) The RS initiates an ORP placement and notifies the responsible CE in any case already open for vocational rehabilitation which, in his or her opinion, may benefit from this type of service.

2. The RS reviews these cases and verifies that they meet the criteria detailed in Chapters 1-2 of the attached Guidelines.

3. Cases referred by the CE that meet the basic criteria are opened for rehabilitation. To open these cases, the RS introduces the appropriate case information in the RTS, using status M (medical rehabilitation), assigns a Rehabilitation Counselor (RC), and selects an ORP facility that meets the provider criteria and is as close as possible tot he claimant's residence. If the case is already in an open rehabilitation status, the RS changes the status to M.

4. The RS refers the case to a RC for a screening interview and the scheduling of a Functional Capacity Evaluation (FCE) to determine the type and character of the ORP most suited to the claimant's needs. As usual, the RS forwards pertinent claim documentation, and a completed Form OWCP-35A to the RC. A Form OWCP-3 with detailed instructions relating to the ORP is also forwarded, accompanied by a completed authorization form for a Functional Capacity Evaluation with an Occupational Rehabilitation Plan (Table I). A maximum of three (3) months and twelve (12) professional hours are allowed for this status.

5. The RC assigned to the case previews the pertinent documentation and performs the claimant interview and categorizes the claimant as a potential candidate for a Return to Work (RTW) or a Work Readiness (WR) ORP in keeping with the criteria set forth in Chapters 2 and 3. The RC schedules a Functional Capacity Evaluation (FCE) in the selected facility and:

(a) Transmits all available information regarding job availability job description(s), the current work tolerance of the claimant and other relevant work site considerations,

(b) advises the facility of the purpose of the FCE, report requirements, and the necessity for a detailed description of any recommended ORP, including treatment schedules and cost,

(c) communicates timeliness requirements and instructions for billing, and sends a copy of the ORP-FCE authorization form (Table I).

6. Once the FCE is completed, the RC forwards the facility report with his or her own brief report, which should contain recommendations for actions. Based on these documents, and using the criteria detailed

in Chapter 3, the RS selects and authorizes the appropriate ORP "class" for the claimant. He or she advises the facility and the RC of the types and number of services authorized. Tables II or III should be used for this purpose. Additionally, the RS or RC provides instructions on billing procedures and requirements, and informs the facility about the applicable price maxima.

7. The RS or another DO staff enters the authorization for the ORP in the "notes" section of the Claimant Management File (CMF). To ensure the accurate processing of facility bills, the following information must be included: the approved ORP category (RTW vs. WR) and class, the date range for the approved services. If additional services, such as work-site visits, or the use of modifiers are approved, a notation to this effect must be also included (See Guidelines, Chapter 4).

8. Once the particular program has been authorized and the claimant is enrolled in the ORP, the treating physician, employer (when available), the RC and the CE are notified using a Form OWCP-3.

9. The RC continues to act as a liaison with the ORP facility and he or she works with the claimant to ensure attendance and to resolve issues that arise during the ORP which may interfere with the completion of the program. Medical or other issues which could delay or terminate the ORP, such as the appearance of non-work related conditions, recurrences, complaints of high levels of pain, etc. have to be reported immediately to the RS and CE.

10. The RC provides reports as established in the district office, including a brief summary of the ORP activities, the progress of the claimant, problems awaiting resolution, and expected completion date. All request for extension of services or the provision of additional services such as work-site visits, follow-up treatments and the use of modifiers, should be reviewed and decisioned by the RS.

11. The RC must notify the RS immediately when an ORP is completed and he or she forwards the ORP final report to the RS as soon as this document is available. As a response, the RS changes the status to W, Placement Previous Employer with Services, to P, Placement New Employer, or to T, Training, as warranted in the particular case. The RS transmits this change and further instructions to the RC using a Form OWCP-3.

12. In instances where the results of the ORP indicate that the claimant is not able to perform the duties of the previous employment or the targeted jobs, the RS may place the case in D, Plan Development, with the concurrence of the CE to consider other rehabilitation solutions. In instances where the result of the ORP indicate that the claimant is <u>able</u> to perform the duties of the date of injury job, the RS should notify the CE immediately. Alternatively, the RS may select other options (eg. recommend the application of sanctions or the performance of a second opinion) and forwards the case to the CE.

13. When the ORP is interrupted before completion, the RC notifies the RS immediately, carefully detailing the reason(s) for the interruption. The RS communicates this fact to the CE and recommends an appropriate course of action based on the circumstances of the case. He or she also includes mention of this event in the CMF "NOTES", and change the approved last date of service to coincide with the date of the interruption.

14. Processing of ORP Facility Bills.

(a) Bills from an ORP facility that is providing authorized services are "prompt pay" bills.

(b) Facilities should submit a single global bill at the end of the ORP on a Form HCFA-1500 or UB-92. The bill should contain all the data elements required to process bills through the automated bill processing system, including: the claimant's name, address, and claim file number; and the provider's name, address, and EIN. In addition, the provider must include the

pertinent OWCP ORP codes, with the corresponding units (hours), the amount billed code, and the total amount of the bill.

(c) Because these bills will contain unique alphanumeric codes, they can be identified and batched together prior to data entry. Once data entered, the bill lines will fail Error Code 302, and manual resolution will be required to process them to completion. To resolve these suspensions, the designated district office staff should access the CMF "Notes" and verify whether an ORP has been authorized. If so, the codes on the bill are matched against the ORP category (RTW vs. WR) and "class", and the dates of services on the bill are matched against the authorization period present in the "Notes". If a line meets the above conditions, the edit failure is overridden.

(d) If a line does not meet the above condition, the bill resolver forwards the bill to the district office staff responsible for the resolution of problematic rehabilitation bills. This other staff consult with the RS and the facility as necessary and take appropriate action.

Disposition: Retain until the indicated expiration date.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Distribution: List No. 1
(Claims Examiners, All Supervisors, District Medical Advisors, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

Attachment

FECA BULLETIN NO. 96-10

FB 96-10 Adjudication of Claims: Use of Incorrect Form

Issue Date: May 9, 1996

Expiration Date: May 8, 1997

Subject: Adjudication of Claims: Use of Incorrect Form

Background: In examining cases received in the Branch of Hearings and Review, National Office staff have increasingly noticed that claims are sometimes denied because they are filed on the incorrect form, without substantive development. For example, Form CA-1 may be submitted to claim a recurrence, or Form CA-2a may be submitted for another episode of a condition for which a Form CA-2 is already on file. (With respect to the latter instance, see FECA PM Chapter 1500.3b(2)(e), which states that a new claim need not be filed.)

Submission of an incorrect form is only a technical error, and it is improper to deny a case simply because the claimant has not submitted the correct form. The case should be developed and adjudicated

on the basis of the evidence submitted. Moreover, to the extent possible, the same Claims Examiner should handle all claims involving the same part of the body for a given claimant.

Reference: FECA PM Chapters 2-400.8, 2-800.4 and 2-1500.3

Purpose: To describe actions to be taken when an injury, illness or recurrence of disability is claimed using an incorrect form

Applicability: All Claims Examiners, Supervisors, and Technical Assistants

Action:

1. As indicated in FECA PM 2-800.4, if a Form CA-1, Form CA-2 or Form CA-2a is incorrectly submitted in place of another form, the Claims Examiner (CE) should develop the claim based on the facts at hand. The development letter should include a request that the claimant complete the proper form, and the CE should include a blank copy of the proper form with the current claim number written in large letters on the top of the form.

2. The CE should not deny the case on the basis of the form filed, even if the case is technically in posture for denial. For instance, if Form CA-1 is received and Form CA-2 is actually required, the CE should not deny the case on the basis that fact of injury is not established.

3. However, if Form CA-1 has been submitted in error, it may be necessary to deny payment of continuation of pay. This action may be taken in conjunction with the development letter. 4. When the requested Form CA-1 or CA-2 has been received, the Case Management Record should be changed to reflect the correct form, so that the adjudication time frame for the case will be accurate. A case previously entered into the Disability Tracking System in error should be removed. Similarly, if Form CA-2a was requested and received, the case should be entered into the Disability Tracking System.

5. The CE should evaluate the evidence as a whole as it pertains to a given part of the body. To do so, case doubling may be necessary. FECA PM 2-400.8 describes the current criteria for doubling cases, which are being modified to include the following situations:

a. A new injury is reported for an employee who has filed a previous injury claim for a similar condition;

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

c. Adjudication or other processing of a case will require frequent reference to an earlier case for a dissimilar condition. Cases of this nature include those where problems arise with bill pay and/or mail placement, such as when the same physician is treating the claimant for more than one injury; and those with overlapping periods of disability.

Cases should be doubled as soon as they are identified as proper to double. Changes of responsible CE should be avoided if possible.

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. 96-11

FB 96-11 Compensation - Revised Leave Buy-Back Procedures

Issue Date: July 9, 1996

Expiration Date: July 8, 1997

Subject: Compensation - Revised Leave Buy-Back Procedures

Background: In February 1995, a team of OWCP employees met in Washington D.C. to reinvent the current leave buy back (LBB) procedures.

Surveys of OWCP employees indicated that the existing LBB process was cumbersome and time-consuming for claims examiners, and often confusing for both injured workers and federal employing agency staff. In addition, data shows that only about one-half of claimants elect to repurchase their leave after the CA-1207 is issued and they become aware of the additional payment the agency requires beyond the amount of their FECA entitlement.

A decision was made to simplify the current procedures from a two step process to a one step process, with the CE issuing an immediate payment (instead of a CA-1207) where possible.

Two new forms, a Time Analysis Form (CA-7a) and a Worksheet/ Certification and Election Form (CA-7b), have been developed to be filed with Form CA-7 in LBB claims. The new form CA-7a is to be used when leave dates are intermittent or when more than one continuous period of leave is claimed. The CA-7b fully explains the process to the claimant and allows an estimate of the FECA entitlement. It requires the employing agency to advise the employee of the amount required by the agency to reinstate the leave in question and to agree to the process in advance of submission of the form. Based on past experience with non-returned EN-1207s, many claimants will decide at this point not to file the claim when they become aware of the balance they must pay to have their leave restored.

The revised CA-7 claim form refers the claimant to new forms CA-7a if time was lost for intermittent hours or days and CA-7b for leave repurchase. These forms are supplements to the CA-7 and a CA-7 must be submitted as part of the claim. If the claim is incomplete, it may be returned to the employer for completion and tracking is not required, as with current practice.

Unless there is a significant variance between the agency estimate of FECA entitlement and the actual entitlement, the LBB claim can be paid immediately upon receipt of the completed claim providing the medical evidence supports injury related time loss for each date claimed. A significant variance exists where the estimated entitlement is more than 10% above the actual entitlement. If there is a significant variance between the agency estimate and the CE's calculation and supporting medical evidence has been provided for all hours claimed, the CE advises the claimant of this via CA-1207 and requires return

of a signed EN-1207 election before the claim is paid. If there is a 10% variance and medical evidence has not been provided for some or all of the hours claimed, the CE will develop the medical status before proceeding further. Please see item 7 under "Action" for a more detailed explanation.

If the estimated entitlement was calculated accurately but there is insufficient medical evidence to support all hours claimed, the CE will process the claim for the verified hours.

ACPS will be updated to include a relationship code "LB" which will automatically generate the correct agency payee address for leave buy back. The claims examiner will have the option of automatic or manual generation of a revised Form Letter CA-1208. If the claim is payable as presented, the automatically generated CA-1208 will be used. If only a portion of the claim is payable, the CE will generate a manual version of the CA-1208 (designated CA-1208a) and enter text concerning the unpaid periods.

The CA-7b instructions request the claimant to submit the LBB claim within one year of the date the leave was used or the claim was accepted, whichever is later. While the CA-7b instructions are designed to encourage more timely submission, claims older than one year cannot be denied on that basis.

The CA-7b instructions also request that claims be submitted for a minimum of ten hours of leave unless no further claims are anticipated. This is intended to reduce the frequency of claims and time required for processing by both the agency and OWCP.

This revised LBB process enables the examiner to resolve most LBB claims to conclusion upon initial submission, even where payment is not made for all dates claimed.

Copies of the new CA-7a, CA-7b, CA-1207, CA-1208, and CA-1208a form letters are attached.

Purpose: To provide instructions for implementing streamlined leave buy-back processing.

Applicability: Claims examiners, Supervisors, Systems Managers, Technical assistants, Fiscal Personnel, and other appropriate staff of the National and District Offices, and the Branch of Hearings and Review.

Reference: 20 CFR 10.310, Buy back of annual or sick leave Federal (FECA) Procedure Manual, Chap 2-901 (13) Comptroller General decision B-112786, January 26, 1953

Action: Each office Systems Manager or other designated staff
will enter specific agency addresses for LBB payments into a new LBB address maintenance table.

Effective August 1, 1996, except as noted in paragraph 8 (below), LBB claims will be processed as follows:

1. On receipt of the agency certified LBB claim (CA-7, CA-7a, CA-7b) mailroom staff will key it into the TPCUP system and deliver it to the office designated location.

2. The CE will review the claim to insure it is complete. If the claim is incomplete or unsigned, the CE will return the claim for completion. The CE will advise the claimant by letter as to what was missing and document the case file with a copy of the letter. Returned claims do not have to be tracked and can be deleted from TPCUP as with current practice.

3. When the FECA District Office receives the package, the CE will first review the estimate of FECA entitlement on the CA-7b. If the estimate of entitlement is within 10% of the amount determined to be accurate by the CE, the CE proceeds to review the supporting medical evidence.

For example, let us assume that the agency has estimated FECA entitlement to be $1500 for 100 hours of leave use. The CE, using the correct pay rate and compensation rate, determines the correct amount to be $1470 for those hours. Since the agency's estimate is less than 10% above the correct amount, the CE will proceed to evaluate the medical evidence.

4. If the claim is payable for all hours claimed, the CE will round the total number of hours payable to the nearest whole hour, key the payment using relationship code "LB", and obtain payment certification. Entry of the relationship code "LB" will cause the payment to be made to the agency address designated for LBB payments (this may be the same as the agency correspondence address). Answer "yes" to the system prompt for automatic generation of the CA-1208. This action will automatically generate the revised form letter CA-1208 to the claimant and agency showing that the claim was accepted in full with the inclusive dates and amount of the payment made. The CA-1208 will not have to be signed by the CE and can be mailed by other staff.

In rare situations, the total FECA entitlement will exceed the amount owed by the claimant to the employing agency. In these instances, the employing agency will pay the claimant any balance due.

5. Where there is medical support for some but not all of the hours claimed, the CE will key a payment for the approved hours.

Using the example in 3 (above), if medical evidence only supports 80 of the 100 hours claimed, the CE will key the payment for the 80 approved hours, and will manually generate Form Letter CA-1208a. Even though we are not paying all of the hours claimed, payment can be made because the amount actually paid will be proportionately the exact same percentage of the agency estimate of FECA benefits.

The Letter CA-1208a will show the total number of hours approved and the inclusive dates, with a freeflow entry explaining any additional hours not approved for payment. The CE will enter a TPCUP "D1" code. This will close out OWCP processing of that particular leave buy back claim. If the claimant is able to obtain medical support for the unpaid hours, he/she may initiate a new leave buy back claim specifically for those hours.

6. If medical evidence received is insufficient to support payment of the hours claimed, the CE will defer a decision on the claim. The claimant will be advised in writing of the deficiency of the claim and given 30 days to provide the supporting evidence.

If medical evidence is received in response to the request, the CE will evaluate it and proceed as outlined in paragraph 4 or 5 above.

If no medical evidence is received or if the evidence is not sufficient to establish entitlement for any of the hours, the CE will deny the leave buy back claim by formal decision.

7. If the employing agency's estimate of FECA entitlement differs from the CE's calculation of the correct amount by more than 10%, the CE will review the medical evidence before proceeding further.

Using the example in 3 with the agency estimate of $1500, let us assume that the CE determines the correct amount of FECA entitlement to be $1250 for the hours claimed. Since this is a variance of more than 10%, the CE will proceed as shown below after evaluating the medical evidence.

If there is medical evidence for all hours claimed, the CE will issue a letter CA-1207 showing the correct entitlement amount. If the claimant still wishes to pursue leave repurchase, he/she will then complete

his/her portion of the enclosure EN-1207 and return it to the employing agency. If the parties reach an agreement on restoration of leave, the agency will complete its portion of the EN-1207 and forward the completed form to OWCP. The CE will then issue a compensation payment to the agency and release letter CA-1208 to the claimant, with a copy to the agency.

Where the medical evidence is insufficient to support all of the hours claimed, the CE will defer payment of the claim and send the claimant a narrative letter requesting additional medical documentation. The CE may also contact the employer if there is a question as to the correct pay rate to be used.

If there is no medical evidence to support any of the hours claimed, the CE will deny the leave buy back claim by formal decision.

8. District offices will use the old procedures to process LBB claims filed with the employing agency in the old format prior to 10/1/96, and will not require these to be resubmitted in the new format. The old form CA-1207 has been modified to advise parties of the new process and has been renumbered as CA-1206, and will be used to process these old claims.

9. All District Offices will conduct training on this bulletin prior to August 1, 1996. Please address any questions on any of this material to Cecile Moran (202) 219-8461 or email cmf@fenix2.

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

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)

DRAFT//////////////////////DRAFT/////////////////DRAFT

Month 9, 1999

File Number: 99999999
Date of Injury: 99/99/1999
Employee: FIRSTNAME M. LASTNAME
SSN:

claimant name/address
00000000000000000000
00000000000000000000

Dear FIRSTNAME M. LASTNAME:

Your claim for compensation to repurchase leave for the period indicated below has been approved in full.

This payment is based on your weekly salary of ($ ENTERED BY SEQUENT), as of (effective date of payrate used, ENTERED BY SEQUENT). This is paid at the rate of (the without dependents rate of 66 2/3rds, OR 75%, as you have one or more dependents - ENTERED BY SEQUENT).

The amount of compensation paid and the period covered are shown below. The full FECA payment has

been made directly to your employing agency at the address below. If you have not already done so, you must make arrangements with your employing agency to pay any balance due for the repurchase of your leave. If your FECA entitlement exceeds the total amount required by your agency, your agency will pay you any balance due.

FECA compensation paid: $ (ENTERED BY SEQUENT)

Period covered by payment: 00/00/0000 to 00/00/0000 (ENTERED BY SEQUENT)

Sincerely,

Fname M. Lname
Claims Examiner

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COPY TWO TO ??????????????????
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C11
CA12-08-0896

Month 9, 1999

File Number: 999999999
Date of Injury: 99/99/1999
Employee: FIRSTNAME M. LASTNAME
SSN:

claimant name/address
000000000000000000000
000000000000000000000

Dear FIRSTNAME M. LASTNAME:

Your claim for compensation to repurchase leave for the period indicated below has been approved in part.

This partial payment is based on your weekly salary of ($ entered by CE), as of (effective date of payrate used, entered by CE). This is paid at the rate of (the without dependents rate of 66 2/3rds, OR 75%, as you have one or more dependents - entered by CE).

The amount of compensation paid and the period covered are shown below. The FECA payment has been made directly to your employing agency at the address below. If you have not already done so, you must make arrangements with your employing agency to pay any balance due for the approved period. If your FECA entitlement exceeds the total amount required by your agency for the approved period, your agency will pay you any balance due.

FECA compensation paid: $ (entered by CE)

Period covered by payment: 00/00/0000 to 00/00/0000 (entered by CE)

We are unable to approve payment for the following dates and/or number of hours for the reasons stated:
FREEFLOW TEXT UP TO 10 LINES
2
3
4
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10

If you wish to pursue a claim for the unpaid time, please submit a new claim for the balance along with medical or other evidence relating to the reason for non payment.

Sincerely,

Fname M. Lname
Claims Examiner

COPY ONE NAME AND ADDRESS	COPY TWO NAME AND ADDRESS
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000000000000000000000000	000000000000000000000000
000000000000000000000000	000000000000000000000000
000000000000000000000000	000000000000000000000000

C11

CA1208a-0896

Month 9, 1999

File Number: 99999999
Date of Injury: 99/99/1999
Employee: FIRSTNAME M. LASTNAME

claimant name/address SSN:
00000000000000000000
00000000000000000000

Dear FIRSTNAME M. LASTNAME:

This refers to your claim for compensation for leave buyback for the period (to/from dates manually entered by CE).

Your agency's estimate of your FECA entitlement exceeded your actual entitlement by more than 10% Therefore, we must advise you of your actual entitlement, and require your election as whether you desire to pursue your claim since you must pay a greater amount to your employing agency than originally estimated.

Your actual entitlement is calculated as follows:

a. Weekly pay rate as of (DOI, DDB, DOR as entered manually by CE) $_____

b. Above weekly pay times either 2/3 (if no dependents) or 3/4 (with dependents) $_____

c. Number of leave hours approved for buyback ____hrs

d. Total hours worked per week (see CA 7b, item F) ____hrs

e. TOTAL actual FECA entitlement (B above times C above divided by D) $_____

Calculation for payment due to employing agency by employee

1. Total amount required by your agency to recredit leave $_____

2. Actual FECA entitlement in (e) above $_____

3. Amount you owe your agency Item (1) LESS item (2) $_____

If you desire to proceed with you claim, please complete the staement below, give a copy to your agency, and return the original to us. We will assume you do not desire to pursue your claim if your signed statement is not returned to us.

Sincerely,

Fname M. Lname
Claims Examiner

TO OWCP: I desire to proceed with my claim, and have made arangements to refund all leave pay received.

Signed_____ Date_____

COPY ONE NAME AND ADDRESS
000000000000000000000000
000000000000000000000000
000000000000000000000000
000000000000000000000000

COPY TWO NAME AND ADDRESS
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000000000000000000000000
000000000000000000000000
000000000000000000000000

C11

CA1207-0896

FB 96-11 Compensation - Revised Leave Buy-Back Procedures
TIME ANALYSIS FORM

EMPLOYEE STATEMENT - Please carefully read instructions on reverse

1. Name of Employee Last First Middle **2. SSN** **3. OWCP File Number**

4. Period covered by this form

From ___/___/___ To ___/___/___

5. Total Hours Claimed

for LWOP _____

for leave buyback _____

6. In "Type Leave" column use codes "S"=sick, "A"=annual, "O"=other If compensation is claimed for date, indicate "Yes" in "COMP claimed" column.

DATES	COMP CLAIMED?	NUMBER OF HOURS				TYPE LEAVE	Reason For Leave Use/Remarks (e.g.,DR visit, therapy)
		LWOP	Worked	Ho1	LVE		
TOTALS							

Signature of Claimant Date Signed

7. AGENCY STATEMENT/CERTIFICATION: I certify the above is accurate, except as follows:

Signature Agency Official Date Signed

CA-7a

INSTRUCTIONS FOR COMPLETING FORM CA-7A
LEAVE ANALYSIS

GENERAL: This form is used when claiming FECA compensation, including for repurchase of paid leave. It must be used when claiming compensation for more than one consecutive period of leave.

INSTRUCTIONS FOR EMPLOYEE:

Blocks 1, 2 and 3 are self-explanatory.

Block 4:indicate beginning and ending dates covered by this form. These must be the same as on forms CA-7 and CA-7b.

Block 5:if claiming compensation for any dates detailed in block 5, state total number of hours claimed for leave without pay and total number of hours of leave. This should be at least 10 hours unless this is your final claim.

Block 6:

1st Column: Show full date

2nd Column: For each date noted in column 1, state Y if you are claiming compensation for that date and N of you are not.

3rd, 4th, 5th and 6th columns: Show the number of hours of LWOP, number of hours worked, paid holiday hours, and number of hours of paid leave.

7th Column: Using the legend provided, indicate the type of leave used.

8th Column: State the reason you were off work. For each date for which compensation is claimed, there must be medical evidence supporting entitlement.

SIGN AND DATE FORM AND SUBMIT TO THE APPROPRIATE AGENCY OFFICIAL.

INSTRUCTIONS FOR EMPLOYING AGENCY

Block 7: Verify accuracy of hours and status for each date listed. If challenging entitlement for any date, attempt to resolve discrepancies prior to submitting the claim to OWCP. If discrepancy cannot be resolved, indicate the specific basis for the challenge in the space provided.

LBB WORKSHEET/CERTIFICATION AND ELECTION FORM

A. Name of Employee: Last First Middle B. OWCP File No.

C. Social Sec. No.

D. Period for which compensation is claimed to repurchase leave
From ___/___/___ To____/____/____

I. AGENCY ESTIMATE OF FECA ENTITLEMENT:

A. WEEKLY BASE PAYRATE (excluding overtime)

- o Date of Injury ___/ /___ $_____
- o Date Stopped Work ___/ /___ $_____
- o Date of Recurrence ___/ /___ $_____

Enter the greatest amount & the effective date of that amount on line 1. 1. _____ _____

___/___/___
(eff. date)

B. ADDITIONS TO BASE PAY: If employee works a regular schedule, state the amount earned weekly. If irregular schedule, state amount earned 1 year prior to date entered on line 1 ö by 52.

- o Night Differential 2. _____
- o Sunday Premium 3. _____
- o Subsistence/Quarters 4. _____
- o Other (specify) 5. _____

C. TOTAL WEEKLY PAYRATE (Add lines 1 thru 5) 6. _____

D. COMPENSATION RATE (Circle either 2/3 or 3/4) 7. 2/3 3/4

E. TOTAL HOURS CLAIMED ON CA-7a 8. _____

F. TOTAL HOURS WORKED PER WEEK 9. _____

G. FORMULA (FOR FECA ENTITLEMENT)

$_____ X _____ X _____-- _____ = 10. $_____
(Wkly Payrate - (Comp Rate - see line 6) (Hrs - see line 7) (Hrs Wkd/wk - see line 8) see line 9)

II. AGENCY CERTIFICATION:

H. Total amount due agency to repurchase leave 11. $ _____

I. Estimate of FECA entitlement (See Line 10) 12. $ _____

J. Balance due Agency from Employee 13. $ _____
(Line H minus Line I)

I hereby certify that the above is consistent with agency payroll records.

The employing agency agrees to allow the employee to repurchase his/her leave. Leave records will be, or have been, changed from "Leave With Pay" to "Leave Without Pay" for the period shown on the leave analysis.

I further certify that if this claim is signed by the employee, the employee has made arrangements to pay the agency the balance between the total amount the agency requires to recredit leave and the amount of the FECA entitlement.

_____ _____
(Signature of Agency Official) (Title/Position)

Phone No:_____ Date Signed_____

Employing Agency Address for Check: _____
_____
_____

III. EMPLOYEE CLAIM

____ **K**. I hereby elect **NOT** to repurchase the leave used at this time.

____ **L**. I hereby elect FECA compensation to repurchase leave used for medical care or disability resulting from my job-related injury or condition.

I understand that I am responsible for paying my agency the difference between the FECA entitlement and the amount my agency requires to restore my leave, and have done or made arrangements for this.

I understand that if my actual entitlement to FECA compensation is within 10% of the amount estimated above, OWCP will process the leave buy back. If the payrate used in the worksheet above is within 10% of the payrate determined by FECA, and less than the full period claimed is approved, OWCP will process payment for the approved period.

_____ _____
(Signature of Claimant) (Date Signed)

INSTRUCTIONS FOR FORM CA-7B, LEAVE BUY BACK WORKSHEET

This form is intended to accompany Form CA-7, Claim for Compensation, when the employee is claiming leave buy back.

THINGS TO KNOW ABOUT LEAVE BUY BACK: When an employee uses their sick or annual leave to cover an injury-related absence from work, they may elect to receive compensation instead. Compensation is paid at 2/3 of the employee's base pay if there are no eligible dependents, or at 3/4 with 1 or more dependents. The agency pays leave at 100% of salary. In order for leave to be reinstated, the employee must refund to the agency the difference between the compensation entitlement and the total amount of leave paid by the agency.

The employee's pay status must be changed to LWOP in order for compensation to be paid. Leave is not earned while in LWOP. Also, contributions to the Thrift Savings Plan (TSP) are not made during LWOP. Therefore, the repurchase of leave may result in a reduction in an employee's leave and/or TSP balance. Consult your personnel office to learn how the change to LWOP would effect you.

When a Leave Buy Back (LBB) payment is made during the same year that leave is used, the employee's earnings are reduced by the amount repaid, and tax is not paid for the compensation received. Where leave repurchase is not completed during the same year in which leave is used, the employee may not adjust their prior year tax form. They may only claim the amount of leave paid as an employee expense, if they itemize deductions. Further questions regarding tax implications of LBB should be addressed to the IRS.

A claimant may not repurchase leave used during a period they were eligible for COP.

When disability does not exceed 14 days beyond the COP period, 3 day LWOP must be charged before compensation can be paid. If leave was used for this period, compensation can not be paid for the 3 days, but the claimant will have to pay back leave paid during the 3 days to repurchase the leave.

INSTRUCTIONS TO THE EMPLOYEE:

Please submit a claim for a minimum of 10 hours unless no further claim is anticipated. Medical documentation must be provided for all dates claimed.

1. Complete the Form Ca-7 for the dates claimed. Where more than one continuous period of leave is claimed, complete From CA-7a following the instructions for completing that form.

2. Submit the completed CA-7, CA-7a, if appropriate, and medical documentation for all dates claimed, to your agency official. If there are discrepancies, try to reconcile the difference with your agency official prior to submission of the claim.

3. The agency official will provide you with an estimate of worker's compensation benefits due, the total amount owed the agency in order for the leave to be restored, and the amount you must pay the agency. Using this information, determine whether you wish to repurchase your leave, and check the appropriate block. If you choose to repurchase the leave, you will be required to pay to the agency the difference between the compensation due and the amount owed to the agency.

> a) If the total amount of FECA benefits estimated by the agency is not more than 10% above the amount determined by OWCP to be accurate, OWCP will process a payment for all hours supported by medical evidence. If medical evidence supports some, but not all of the hours claimed, payment will be made for the approved hours. You may submit a new claim with medical support for the additional hours.
>
> c) If the total amount of FECA benefits estimated by the agency is more than 10% above the correct amount, OWCP will not process the payment. Instead, the Office will offer you a new election with the correct amount of FECA benefits payable.

INSTRUCTIONS TO THE AGENCY:

Items A through D (top of form) are self-explanatory.

Section I (Agency Estimate of FECA Entitlement):

Item A: Enter all three pay rate types and effective dates if applicable. Choose the greatest amount of the three and enter the amount and effective date in Line 1. A recurrent pay rate should only be used if: (1) the employee stops work more than 6 months following their first return to regular, full time duty and (2) the loss of time is due to disability rather than medical examinations or treatment.

For unusual situations, please refer to Payrate Desk Aid.

Item B: If the employee works a regular schedule, enter the differentials earned weekly. If an irregular schedule, give the total amount earned for the year prior to the date in Line 1 divided by the number of weeks worked in that year.

Please refer to Payrate Desk Aid for guidance on inclusions and exclusions. If in doubt, consult a Claims Examiner.

Item C: Add lines 1 through 5 and enter the total in Line 6.

Item D: Circle the appropriate rate: 2/3 for employees without dependents; 3/4 with dependents. Dependents include: spouse; children under 18 living with or supported by the employee; children under 23 in school full time; children over 18 incapable of self support; and parents wholly supported by the employee.

Item E: Enter the total hours **claimed**, from Form CA-7a.

Item F: Enter the total hours in the employee's normal work week.

Item G. Formula For FECA Entitlement: Use this formula to calculate estimate of FECA entitlement and enter the result in Line 10.

Example of computation: The weekly pay from line 6 is $574.00. The employee is married, works 40 hours a week, and is claiming 82 hours of leave. FECA entitlement is calculated as follows:

$574.00 x 3/4 x 82 hrs -- 40 hrs = $882.52

II. Agency Certification

Item H & I are self explanatory. For Line J, subtract Line I from Line H.

Sign and date and advise the employee of the amount they owe to the agency.

III. Employee Claim: If the employee elects not to repurchase the leave, retain the form in the agency files. If the employee elects to repurchase the leave, submit all claim documents (CA-7, CA-7a & CA-7b) plus any medical documentation too OWCP for processing.

FECA BULLETIN NO. 96-12

FB 96-12 OWCP Guidelines for General Purpose Functional Capacity

Issue Date: June 30, 1996

Expiration Date: June 29, 1997

Subject: OWCP Guidelines for General Purpose Functional Capacity Evaluations

Background: District offices report significant variability in the content, cost and quality of the Functional Capacity Evaluations (FCE's) provided to injured Federal workers. In addition, because there are no well-structured codes for these various services, processing of FCE bills often involves edit failures, manual resolutions, inappropriate fee schedule reductions, as well as telephone calls and letters from providers. To ensure the quality of these services, control their cost, and simplify the processing of bills, OWCP has developed guidelines for the authorization, evaluation, and payment of FCE's.

Under these guidelines, FCE's can be classified in two primary types according to their purpose, duration and content: (1) a general purpose GP-FCE, and (2) an FCE for placement into an Occupational Rehabilitation Program (ORP-FCE) such as Return to Work or Work Readiness (commonly called work-hardening, work conditioning, etc.). This bulletin discusses the General Purpose FCE (GP-FCE) while the FCE's associated with rehabilitation services are described in Bulletin No. 96-9.

Purpose: To transmit procedures and guidelines for the authorization and reimbursement of General Purpose Functional Capacity Evaluations (GP-FCE's).

Applicability: Claims Examiners, Senior Claims Examiners, Hearing Representatives, Technical Assistants, Rehabilitation Specialists, Staff Nurses, and Bill Resolution staff.

Action:

1. A CE or Staff Nurse (SN) may authorize a GP-FCE in the following instances:

    a. QCM cases undergoing nurse intervention where the treating physician recommends a FCE;

    b. cases where management of disability call for clarification of job tolerances, job modifications, etc. and the treating physician, or the second opinion or referee specialist recommend or require this service.

2. Before authorizing the FCE, the CE or SN reviews the case and verifies that: the injury is greater than 3 months old, the functional impairment is of moderate to high complexity, and the services recommended by the physician exceed routine physical performance tests and measurements (e.g. CPT 97750).

3. The CE or SN authorizes the FCE and communicates the approval to the recommending physician, who in turn, makes the referral after requesting the name of a FCE facility. Based on the severity of the case, and the presence or absence of complicating factors, the CE or SN can approve up to eight hours for the GP-FCE.

4. The CE or SN completes the authorization form (Table A) and enters the authorization in the "Notes" section of the Case Management File (CMF). To ensure the accurate processing of facility bills, the following information must be included: the approved service code, the number of hours approved, the name of the provider, and, as necessary, the use of modifiers. He or she notifies the Field Nurse (FN) assigned to the case of the authorization of the FCE and provides the FN with a copy of the authorization.

5. After the FCE referral has been made, the FN conducts a brief telephone interview with the claimant to explain the purpose and expected content of the FCE, and to discuss any concerns the claimant has voiced regarding the FCE, expectations pending the outcome of the FCE, and related issues such as return to work. The claimant is to be made aware of his or her responsibilities regarding attendance, effort and cooperation.

6. The FN schedules the FCE in the selected facility and:

(a) transmits medical and work site information as necessary to the facility,

(b) advises the facility of the purpose of the FCE, the program's requirements regarding the content and timeliness of the facility's report,

(c) provides instructions for billing, and sends copy of the FCE authorization form.

(d) continues to be available to the claimant and the facility to resolve issues that may arise during the performance of the FCE.

7. It is expected that the GP-FCE report will be submitted to the CE or SN within three working days after completion of the evaluation and that it will meet OWCP guidelines (see Table B). Recommendations detailed in the GP-FCE report are evaluated by the CE in light of the nature of the case and the status of other case management procedures. If recommendations are made for a Return to Work or a Work Readiness Occupational Rehabilitation Program, the case is referred to the RS as described in Bulletin No. 96-9.

8. Processing of GP-FCE bills.

(a) Bills from a facility that is providing authorized services are "prompt pay" bills.

(b) The facility should submit a single global bill for the GP-FCE on a Form HCFA-1500 or UB-92. It should contain all the data elements required to process bills through the automated bill processing system, including: the claimant's name, address, and claim file number; and the provider's name address and EIN. In addition, the provider must include the pertinent OWCP service code with the corresponding units (hours) and amount billed.

(c) Because these bills will contain unique alphanumeric codes, they can be identified and batched together prior to data entry. Once data entered, the procedure code will fail Error Code 302, and manual resolution will be required to process the bill to completion. To resolve these suspensions, the designated district office staff should access the CMF "Notes" and verify whether the service has been previously authorized. If so, the date(s) of service on the bill is matched against the authorized date(s) in the "Notes". If a line meets these conditions, the edit failure is overriden.

(d) If a line does not meet the above condition, the bill resolver forwards the bill to the district office staff responsible for the resolution of problematic prompt pay bills. This other staff will consult with the CE, SN and/or facility as necessary and take appropriate action.

Disposition: This bulletin is to be retained in the OWCP (FECA) Procedure Manual until further notice or the indicated expiration date.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

TABLE B
DEFINITIONS AND GUIDELINES FOR GENERAL PURPOSE FUNCTIONAL CAPACITY EVALUATIONS (GP-FCEs)

A GP-FCE consists of a series of physical and behavioral tests, measurements, and evaluations. A GP-FCE includes the following evaluations and measurements:

* Functional work capacity
* Musculoskeletal status/strength measurements
* Cardiovascular status
* Cognitive status
* Behavioral/attitudinal status, and psychologic-readiness/ barriers to return to work, routinely conducted under FCE's
* Work tolerance assessments for a specific job and/or vocational options
* Other assessments as specified by the requesting claim manager

The GP-FCE Report includes the following information:

* Description of evaluation performed
* Test, and measurement results, both raw and tabulated data
* Normative values where available
* Work capacity assessment findings
* Activity restrictions when applicable
* Attitudinal status, psychologic/behavior work-readiness evaluation results
* Vocational status of claimant related to targeted jobs, including accommodation or safety issues, and other factors as relevant
* Recommendations regarding therapy needs when indicated and/or requested, such as enrollment in an occupational rehabilitation program, physical conditioning exercises, pain management techniques, or other restorative services with comments on expectations for outcomes.

When a claimant is being evaluated for an Occupational Rehabilitation Program (ORP), the FCE is specifically tailored to help identify the health care and rehabilitation needs of the claimant who is transitioning back to work. A description of FCE's for ORP's is found in FECA Bulletin No. 96-9.

TABLE C
GENERAL PURPOSE FUNCTIONAL CAPACITY EVALUATION (GP-FCE)
PROCEDURE CODES, MODIFIERS AND MAXIMA ALLOWABLES

	RVU Work	RVU Overhead	RVU Mal-practice

Type of Service:	GP-FCE			
Procedure Code:	RE100	46.73	41.68	5.04
Conversion Factor:	1.00			
Units:	Hour			
Modifier Code: (RE10010)	10	Allows for a 20% differential of the total allowable amount after geographic adjustment		

Services authorized: The purpose and the established goals for the GP-FCE, and the claimant's physical limitations and deconditioning influence the duration and the complexity of the evaluation required to complete a FCE of high quality. Four to eight hours may be authorized for the GP-FCE. The authorization is recorded as indicated on Table A.

Modifiers:

On rare occasion, a claimant's condition requires professional assistance beyond the usual scope, or other circumstances are present that require special care and attention. When such claimants require a functional capacity evaluation, fee schedule adjustments for the additional professional time required may be made through the use of the OWCP modifier code "10". This modifier code must be added to the primary code by the FCE provider when services are billed. Also, "10" must be added to the authorization codes entered into the "Notes" area by the claims manager. In most cases, however, the use of modifiers will not be necessary, and the required FCE can be provided within the scope of the OWCP guidelines.

Reimbursement Rates:

Fee schedule rates are established to set maximum amounts for services prior-authorized by OWCP. They are not to be considered expected amounts. Providers are required to bill OWCP at their usual and customary rates; rates greater than those allowed under the OWCP fee schedule are reduced according to the schedule. Maxima are adjusted for geographic variance by multiplying the base rate relative value units times the fee schedule Geographic Adjustment Factor (GAF) values for the appropriate Metropolitan Statistical Area (MSA). Providers should have a clear understanding at the time an FCE is authorized that both time and dollar limitations will apply; related reimbursement issues should be resolved at the time authorization occurs. The provider should always be given a copy of Table A - OWCP FCE Guidelines and Authorized Procedure Code with the approved number of hours indicated.

Coding Conventions: FCE's are included under the general group of services called Occupational Rehabilitation. The first letter (R) of the procedure code indicates Rehabilitation, the second letter (E) indicates evaluation.

Note: Routine psychometric testing performed as a portion of the GP-FCE are included in the FCE reimbursement rate. Comprehensive evaluation services by a psychologist or psychiatrist are not usually anticipated. In those instances where it is believed necessary to treat the work-related injury, justification is to be provided and the services are to be prior authorized by the claims examiner. They are billed under CPT.

TABLE D
PROVIDER DIRECTORY
OCCUPATIONAL REHABILITATION PROVIDERS

A GP-FCE is conducted by trained and licensed medical professionals who are knowledgeable about work-related disorders and occupational rehabilitation services. To ensure the quality of the facilities providing this service, OWCP has developed a Provider Directory based on those facilities that have

been certified by the Commission on Accreditation of Rehabilitation Facilities (CARF). The directory contains type of service identifiers and includes those that provide FCE's and ORP services. District offices can add to the directory as more facilities are found that meet OWCP's requirements and provide FCE's of high quality. The directory provides space for comments and the listing of claimants referred; guidelines for additions to the directory at the level of the district office are detailed in FECA Bulletin 96-9. The National Office will also provide periodic updates to the Directory.

FECA BULLETIN NO. 96-13

FB 96-13 BPS - Revision in the Reimbursement Rate Payable for the Use of Privately Owned Automobiles Necessary to Secure Medical Examination and Treatment

Issue Date: June 24, 1996

Expiration Date: June 23, 1997

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

Background: Effective June 7, 1996, the mileage rate for reimbursement to Federal employees traveling by privately-owned automobiles was increased to 31 cents per mile by GSA. No restriction is made as to the number of miles that can be traveled. As in the past, determination has been made to apply the applicable rate to disabled FECA beneficiaries traveling to secure necessary medical examination and treatment.

Applicability: Appropriate National Office and District Office personnel.

Reference: Chapter 5-0204, Principles of Bill Adjudication, Part 5, Benefit Payments, Federal (FECA) Procedure Manual; Instruction CA-77, Instructions for Submitting Travel Vouchers; and 5 USC 8103.

Action: Instruction CA-77, Instructions for Submitting Travel Vouchers, has been revised to reflect the indicated rate change. A copy of the revised instructions is attached to this bulletin and may be reproduced at local levels. It will not be necessary to search and locate vouchers processed subsequent to June 7, 1996; however, if inquiry is received, appropriate adjustment should be made.

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

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Attachment

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. 96-14

FB 96-14 Employees' Compensation Appeals Board--New Address (07/96B)

Issue Date: July 15, 1996

Expiration Date: Indefinite

Subject: Employees' Compensation Appeals Board--New Address

Background: Effective July 29, 1996, the Employees' Compensation Appeals Board (ECAB) is moving to the Frances Perkins Building. The new address is:

Employees' Compensation Appeals Board
U. S. Department of Labor
200 Constitution Avenue, N.W., Room N-2609
Washington, D. C. 20210

Purpose: To provide the ECAB's new address to employees of the Division of Federal Employees' Compensation

Applicability: All FECA employees

Action: All form letters in the WP letters system which include appeal rights, and thus contain the ECAB's address, will shortly be modified to show the new address. Managers of each district office must ensure that all macros used locally reflect the new address.

Disposition: Retain until the indicated expiration date.

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. 96-15

FB 96-15 Forms--Distribution of FECA Customer Service Brochure (08/96A)

Issue Date: July 28, 1996

Expiration Date: July 27, 1997

Subject: Forms--Distribution of FECA Customer Service Brochure

Background: A customer service brochure has been developed to advise disability claimants of basic information about the Federal employees' compensation program. A customized version has been developed for each district office so that information specific to individual district offices can be conveyed along with generic text which applies program-wide. This brochure, which is designated Form CA-14, is to be sent shortly after case creation to all disability claimants whose cases are in UD status (i.e., not closed C1 or C4).

Purpose: To describe how Form CA-14 is to be distributed

Applicability: All FECA personnel

Action:

1. Although the printing order included the request that the brochures be sealed during printing, so that they would be ready to mail on delivery, this was not done. Therefore, it will be necessary for each district office to order enough wafer seals for the current printing (or, in the alternative, the brochures may be stapled together). Future printings will be wafer-sealed.

2. Address labels are to be obtained by running CASE624 during case create. The case create clerk should use these labels to send the brochures to the claimants. Brochures are not to be sent in death cases and in cases closed at the time of case create.

Disposition: Retain until the indicated expiration date.

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. 96-16

FB 96-16 Bill Payment/BPS - Physical Therapy Authorizations (09/96A)

Issue Date: August 12, 1996

Expiration Date: August 11, 1997

Subject: Bill Payment/BPS - Physical Therapy Authorizations

Background: FECA Bulletin 90-22, dated August 1, 1990, issued new procedures for authorizing physical therapy services (PT). To summarize briefly, for orthopedic or neurological cases accepted on or after September 1, 1990, an initial 90-day period of PT was to be authorized via the initial acceptance letter. Additional periods of PT authorization were to be specifically requested and authorized. Indefinite PT was to be authorized for brain and spinal cord injuries, extensive second and third degree burns, and other conditions which rendered the claimant bedridden. For cases accepted prior to September 1, 1990, PT services were to continue to be paid, without prior authorization.

When the bill processing system (BPS) was enhanced during FY 1993, physical therapy edits were put in place which essentially mimicked the existing procedures (now found in the Federal [FECA] Procedure Manual, Chapter 2-0810.16). Because of the inconsistencies which could arise from using the date of adjudication as a starting point for authorizing services, the date of injury was used instead, and the period of initial authorization which did not require pre-approval was 120 days instead of 90. A physical therapy authorization function was placed on the system, so that the BPS edits could automatically check the authorization for services after 120 days from the date of injury. These edits (710, 720, 721) were potentially applicable to cases in which the date of injury was on or after August 1, 1990 (to mirror the September 1, 1990 adjudication date in the original procedures). If the date of injury was prior to August 1, 1990, and the accepted conditions were orthopedic or neurological in nature, PT services usually were paid automatically by the BPS without a PT authorization on the system. If the accepted conditions in a case were such that PT would never be appropriate, or would be questionable, the bills would either be denied automatically or suspend for review.

DFEC has continued to pay for a substantial amount of PT on cases with a date of injury prior to August 1, 1990. The enhanced BPS has now been in place in excess of three years. A number of offices have expressed concern about continuing to pay for unauthorized PT in the older cases. Therefore, effective October 1, 1996, the BPS edit program will be modified to apply the physical therapy edits uniformly to all cases, whether the date of injury is before or after August 1, 1990. The effect of this change is that PT bills which have previously been paid on older cases regardless of (or without) PT authorization will now require specific PT authorization on the system.

The National Office is in the process of mailing letters to claimants who have received PT during the past six months, and whose date of injury predates August 1, 1990. Letters are also being sent to the providers of the PT. The letter informs them that effective October 1, 1996, PT performed more than 120 days after the date of injury must be authorized in advance by OWCP. The requirements for the medical evidence required to authorize PT are also outlined. As a result of these letters being sent out, offices may expect to receive an increase in the number of requests for PT authorization.

In addition, each district office has been provided with a report showing cases with date of injury prior to August 1, 1990, in which PT has been paid during the past six months.

References: FECA Bulletin 90-22, dated August 1, 1990; FECA Bulletin 93-9, dated May 12, 1993; Federal (FECA) Procedure Manual, Chapter 2-0810.16.

Purpose: To outline revised PT authorization requirements.

Applicability: All supervisors, claims examiners, bill resolution personnel, and mail room personnel.

Action:

1. Prompt action should be taken on requests for authorization of physical therapy.

2. Cases which appear on the list provided by National Office should be reviewed prior to October 1, 1996 to determine whether there is sufficient information in the case file to authorize PT. If PT is authorized, the provider and claimant should be notified in writing, and the dates of the authorization should be placed on the system under "PT authorization", case management menu item 34.

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. 96-17

FB 96-17 Impairment/Schedule Awards: Further Issues in Computing Awards Using the Fourth Edition of the AMA Guides (09/96B)

Issue Date: September 20, 1996

Expiration Date: September 19, 1997

Subject: Impairment/Schedule Awards: Further Issues in Computing Awards Using the Fourth Edition of the AMA Guides

Background: FECA Bulletin No. 95-17 described various differences between the fourth edition of the AMA Guides to the Evaluation of Permanent Impairment and previous editions of this volume. Since that bulletin was released, several medical and administrative questions have arisen from various district offices and the Branch of Hearings and Review concerning the calculation of schedule awards.

Several comments addressed reports from examining physicians, which sometimes lack complete (or any) citations to tables and figures used and which do not always show clearly how the physician performed his or her calculations. Not surprisingly, examining physicians are usually more aware of the requirements of their respective state systems than those of the Federal Employees' Compensation Act. However, the differences in interpretation result in the need for OWCP staff to make time-consuming clarifications of medical reports.

Several other comments concerned the reviews performed by District Medical Advisors (DMAs) and District Medical Directors (DMDs). Here, too, incomplete or absent citations to tables and figures used in calculating awards and lack of clarity in calculations were noted, as well as illegibility of reports.

It was also indicated that disputes often arise over small differences in calculations as performed by the examining physician and by the DMA or DMD. Such disputes often result in lengthy and time-consuming appeals, and it was suggested that a range be established within which differences between evaluations would be administratively disregarded.

Reference: FECA PM Chapters 2-808 and 3-700; FECA Bulletin No. 95-17

Purpose: To address various issues pertaining to calculation of schedule awards

Applicability: Claims Examiners, Senior Claims Examiners, Hearing Representatives and Examiners, All Supervisors, District Medical Directors and Advisers, Technical Assistants, and Rehabilitation Specialists

Action:

1. Claims Examiners are reminded that where a claim has been accepted for temporary aggravation of a condition, consideration for a schedule award is not appropriate.

2. The attachment to FECA Bulletin No. 95-17 contained lists of tables which should not be used together, because doing so will result in inflated percentages of impairment. This list may be sent to examining physicians, along with a statement that it represents OWCP policy in determining impairment. (As the attachment contains information which is not customized to the individual case, it is not being added to Form CA-1303.)

3. Schedule award evaluations prepared by DMAs and DMDs should include the following information:

the part of the body involved, the particular motion(s) affected, and the range of each pertinent motion in degrees; the percentage of impairment; the number of the figure or table used to reach the percentage stated; and the page number of each figure or table used. The DMA or DMD should also indicate how he or she arrived at the total percentage of impairment, i.e, whether by simple addition or use of the combined values table.

The attached form, which is adapted from a form developed in the New York District Office, may be used for this purpose. It is analogous to Form CA-51, which is used to calculate awards for hearing loss. The DMA or DMD's evaluation should be legible (i.e., printed or typed).

4. To address the problems noted in the second paragraph of the Background section above, we will no longer ask the examining physician to calculate a percentage of impairment. Rather, the DMA or DMD will be responsible for taking the calculations provided by the examining physician and arriving at an overall percentage rating. Form CA-1303 will be revised to remove the last question on each attachment, which asks the physician for a percentage of impairment. Also, the form appended to this bulletin may be sent to examining physicians.

5. In some instances, examining physicians may still provide summary ratings. The DMA or DMD will still need to compute the percentage of the award, and his or her assessment will be used as the basis of the award issued.

6. Where more than one method of calculation may be used, the DMA or DMD should use the same one as the examining physician did. Where more than one physician in the case has performed a schedule award evaluation, each using a different method, the DMA or DMD should calculate the award using both methods, and the percentage awarded should be the higher of the two. If the examining physician's calculations are in error, the DMA or DMD's calculations may be used without further medical evaluation.

7. After a schedule award is issued, additional medical evidence showing a different percentage of impairment may be submitted. If there is less than a five percent difference between the DMA or DMD's review and the examining physician's review, no change to the rating will be considered unless the supporting measurements have changed.

8. With respect to particular tables and issues of medical evaluation, the following points are offered (references are all to Chapter 3 of the AMA Guides):

a. Table 16, which addresses upper extremity impairment due to entrapment neuropathy, is used to evaluate impairment due to carpal tunnel syndrome. In ambiguous cases, the choice between mild and moderate impairment may depend on EMG results and/or an assessment of the effect of the impairment on activities of daily living, which in turn depends on the availability of clinical information. The most significant difference between Table 16 and its predecessors is in the calculation of severe impairment.

b. Table 62, which addresses impairment due to arthritis, may be used only if no other abnormality is present, with the exception of joint fractures. The last two paragraphs on p. 82 describes the x-rays needed to support a rating derived from this table. Specifically, a "sunrise view" x-ray is required. Neither an MRI nor any other test may be used instead of the sunrise view x-ray.

c. Pain which is neurological in origin may be included in evaluations for schedule awards, but pain which has other sources (e.g., that which accompanies sprains and strains), must be excluded from evaluation. It is therefore essential to distinguish between these types of pain in evaluating claims for schedule award.

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)

Attachment to FECA Bulletin 96-17

OWCP SCHEDULE AWARD (SA) WORKSHEET

Resource: AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition

Claimant Name:_____ Case#_____

Date of Maximum Medical Improvement:_____ CE:_____

CALCULATION

Body Part/Data/ROM (degrees)	Percent of Impairment	Page #	Figure/ Table

Comments_____

_____

_____

_____

_____ _____

Reviewer Signature Date

FECA CIRCULARS INDEX

FECA CIRCULARS TEXT

FECA CIRCULAR NO. 96-01 **October 25, 1995**

FC 96-01 Subject: Selected ECAB DECISIONS for APRIL through JUNE 1995

Attached is a group of abstracts of selected ECAB decisions for study and individual filing by subject.

This group of decisions includes three that discuss medical evidence, one of which addresses the questions of whether a telephone contact with the contracted physician was proper and whether questions posed to the doctor by the Office were or were not leading questions. There are two summaries which relate to overpayments, one which concerns forfeiture and the other which addresses fault finding. There are four summaries which deal with the issue of performance of duty, none of which were affirmed by the Board. In two of those decisions the Office was reversed, one was a rescission of the acceptance, and the other concerned whether or not the injury occurred on the employer's premises. In the other two performance of duty decisions, both of which alleged harassment, the Board remanded the case for the Office to make findings of fact. There is one decision in which the Board affirmed the Office's rescission, and there are three decisions which address the issue of wage-earning capacity.

The selected ECAB decisions for January through March 1995 were not published as no decisions on novel issues were made during that period.

THOMAS M. MARKEY

Director for
Federal Employees' Compensation

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

IMPARTIAL EVALUATIONS - LEADING QUESTIONS AND TELEPHONE CONTACT

Carl D. Johnson, Docket No. 94-404, Issued May 31, 1995

In this case, the claim had been accepted for temporary aggravation of multiple sclerosis. A previous Office decision terminating benefits had been reversed by the Board. The Office subsequently referred the claimant to a Board-certified neurologist for an impartial medical evaluation. The Office asked the specialist to answer the following questions:

1. Has the temporary aggravation of the preexisting multiple sclerosis ceased? Please explain how you arrived at your conclusion and note the findings you used.

2. If the temporary aggravation has not ceased, when would it be expected to do so? Please explain.

After receiving the specialist's initial report, the Office sent a letter requesting clarification. The specialist telephoned the Office a few days later, and spoke with a senior claims examiner. The physician stated that he was confused by a letter concerning permanent aggravation that he had received from the claimant's attorney. The specialist was informed by the senior claims examiner that the attorney was not to interfere with the impartial evaluation process, and that the physician should respond directly to the questions posed by the Office.

After receiving the specialist's supplemental report, the Office terminated benefits on the basis that the work-related temporary aggravation of the claimant's pre-existing condition had ceased. The Board affirmed the decision.

In forming their decision, the Board considered whether the questions posed to the specialist were leading questions. The Board found that the questions were not leading, as they did not suggest or imply an answer to the questions posed. They also considered whether the contact between the senior claims examiner and the specialist was improper. They found that the contact was not improper in this instance, as there was no discussion of the disputed issues.

MEDICAL EVIDENCE - WEIGHING AN IMPARTIAL SPECIALIST'S REPORT

William P. Levis, Docket No. 93-2321, Issued May 1, 1995

In this interesting decision, the Board made a tough call on the relative weight of an impartial specialist's report.

The claimant's injury was sustained when he was standing on a chair, reached to water a plant, and felt pain in his right groin area. Notice of injury was filed more than two months after the injury. The Office accepted a right groin strain and paid appropriate compensation. Several months later, the Office received a report from the claimant's attending orthopedist, who noted that the claimant had advanced degenerative arthritis of the right hip and recommended hip joint replacement surgery. The Office denied

authorization for the surgery on the basis that the medical evidence did not support a causal relationship between the work injury and the need for surgery. The claimant was instructed to submit medical evidence which contained a well-rationalized opinion supporting the relationship between the requested surgery and the work injury.

The attending orthopedist subsequently submitted another report, in which he stated:

> FC 96-01 Selected ECAB Decisions for April through September 1995
> In regard to the causal relationship between the ... injury and the resultant hip injury, it is well known that a person can have progressive underlying, but nonsymptomatic development of degenerative change until a specific incident or injury which will stress the diseased joint ... it is my opinion that [the claimant] likely was developing progressive degenerative changes of both hips, but that this problem remained nonsymptomatic until his [work] injury which placed an increased degree of physical stress on the right hip joint which has resulted in the current progressive symptomology and physical limitations ... This ... falls under the category of a disease which has been materially aggravated by an on-the-job injury...I feel that this is classified as a permanent aggravation as [he] has certainly continued to have progressive symptomology over the previous six months which has not responded to conservative treatment modalities.

An Office referral physician, an orthopedic surgeon, stated that there was nothing unusual or traumatizing in the claimant's stepping down from a chair after watering a plant. He stated that there was a definitive difference between the onset of pain in the course of normal activity and another action which actually increases the pathology to render the pre-existing condition painful.

The Office referred the claimant to an impartial orthopedic surgeon for examination, who stated, "appellant had a compensated type of arthritis which became decompensated in the normal course of his employment with any injury...there is no history of an actual injury occurring and, therefore, I cannot substantiate that this was an injury arising out of employment but rather could have arisen in the course of his normal every day activities whether he was employed or not."

The Office denied authorization for right hip replacement surgery on the basis that the right hip condition was not related to the work injury.

The Board found that the case was not in posture for a decision. They found that a conflict of medical opinion still existed because the impartial physician's opinion contained little rationale and was based on an inaccurate factual background. The Board stated that the physician was apparently under a mistaken impression that an unusual injury at work was necessary in order for a claim to be work-related, and directed the Office to obtain another impartial evaluation.

When a conflict of opinion is resolved through the use of an impartial medical examiner, the Office must thoroughly assess whether the impartial physician's report is based upon an accurate history, and whether it is sufficiently rationalized to be accorded special weight.

MEDICAL OPINIONS

Frank P. Siderio, Docket No. 94-33, issued April 25, 1995

While the primary issue in this case is whether the claimant sustained a recurrence of disability, the interesting point involves the medical evidence.

On a prior appeal, the Board remanded the case for referral of the claimant, the medical record and a statement of accepted facts to a Board-certified specialist for a reasoned opinion regarding whether the

claimant's current condition is causally related to his employment-related injury. The physician selected noted his findings on examination and stated:

> The records that I reviewed indicate that he sustained a relatively mild neck sprain in March 1989, he was subsequently treated for right upper extremity symptoms after two subsequent traumatic episodes, he had an EMG [electromyogram] more than six months after the auto[mobile] accident and at that time there was no evidence of any cervical nerve root irritation and he was instead considered as having a carpal tunnel syndrome and a shoulder tendinitis that responded to local injection, and it is therefore impossible for me to tell what role, if any, the March 1989 accident played in the need for the subsequent surgery that was performed several years later. The records reflect that he had x-ray evidence of cervical spine degenerative arthritis in March 1989, and it is quite possible that a strained neck in March 1989 might have been followed by symptoms that were prolonged because of his preexisting degenerative arthritis, however, because of the above factors and the additional fact that there is no mention of any neck symptoms during much of the time that he was treated for right upper extremity symptoms, I believe that it is impossible for me or anyone else to offer any opinion with reasonable certainty about any causal relationship between the 1989 accident and the need for the subsequent surgery such a long time later.

The OWCP then denied the claim on the grounds that the evidence was insufficient to establish a recurrence of disability causally related to the employment injury.

However, the Board found that the case was not in posture for decision and remanded it. Because the physician selected by OWCP stated that it was impossible for him to offer any opinion with reasonable certainty about the causal relationship between appellant's accident and need for the subsequent surgery, the OWCP should refer appellant to another specialist for an opinion on this issue.

FORFEITURE DUE TO UNDERSTATEMENT OF EARNINGS

Mike Rabago, Docket No. 94-124, issued June 7, 1995

The Board ruled that the Office had improperly found that the claimant had forfeited his right to compensation for the periods May 4 to November 30, 1991 and May 12 through September 10, 1992.

The claimant then requested a hearing, prior to which he submitted an affidavit attesting to alleged repercussions from writing to a Senator about a various problems at work, including racial discrimination, verbal abuse, threats of physical violence, removal of employees and denial of union representation. He also stated that the employing agency had refused to give him copies of documents showing hours of sick and annual leave, which he needed to pursue various grievances, and that the agency had stated that the grievances themselves would be handled at a level where management would not have to deal with him. The claimant also submitted a letter written by the employing agency's Field Division General Manager/Postmaster on this subject.

At the hearing, the claimant testified about problems at the employing agency since he began working there in 1976. He also testified about his union activities, stating that he had been active as a steward for approximately 1« years. The claimant alleged that after he became union steward he was removed from this position for 30 days because management was afraid of him and that eventually he filed a grievance with the National Labor Relations Board alleging retaliation. He indicated that he was informed that he would not be promoted to a supervisory position because of the time lost from his employment injuries, and that he had an argument with a supervisor in a local bar regarding grievances he had filed and that friends of the supervisor attempted to jump him. The claimant stated that he was disciplined for

conducting union business without first requesting union time, and that he had filed a number of Equal Employment Opportunity Commission (EEOC) complaints and each time that he filed a complaint he would be harassed by management.

The hearing representative affirmed OWCP's decision denying the claim. The hearing representative found that the claimant had not alleged any factors of employment which were compensable under the FECA.

The Board found that this case is not in posture for decision. Some of the claimant's allegations clearly fell outside performance of duty: he was denied a promotion, and he perceived harassment where none was established. However, he also alleged that while he was performing his duties as a union steward, management refused to act in ways which were in violation of the National Agreement. The claimant introduced evidence indicating that the employing agency admitted that its failure was in violation of the National Agreement.

The case was remanded for further development, including a finding as to whether appellant was performing "representational functions" which entitled him to official time. If so, then an incident occurring as a result could constitute a compensable factor of employment. The OWCP was directed to issue a de novo decision after appropriate development.

PERFORMANCE OF DUTY: EMOTIONAL CONDITION DUE TO COWORKER HARASSMENT

Joseph A. Pietro, Docket No. 94-211, issued June 26, 1995

The Board ruled that the Office had erred in its finding that the claimant's reaction to a harassing sign placed by a coworker did not occur in the performance of duty. The decision was set aside and the case remanded for further development to include a proper finding of fact.

The claimant was a 47-year-old clerk for the U.S. Postal Service who claimed the development of stress, a depression and the worsening of his tinnitus as having resulted from the placement of a blatantly discriminatory sign being placed in his work area. The claimant submitted his own narrative statement and witnesses' statements supporting that the following sign was hand-written and hung in the light-duty work area by a co-worker: "No Physically or Mentally Impaired People Belong in this Area. Thank you." The claimant's statement also explained that he and other partially disabled people were assigned to work in the limited duty area in order to accommodate their medical restrictions. In a grievance filed relating to this issue, the claimant also produced a witness statement indicating that a general clerk had showed the witness a computer printout with private medical information regarding the witness and himself. He objected to such information being accessible to unauthorized personnel at the employing agency.

The claimant's employer responded to his allegations in a letter some three months after he filed his compensation claim. It acknowledged that the sign had been placed in the claimant's work area, and stated that the sign had been removed and destroyed. The Office subsequently denied the claim stating that the claimant had failed to establish that his injury occurred in the performance of duty. It further found that the claimant's reaction to the computer printout of private medical information was not in the performance of duty as it was an administrative practice not established to have been abusive or in error.

On finding that the case was not in posture for decision, the Board noted that in cases involving emotional conditions, the Office must make findings of fact, as part of its adjudicatory function, specifying which of the working conditions claimed would be considered employment factors and which would not. Once one or more employment factors have been established, the Office must determine whether the evidence of record supports the truth of the matter asserted.

The Board noted that the Office's finding that the claimant's reaction to the harassing sign was not in the performance of duty was in error. The Board cited its ruling in Gregory J. Meisenburg, Docket 92-1098, issued February 24, 1993:

> To the extent that disputes and incidents alleged as constituting harassment by coworkers are established as occurring and arising from appellant's performance of his regular duties, these could constitute employment factors.

It was also noted that even if the placement and content of the sign arose from a personal matter between the claimant and the coworker, this fact would not have the force of disproving its connection to work. The Board further noted that even if an altercation or, as in this case, harassment arose from a nonwork topic, it could still be compensable if the employment brought the claimant and his coworker together and created the condition which resulted in the altercation or harassment. In this case the Board held that the claimant's and coworker's work brought them together and created the conditions that resulted in the harassment which was the culmination of daily work contact pressure. Therefore, the claimant had established a compensable employment factor.

In addition, the Board noted that the Office shares the responsibility of developing the evidence where the claimant submits clearly supportive evidence which is not sufficient to carry the burden of proof. The Board directed the Office, therefore, to advise the claimant of the remaining deficiencies in the case and to allow him at least thirty calendar days to submit additional evidence sufficient to discharge the required burden of proof.

PERFORMANCE OF DUTY: PREMISES

John R. Harrington, Docket No. 94-128, issued June 6, 1995

The Board found that the claimant had established that his injury occurred in the performance of duty in that the snow covered parking lot should be considered part of the employer's premises.

The claimant was a 47-year-old aviation safety inspector when on December 3, 1991 he slipped and fell on wet snow in the parking lot after arriving for work. The case had initially been denied on the basis that the medical evidence was insufficient to establish fact of injury. Subsequently, a hearing representative found that the medical was sufficient to establish an injury but that the issue of performance of duty needed to be addressed.

On requesting additional evidence from the employer, the Office determined that the parking lot was not owned by the employing establishment, nor did the employer contract for the exclusive use of the parking area, and it denied the claim in a de novo decision finding that the injury did not occur in the performance of duty. In a reconsideration decision of August 1993 the Office again denied the claim on the basis that the evidence was insufficient to warrant modification of the previous decision. The decision asserted that the government could not be held liable for a slip and fall in an area which it did not maintain or control.

The Board pointed out, however, that while it was evident that the employer did not own or maintain the parking lot, the lack of ownership and control alone do not establish that the parking lot was outside the premises of the employer. The Board stated:

> The term `premises' as it is generally used in workmen's compensation law, is not synonymous with `property.' The former does not depend on ownership, nor is it necessarily coextensive with the latter. In some cases `premises' may include all the property owned by the employer; in other

cases even though the employer does not have ownership and control of the place where the injury occurred the place is nevertheless considered part of the `premises.'

The Board noted further that the premises of the employer is more dependent on the relationship of the property to the employment than on the status or extent of legal title. It enumerated the several factors which determine whether a parking lot used by employees may be considered part of the employer's premises: 1) whether the employing agency contracted for the exclusive use of the parking area by its employees; 2) whether the spaces on the lot were assigned by the employer to its employees; 3) whether the parking areas were checked to see that no unauthorized cars were parked in the lot; 4) whether parking was provided without cost to the employees; 5) whether the public was permitted to the use the lot; and 6) whether other parking was available to the employees.

The Board used the above factors to determine whether the parking lot should be considered part of the employer's premises for the purposes of the FECA. On review of the record it was noted that: 1) the employer was the primary tenant of Building 12 with some 400 employees using a 300-space parking lot; 2) the employees were clearly expected to use the parking lot; 3) parking permits were issued to the employees, although spaces were not assigned; 4) the public was not allowed to park in the lot, and the lot was monitored at times to ensure that unauthorized vehicles were not parked there; 5) the lessor of the building had, at the employer's request, ensured that tenants from other buildings would not be allowed to park in the Building 12 lot; and 6) other parking was not specifically made available to the employees if their designated lot was full.

The Board found under the circumstances that the relationship between the parking lot and the employing establishment was sufficiently close as to constitute the "premises" of the employer. It therefore reversed the August 1993 decision of the Office, finding that the claimed injury was sustained in the performance of duty.

PERFORMANCE OF DUTY/RESCISSION OF CLAIM

Thomas E. Keplinger, Docket No. 93-2359, issued April 12, 1995

This claim was based on a dog bite which occurred when the claimant, a letter carrier, stepped inside of a postal patron's garage. The claim was originally accepted for dog bites to the right hand and left leg, but the acceptance was later rescinded on the basis that the claimant removed himself from the performance of duty and deviated from his usual mail delivery route when he entered the garage to canvass the patron for permission to cross the lawn in the course of delivering mail. Various statements were submitted by postal supervisors and co-workers concerning this issue.

In the Memo to the Director which accompanied the rescission, the claims examiner stated that obtaining such statements was not a requirement of appellant's job and that he apparently did so to extend his street time. The claims examiner concluded that, by entering the patron's home, the claimant removed himself from his regular duties, and it was this action that precipitated the attack by the dog.

The claimant then requested a hearing, prior to which he submitted statements from co-workers which provided various accounts of the instructions given the carriers concerning the statements to be obtained from postal patrons about crossing lawns. At the hearing itself, the claimant testified concerning various aspects of his route and the rules governing where he should walk. The Hearing Representative affirmed the rescission of the acceptance on the basis that the claimant did not show that he was fulfilling the duties of his employment or engaged in incidental activities.

FC 96-01 Selected ECAB Decisions for April through September 1995
The claimant's previous injury was a lumbosacral strain which occurred on May 31, 1991 when she bent

over to pick up mail. She had returned to work with restrictions on November 12, 1991. The claimant filed a CA-8 on December 23, 1991 for disability from work beginning December 10, 1991 and continuing. She returned to duty with restrictions on March 9, 1992. Based on the claims and the medical evidence from the claimant's attending physician, the Office accepted the recurrence and paid compensation until her return to duty.

As a result of a Postal Service investigation, it was revealed that the claimant was in a non-work-related auto accident on December 9, 1991 for which she received medical treatment. As exhibits to the investigative memoranda there were numerous documents, including statements from the claimant, a police report, and a number of medical reports noting the claimant's injuries to the head, neck and left shoulder resulting from the automobile accident. The Office, on November 5, 1992, rescinded its acceptance of the claimant's recurrence of disability on December 10, 1991 and terminated compensation based on no evidence of residuals from the original injury. A hearing decision of September 9, 1993 affirmed the district office decision.

The Board found that the Office properly rescinded its acceptance of the recurrence, noting:

> Once the Office has accepted a claim, it has the burden of justifying termination or modification of compensation. This holds true where the Office later decides that it erroneously accepted the claim. To justify rescission of acceptance, the Office must show that it based its decision on new evidence, legal argument and/or rationale.

After recounting the new evidence the Board found that the Office had met its burden of proof by advancing sufficient new evidence to establish that it had erroneously accepted the appellant's claim of recurrence of disability commencing on December 10, 1991. It is also important to note that the basis for a rescission may not merely be a reinterpretation of the same set of facts, or a look with new eyes. In the present case there was clearly compelling new evidence that the previous acceptance had been in error, and that the rescission was warranted.

REDUCTION OF COMPENSATION TO ZERO FOR FAILURE TO COOPERATE WITH VOCATIONAL REHABILITATION

Tony R. Scott, Docket No. 95-252, Issued May 23, 1995

The claim was accepted for a low back strain and herniated nucleus pulposus at L4-5. In April of 1992, an Office rehabilitation specialist referred the claimant to a rehabilitation counselor (RC) for plan development. In a work restriction evaluation dated May 1992, the claimant's attending physician indicated that the claimant could work eight hours per day with certain restrictions.

The RC conducted an initial interview with the claimant. The claimant was referred for psychological and functional capacities evaluation. The RC then performed a private-sector labor market survey, and identified several jobs which were available and appropriate for the claimant. She provided descriptions of these jobs and three jobs which were available at the employing agency to the claimant's attending physician, and asked that he state whether they were compatible with the claimant's residual disability. The physician approved the jobs of video clerk, delivery driver, cab driver, telemarketer, cashier, food aid, sewing machine operator, surveillance, and light-duty clerk.

In the meanwhile, the claimant and the RC had discussed vocational training. The RC gave the claimant the address of an agency which could provide training, and told the claimant that testing required by the agency could be waived because of the testing already done by the Office.

The claimant advised the RC that the existing job opportunities available to him would not provide him or

his family adequate security. The RC informed the Office that the claimant felt he was unable to work eight hours per day and was seeking treatment from another physician. When informed that the RC was continuing to look for job or training activities based upon the attending physician's reports, the claimant responded, "I am unable to engage in any job development activities or training opportunities."

On February 1, 1993, the Office advised the claimant of the provisions of 5 U.S.C. 8113(b) and 20 C.F.R. 10.124(f) regarding failure or refusal to participate in vocational rehabilitation. The claimant was given 30 days within which to make contact and make a good faith effort to participate in the rehabilitation effort, or to provide his reasons for non-compliance. He was informed that failure to comply would result in reduction of his compensation.

On February 24 the claimant restated that he was not able to participate in the rehabilitation program, that the medical evidence was now nearly one year old, and that the Social Security Administration (SSA) had found him totally disabled. He requested authorization to be treated by another physician.

The RC had sent the claimant an Individual Placement Plan (IPP) on February 12 for his signature. The claimant did not sign or return it. On March 1 the Office informed the claimant that SSA benefits did not determine his disability status under the FECA, and that he was compelled to cooperate with the rehabilitation effort, or face the consequences which were explained in the earlier letter. When the claimant did not subsequently cooperate with the RC or sign the IPP, the Office reduced the claimant's monetary compensation to zero effective July 9, 1993, on the grounds that he had failed to cooperate with the rehabilitation effort.

The claimant requested a hearing, after which an Office hearing representative affirmed the district office's decision. The claimant then appealed the decision. The Board found that the Office had improperly reduced the claimant's monetary compensation to zero.

FECA CIRCULAR NO. 96-02 **January 29, 1996**

SUBJECT: Increases in the Reimbursement Rate for OWCP Contract Field Nurses

Using the Division of Federal Employees' Compensation (FEC) experience, outside data, and taking into account geographical differences in the cost of medical services, we have updated the maximum allowable rate for field nurses' services. Effective immediately rates will be: $65.00/hr. for professional services, $32.00/hr. for administrative services. The maximum per case is increased to $4,000 to reflect these increases.

At present, field nurses' cost may be reviewed by accessing the on-line payment history on the Query or Bill Pay Menu in the Medical Bill Processing System (MBPS). The inquiry must include the case file number as well as the nurse's or company's tax I.D. number.

Additionally, we are currently working on a prior-authorization mechanism that will monitor the field nurse's time and money limits in an automated fashion.

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 and Bill Pay Personnel, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

FECA CIRCULAR NO. 96-03 **February 20, 1996**

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

The interest rate to be assessed for the prompt payment bills is 5 7/8 percent for the period January 1, 1996 through June 30, 1996.

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 for the period January 1, 1996 through December 31, 1996 (or until further notified). The Debt Management System will apply this rate to all debts moving into FD status after January 1, 1996.

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 (Claims Examiners, All Supervisors, Systems Managers, District Medical Advisors, Technical Assistants, Rehabilitation Specialists, and Fiscal and Bill Pay Personnel)

PROMPT PAYMENT INTEREST RATES

1/1/96 - 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%

DMS INTEREST RATES

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

FECA CIRCULAR NO. 96-04 **June 10, 1996**

SUBJECT: SELECTED ECAB DECISIONS FOR OCTOBER - DECEMBER 1995

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

Summaries for several decisions which involve performance of duty/compensable factors of employment are included. There are also a number of summaries for schedule award decisions and overpayments. Other subjects include loss of wage-earning capacity determinations, attorney's fees, housing modifications, authorization for an adjustable bed, and suspension of benefits under 5 U.S.C. 8123(d).

THOMAS M. MARKEY
Director for

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)

ATTORNEY'S FEES - ABUSE OF DISCRETION

Cecilia Kalinski, widow of Alex J. Kalinski, Docket No. 94-518, Issued October 23, 1995

In this case, the Office reduced an attorney's fee in the amount of $15,000 for work performed from December 29, 1989 to June 10, 1993 to $4,950. The basis for the reduction was that the attorney's services from December 29, 1989 through July 29, 1992 were in pursuit of a medical negligence claim against the employer's medical clinic and a Federal Tort Claim, and that assistance on the workers' compensation claim did not begin until February 3, 1992.

The Board pointed out that they do not have the authority to determine an appropriate fee for services before the Office, but that their role is to determine whether there has been an abuse of discretion. The Office's regulations at 20 C.F.R. 10.145 state:

> (e) In considering any request for such a fee, the Office will not recognize such items as:
>
> (1) Work performed before any other State or Federal agency or court including the Employees' Compensation Appeals Board, and any State or Federal Court.

The attorney contended that the early medical and legal investigation performed by his office formed the basis for the FECA claim.

The Board found that the early work performed on behalf of the widow and the estate was ultimately in furtherance of the FECA claim, and therefore remanded the case for approval of an appropriate fee for legal services during the period from December 29, 1989 through November 22, 1990.

DEVELOPMENT OF EVIDENCE

Dorothy A. Rimbold, Docket No. 93-2128, Issued October 20, 1995

In this decision, the Board once again reiterated the principle that the Office shares in the responsibility for development of a case.

The claimant was an aircraft mechanical parts worker who filed an occupational disease claim for "multiple chemical sensitivity." Medical evidence from several physicians supported that she suffered several allergic reactions due to various exposures at work. The Office denied the claim, finding that fact of injury had not been established, and that there was insufficient or conflicting evidence regarding the claimed exposures.

The Board remanded the case for additional development. They found that the employing agency had provided a list of chemicals to which the claimant was exposed while at work, and that at least one other exposure was also documented in the file. They stated that proceedings under the Act are not adversarial in nature, and that while the claimant has the burden of establishing the merits of the claim, the Office shares responsibility for developing the evidence, and has an obligation to see that justice is done. The Office was directed to prepare a comprehensive statement of accepted facts, detailing the exposures, and refer claimant for evaluation by an appropriate medical specialist.

HOUSING MODIFICATIONS

Janice Kirby, Docket No. 95-610, Issued December 5, 1995

In this interesting housing modifications decision, the Board affirmed the Office's decision to authorize $60,597.00 in reimbursement for housing modifications.

The claimant sustained severe injuries in a vehicle accident, which resulted in brain damage and left hemiparesis. The claimant was married, but her husband was seeking a divorce. The claimant's parents were willing to provide her with a home, but extensive modifications were needed to the home because the claimant was wheelchair dependent. The parents decided to build a new home rather than modify the existing home. They obtained estimates which showed that the cost of modifying the existing home would be $175,967.00, and that the claimant's portion of the cost of a new home would be $164,000.00.

The claimant and her husband were joint owners of a house worth approximately $175,000.00, according to an appraiser. The Office issued a decision in which they stated that the preinjury value of the claimant's home ($175,000.00) exceeded the value of the new construction, and that the Office would therefore only pay for modifications to the new home which were required to accommodate the claimant's work-related injury. The Office approved payment for designs and plans, a garage door with opener, separate heating, ventilation and air conditioning, special cabinets for the kitchen and bathroom, access ramps, special bath fixtures, a medical alarm and intercom system, and ramp safety railings, a total of $33,450.00.

A hearing was requested. Additional information was submitted by an attorney which showed that the total equity in the claimant's house was $100,000.00, with half of that, or $50,000.00, being the claimant's share. The attorney argued that the Office should pay for the claimant's share of the cost of construction of the new house, less her share of the equity in the old house. This would be $157,800.00 (a new figure based on the actual construction cost) less the $50,000.00 equity, or $107,000.00. The hearing representative noted that under Office procedures, OWCP was responsible only for the modifications to the new purchase or to the plans for the new house which were necessitated by the work injury and not the cost to actually build the house. The hearing representative approved an additional $27,147.00 in reimbursable construction expenses for flooring, doors, an asphalt driveway, and the parent's share of the flooring, doors, asphalt driveway, and the medical alarm and intercom systems (since it was reasonable to allow the claimant access to the rest of the house).

The Board found that the Office did not abuse its discretion in paying only for modifications to the new house. The parents' old house could have been modified to accommodate the claimant. They chose to build a new house for personal and financial reasons, not because of the inability of the old house to withstand modifications. The claimant's equity in her former house and its application to the cost of the new construction was irrelevant. The Office properly limited reimbursement to those items needed to accommodate the claimant's injury-related condition.

LOSS OF WAGE-EARNING CAPACITY - ACTUAL EARNINGS

Lawrence D. Price, Docket No. 93-2007, Issued October 4, 1995

In this case the claimant, a forestry technician, returned to work in a temporary six-month clerical position at the same grade and step as on date of injury. A completed Form CA-816 with "No LWEC" written across it was placed in the file, and the claimant was informed, "Since your current employment does not reflect an actual loss of wages from your preinjury job, you are not entitled to any compensable monetary difference based upon your actual earnings."

The Board found that the Office had properly reduced the claimant's compensation to zero based on the actual earnings, but that the decision did not constitute a formal wage-earning capacity determination pursuant to 5 U.S.C. 8115 because the claimant's capacity to earn wages was not discussed, and there was no attempt to determine if the actual wages "fairly and reasonably" represented his wage-earning capacity. The reduction of compensation, therefore, could only continue as long as the claimant had the actual earnings.

LOSS OF WAGE-EARNING CAPACITY - CONSTRUCTED RATING

Barbara Silvers, Docket No. 94-1007, Issued December 7, 1995

This case had been accepted for aggravation of cervical and lumbar spine strain, and herniated disc at L4-5. The claimant was a former nurse, and was placed in a vocational rehabilitation program. She was enrolled in a pain management program in June, 1991. In September of 1991, a physician at the pain management program stated that the claimant was capable of performing the functional demands of a nursing administrator, that she was capable of a part-time sedentary job, and that she had the potential to increase her capacity to a full-time sedentary job. The same physician completed a work restriction evaluation form on October 21, 1992, indicating that the claimant could work five hours per day, with restrictions, and that she could work eight hours per day on March 1, 1992.

The rehabilitation specialist obtained information on the sedentary position of "nurse consultant," and stated that it was compatible with the claimant's past work history, skills, and training, was being performed in sufficient numbers as to be reasonably available, and had a weekly wage of $596.00. On December 7, 1992, the Office issued a notice of proposed reduction of compensation based on the claimant's capacity to earn wages as a nurse consultant.

The claimant responded on December 30, 1992 that, among other things, part-time work would be more appropriate. A medical report dated January 6, 1993 was submitted, which described current findings, and included a completed work restriction evaluation showing that the claimant could work only four hours per day. The Office proceeded to finalize the proposed reduction by compensation order dated January 14, 1993.

The claimant requested a hearing, during which she testified that she had been working part-time for a pharmaceutical corporation since February of 1993. She also submitted a report from her treating physician which showed that she could work only four hours per day. The hearing representative affirmed the district office's decision.

The Board found that the Office did not properly determine the claimant's wage-earning capacity. The reduction was based on the claimant's alleged ability to work an eight-hour day. The pain management physician stated that the claimant was able to work only part-time, but had the potential to increase her capacity to eight hours. It was not clear from the record whether the October 1992 work restriction evaluation form (which showed eight hours per day work capacity) was based on the previous projected capacity, or upon an actual examination. In addition, subsequent reports which were based upon actual examinations showed only a part-time capacity for work. The Office therefore did not meet its burden of proof to establish that the claimant could perform nurse consultant duties eight hours per day, and the decision was reversed.

MEDICAL BENEFITS - ADJUSTABLE BED

Lillie P. Gross, Docket No. 94-189, Issued October 24, 1995

The claimant in this case was receiving total disability benefits for a herniated disc L4-5 and a laminectomy. The Office received a request for authorization of a Craftmatic adjustable bed, and asked the attending physician to describe the equipment needed to treat the accepted back condition, to provide an opinion as to the effect of the automatic bed, and to state whether the bed was likely to cure, reduce the degree or period of disability or aid in lessening the amount of monthly compensation. The physician replied that the claimant had asked for the bed for her back pain and recurrent deep vein thrombosis, and that he was documenting that the claimant had these conditions.

The Office advised the claimant that the adjustable bed could not be authorized because her physician indicated that she had requested the bed, and the physician did not answer questions they had posed concerning the bed. They also noted that the deep vein thrombosis was not work-related, and that the physician who sent in the request was not treating her back condition.

The claimant's attending orthopedic physician subsequently prescribed the adjustable bed, and stated that it was needed to decrease pain of diagnosed fibromyositis, leg radiculitis, recurrent vein thrombosis, levator scapula syndrome, thoracic outlet syndrome, nerve peroneal irritation, ulnar nerve compression, and spine muscle deconditioning.

The Office denied the claim for the adjustable bed by compensation order, stating that the evidence failed to establish that the bed was medically necessary due to the accepted employment injury. The claimant requested reconsideration, and submitted a report from her orthopedist that stated that he considered the bed to be a medical luxury and not a necessity. The Office denied modification of the prior decision.

The Board affirmed the Office's decisions, and stated that there was no medical evidence that the bed was likely to cure, give relief, reduce the degree or period of disability, or aid in lessening the amount of monthly compensation.

OVERPAYMENT - FINDINGS OF FAULT FOR PAYMENTS RECEIVED AFTER A RETURN TO DUTY

Bobbie G. Brown, Docket No. 94-934, Issued November 21, 1995

An overpayment was created in this case when the claimant returned to work on August 11, 1992, but continued to receive compensation through September 19, 1992 (two checks). A letter had been issued to the claimant on July 1, 1992, stating that he would receive periodic roll payments every four weeks, and that the first regular payment would cover the period June 28 through July 25, 1992. He was also advised to notify the office immediately if he returned to work, to avoid an overpayment.

The Office found that the claimant was with fault in the creation of the overpayment because he had been instructed to return checks received after a return to duty. The claimant requested a hearing, and testified at the hearing that he wasn't certain whether he had received the checks, but that if he had, he had cashed them, and that he thought there was a period of time for which he had still not received compensation (the initial payments were delayed). He requested copies of the checks which comprised the overpayment. The hearing representative affirmed that the claimant was with fault because he accepted compensation payments after he returned to work.

The Board found that the Office had improperly determined that the claimant was not without fault in the creation of the overpayment for the period August 11 through 22, 1992 (this is the portion of the first check received after he returned to work which included a period of time during which he worked and received wages). They reiterated the principle that there must be reviewable evidence of record which establishes that the claimant was advised by the Office at the time the check was received that the check

included compensation to which he was not entitled. The record must contain copies of the compensation checks or other documentation which puts the claimant on notice. In this case, the August 22 check was payment for the period July 26 to August 22, 1992. The claimant was entitled to receive compensation benefits until August 11, 1992. He also testified during the hearing that he believed he was entitled to additional compensation for a previous period of time. The Office should have obtained a copy of the check, or other documentation showing that the claimant was informed of the period of time covered by the August 22, 1992 check. The Board found that the claimant was with fault with respect to the portion of the overpayment attributable to the September 19, 1992 check, which covered the period from August 23 to September 19, 1992, because he had returned to work on August 11, 1992, and should have known that he was not entitled to this second check.

OVERPAYMENT - FINDINGS OF FAULT WHEN DIRECT DEPOSIT IS INVOLVED

William G. Frink, Docket No. 94-736, Issued December 15, 1995

An overpayment was created in this case when the claimant returned to work with no loss of wage-earning capacity on June 1, 1993, but was paid compensation for total disability through July 24, 1993. The Office made a preliminary determination that the claimant was with fault in the creation of the overpayment because he accepted a payment he knew or should have known was incorrect. The Office found that he knew or should have known that he was not entitled to compensation after returning to full-time work, and that the period for which compensation was being paid was on the compensation check he received. The claimant responded that he had been told that he would get a letter telling him that his payments were reduced, but that he never received such a letter, and he assumed that everything was okay.

The Board found that the claimant was without fault in the creation of the overpayment because he did not physically receive the checks in question - they were deposited directly into his checking account. There was no documentation that he knew what periods of time were covered by these deposits into his account, nor was there any indication that he had been put on notice that he was being paid incorrectly for a period of time during which he worked.

PERFORMANCE OF DUTY - COMPENSABLE FACTORS OF EMPLOYMENT

Martha L. Cook, Docket No. 95-429, Issued December 6, 1995

The claimant in this case alleged that her emotional condition was caused by harassment by management. The claim was denied on the basis that the claimant had not substantiated any compensable factors of employment. Various grievances filed by the claimant had been settled without a finding of fault, and an Equal Employment Opportunity Commission (EEOC) claim had not been resolved.

The claimant requested reconsideration and submitted additional evidence, including statements from a former supervisor describing the harassment to which the claimant had been subjected. The Office denied modification of the prior decision, and indicated that the claimant had alleged factors which could be compensable if supported by a factfinding agency.

The claimant again requested reconsideration, and submitted a copy of testimony from an EEOC hearing. The presiding administrative judge had made a recommendation that the claimant be awarded compensatory damages, and that the claimant had been harmed by the ongoing and continuous harassment from her supervisors. The employing agency rejected the administrative judge's recommendations by formal decision dated September 2, 1994, and notified the Office of that decision by letter dated September 6, 1994. Meanwhile, also on September 6, 1994, the Office accepted the claim

for an emotional condition, based upon the administrative law judge's earlier decision.

On September 12, 1994, the Office rescinded the previous acceptance, noting that the final EEOC decision was with the employing agency, who had found no discrimination.

FC 96-04 Selected ECAB Decisions for October - December 1995
The Board found that rescinding the acceptance was improper. They stated that a final decision by an employing agency in an EEOC claim that no harassment existed does not, in and of itself, establish error in the original acceptance by the Office. The issue is not whether the claimant has established harassment under EEOC standards, but whether an injury under the Federal Employees' Compensation Act has been established. The Office must exercise its adjudicatory function and make a findings of fact with respect to the allegations of the claimant. The Office did not make independent findings with respect to the claimant's allegations in this case, but rather, made general reference to the final decision of the employing agency in the EEOC claim. While the Office may look to an EEOC claim for evidence in making a determination, the Office must make an independent determination. A claimant need not have a final EEOC decision upholding harassment to establish a claim for benefits under the FECA. Since the Office did not meet its burden of proof to rescind the acceptance of the claim, the Office's decision was reversed.

FC 96-04 Selected ECAB Decisions for October - December 1995

PERFORMANCE OF DUTY - COMPENSABLE FACTORS OF EMPLOYMENT

Thomas D. Petty, Docket No. 94-507, Issued October 6, 1995

In this decision, which involves a psychiatric condition allegedly due to a job reassignment, the Board remanded the case for further development.

The claimant was reassigned to a job at a lower grade level, and was required to undergo training to prepare for the new position. The claimant, who was of dull normal intelligence, expressed reservations about his ability to cope with the required training. He participated in the training for a short period of time, then dropped out due to stress, depression and a nervous breakdown. He did not return to work and was subsequently terminated by his employer.

The district office denied his claim for benefits, finding that fact of injury was not established. They found that the claimant's reaction to his reassignment, training, and the fear of losing his job were self-generated and therefore not compensable.

In remanding the case, the Board stated that an employee's reaction to being reassigned for training results from an employee's job security or frustration at not being allowed to hold a particular position and is not compensable. In this case, however, the claimant also attributed his condition to the actual training and testing he encountered and was required to undergo. Since the training was a requirement imposed by the employer, it became a specially assigned work duty, and would therefore be a compensable employment factor.

PERFORMANCE OF DUTY - COMPENSABLE FACTORS OF EMPLOYMENT - FITNESS FOR DUTY EXAMINATIONS

David L. Yunt, Docket No. 94-50, Issued November 7, 1995

This decision, which involved a claim for an employment-related emotional condition, contains discussion as to whether the employer's requirement that the claimant undergo a psychiatric fitness-for-duty examination would be a compensable factor of employment. Two opposing positions were cited in the

decision. The first was the decision in Margaret M. Boyle, 13 ECAB 172, in which the employee was required to undergo a psychiatric fitness-for-duty examination because of her bizarre and eccentric behavior at work and an unsatisfactory leave record. The examination resulted in the employee being separated, and her claim was for the mental anguish caused by being separated. In this instance, the Board found that the claimant attributed her emotional condition to her fear of the loss of her position, and not to her regular or specially assigned duties or to a requirement imposed by the employer, and therefore her condition was not compensable. In another case, that of Raymond H. Schulz, 23 ECAB 25, the Board found that the requirement that the employee undergo a psychiatric fitness-for-duty examination was a compensable factor of employment, because the decision to require the examination arose out of his correspondence with a coworker, correspondence that originated in his work activities and was related to the work he was hired to perform.

In the Yunt case, the Board found that the reason for the psychiatric fitness-for-duty examination was vague. The record reflects that the claimant was told that he had said something threatening to his supervisors, but the context of the incidents was unclear, and the Board was unable to determine whether there was a connection to the employment duties. However, since there was no medical evidence supporting a causal relationship between the required examination and the claimant's medical condition, the Office's decision was affirmed.

RESCINDING DECISIONS - OFFICE'S BURDEN OF PROOF

Barbara D. Davis, Docket No. 95-725, Issued October 5, 1995

The claimant in this case, a rural route carrier, injured her right knee in 1968. The Office authorized meniscectomy and patellectomy of the knee. After being paid compensation for various periods of disability, the claimant was re-employed in a modified light duty position in 1982 with no loss of pay. In August 1984 she was terminated by her employer for attempted mail theft. The Office reinstated benefits for total disability effective the date of termination.

The claimant's attending physician, a Board-certified orthopedic surgeon, continued to treat the claimant and submitted yearly reports. In 1985 his report indicated that the claimant was able to work only four hours per day. In 1986 he stated that she could work eight hours per day, with restrictions. In 1987, he stated that the claimant had increasing difficulty due to progressive development of arthritis in the knee and could work only four hours per day. In 1988 and 1989, he continued to state that she could work only four hours per day. In 1990 he stated that she could work eight hours per day in a completely sedentary position. In 1991 he reiterated that she could work in a completely sedentary position only, for an unspecified number of hours.

On November 13, 1991, the Office issued a notice of proposed termination of compensation effective August 1984, on the basis that compensation was paid 1984 and continuing due the employer's having rescinded a light duty job offer, when the evidence of record established that she was terminated due to a criminal offense. The Office found that the claimant's condition had not changed materially since 1982, when her physician found her able to perform full-time limited duty. The proposed termination was finalized in December of 1991.

The claimant requested a hearing and submitted a report from her physician which stated, "it is felt that the patient's condition is worsening. It is felt that she certainly has no improvement and she is just as disabled as she was in 1988 when it was determined that she was unable to work." The hearing representative found that the medical evidence supported that the claimant was able to perform the light duty job until 1990, when her physician restricted her to sedentary duty only. The Office decision regarding entitlement from August 1984 until 1990 was affirmed, and the Office was directed to further develop entitlement from 1990 forward.

The Office then declared an overpayment for the period from August 1984 through 1991 (when benefits had been terminated) of $183,806.45. Two days later, the overpayment decision was rescinded pending a determination concerning entitlement from 1990 until 1991. A second opinion evaluation was obtained, in which the claimant was found to be totally disabled. Compensation for total disability was reinstated as of February 23, 1993. An overpayment of $113,838.25 was declared for the period from August 1984 through 1990. The claimant requested and received a hearing, and the hearing representative affirmed the district office decision.

The Board found that the office had not met its burden of proof to establish that the claimant was not disabled during the period from August of 1984 through 1990, for which it rescinded acceptance of the claim. The medical evidence only supported an ability to work four hours per day for certain periods of time, and seemed to indicate total disability as of 1988. The Office's decision was reversed.

When rescinding prior acceptances, care must be taken that the weight of the evidence supports the decision being made by the Office.

FC 96-04 Selected ECAB Decisions for October - December 1995

SCHEDULE AWARD - APPLICATION OF AMA GUIDES

Elizabeth R. Ryan, Docket No. 94-1023, Issued November 21, 1995

This decision is yet another illustration of the care which should be taken in assigning a percentage of permanent impairment of a schedule member.

The claimant had a left knee injury. Her physician submitted a report which described findings and stated that the claimant had 39 percent impairment of the leg. An Office medical advisor reviewed the report, and through application of the AMA Guides, concluded that the claimant had a 28 percent impairment of the leg. The Office awarded 28 percent impairment of the left leg, and the claimant requested a hearing. The hearing representative remanded the case for additional review by the medical advisor, using the third edition of the AMA Guides. The medical advisor concluded that the 28 percent impairment was accurate, and the Office again found that the claimant had a 28 percent impairment.

The claimant again requested a hearing, and submitted another report from her physician which stated that the claimant had 35 percent impairment of the leg. The claimant then withdrew her request for a hearing, because the claimant's physician was requesting additional surgery. The surgery was authorized by the Office. After the surgery and subsequent recovery, the claimant submitted a report from another physician, which related findings, assigned 29 percent impairment of the left leg based on the AMA Guide, and stated that this impairment was separate and not related to the previous estimate of the prior physician.

An Office medical advisor reviewed the case and concluded that there was 30 percent impairment of the leg. The Office made an award for an additional 2 percent impairment. The Board found that the case was not in posture for a decision, because the medical advisor had used an incorrect table when assigning impairment due to pain, and had not addressed impairment due to loss of strength, in spite of findings of quadriceps atrophy and loss of strength.

SCHEDULE AWARD - PROGRAM MEMORANDUM NO. 134

Camille M. Brown, Docket No. 94-735, Issued November 22, 1995

The claimant in this decision had sustained a crush injury to the foot, and developed Morton's neuromas

in the third and fourth web spaces of the left foot, which were accepted by the Office. The neuromas were surgically excised. The claimant claimed a schedule award and stated that he experienced pain and numbness in his left forefoot, total loss of use and feeling of the three smallest toes, and only 25 percent of the normal bending in the other two toes. The Office requested the attending physician to evaluate the claimant's impairment of the foot based upon the AMA Guides. The physician submitted a report which gave degrees of dorsiflexion, plantar flexion, inversion and eversion of the left foot, and stated that the claimant had no additional impairment of the foot due to weakness, atrophy, paid or anesthesia. An Office Medical Advisor reviewed the case, and based on the attending physician's report and the AMA Guides, stated that there was five percent impairment of the foot. The Office made an award for five percent impairment of the foot.

The claimant requested reconsideration and stated that he should receive a greater award based on the cumulative impairment of his toes. The application for review was denied on the basis that the claimant did not submit new evidence or legal arguments.

FC 96-04 Selected ECAB Decisions for October - December 1995

The Board found that the case was not in posture for a decision. The schedule award had been based upon an evaluation of the hind portion of the foot, whereas the accepted condition had affected the forefoot and toes. They pointed out the Program Memorandum No. 134 provides that where the cumulative allowances for the digits of a hand or foot is greater than the value of the percentage loss of the hand or foot, the claimant should have the benefit of the more favorable award. In this case, the impairment of the toes had not been assessed, and so it was not possible to determine whether an award based on the toes would be more favorable to the claimant. The case was remanded for development of this issue.

FC 96-04 Selected ECAB Decisions for October - December 1995

SCHEDULE AWARD - PROGRAM MEMORANDUM NO. 181

David Wharton, Docket No. 94-1242, Issued December 15, 1995

This decision involves a schedule award for hearing loss. The claimant was issued a schedule award for one percent work-related binaural hearing loss, based on the report of a Board-certified otolaryngologist to whom the Office had referred him, and an Office medical advisor review. The Board agreed that the claimant had no more than a one percent loss of binaural hearing. This was based upon zero percent loss for the right ear, and 3.75 percent loss for the left ear. The combined loss, using the appropriate formula, was .625 percent binaural loss, which rounds up to one percent. However, if an award were made for the left ear loss only, it would be for 4 percent monaural loss, which comes out to 2.08 weeks of compensation (4 percent of 52 weeks), as opposed to the 2 weeks (1 percent times 200 weeks) of compensation awarded. According to Program Memorandum No. 181, if the allowances for each ear computed separately is greater than the allowance for monaural loss, the claimant is to be awarded the more favorable allowance. The Board remanded the case for a redetermination with regard to the number of weeks for which the schedule award was payable.

SCHEDULE AWARD - PROVIDING ATTENDING PHYSICIAN WITH SUFFICIENT INFORMATION TO DETERMINE IMPAIRMENT

Stuart Small, Docket No. 94-1038, Issued November 14, 1995

The claimant in this case sustained a right knee injury. The Office accepted that the work injury resulted in a tear of the anterior cruciate ligament. The Office requested the attending physician to provide a

report for schedule award purposes, using the AMA Guides. The physician reported that the claimant had lost 10 degrees of extension, had a 5 percent decrease in strength, and a 10 percent decrease in the circumference of his thigh. He indicated that the impairment of the leg was 1 percent for the extension loss and 15 percent for the loss of the anterior cruciate ligament, for a total of 16 percent. He also stated, "I am not aware that subjective complaints contribute toward an impairment rating...he has major discomfort following a major ligamentous reconstruction. If subjective complaints are part of the impairment rating, please advise me."

An Office Medical Advisor reviewed the case and concluded that there was 21 percent impairment: 1 percent for loss of extension, 2 percent for pain, 15 percent for loss of the anterior cruciate ligament, and 3 percent for loss of strength. The percentages for pain and loss of strength were derived from various tables in the AMA Guides. The Office issued a schedule award for 21 percent impairment of the leg. The Board found that the case was not in posture for a decision.

The attending physician had asked for assistance in rating the permanent impairment due to pain and loss of strength. The Office did not advise the physician further, but rather, had the Office medical advisor review the case. The medical advisor had not referenced the attending physician's findings sufficiently when using the grading schemes and tables in the AMA Guides. The Board therefore remanded the case so that the attending physician could be advised of the appropriate tables for rating pain and loss of strength, and to obtain measurements for loss of flexion.

SUSPENSION OF BENEFITS UNDER 5 U.S.C. 8123(d)

Tippu Deckard, Docket No. 94-319, Issued October 23, 1995

The claimant in this case was off from work for a period of time due to accepted conditions of multiple contusions, shoulder sprain, and right lateral epicondylitis. By letter dated February 3, 1993, the Office asked the attending orthopedic surgeon, Dr. Chein, when the claimant would be able to return to full or restricted duty. In a report dated February 21, 1993, Dr. Chein stated that the claimant could return to restricted duty four hours per day as of that date. On March 22, 1993, the Office referred the claimant for second opinion evaluation on April 19, 1993. By letter dated April 9, 1993, Dr. Chein stated that the claimant could return to light duty for eight hours per day on April 4, and that after a month, his ability to return to full duty would be evaluated.

The claimant returned to limited duty on April 5, but failed to keep the April 19 second opinion appointment. On May 5 the Office advised the claimant of the provisions of 5 U.S.C. 8123(d), that if he refused to submit to or obstructed an examination, his right to compensation would be suspended until the refusal or obstruction stopped. He was asked to provide a written explanation of why he failed to keep the appointment.

The claimant responded that he had completely forgotten about the appointment after he had returned to work. He stated that he was still willing to undergo examination whenever possible. On June 10 an Office claims examiner left a message on the claimant's telephone answering machine that he should reschedule the appointment with the second opinion physician. On June 16 Dr. Chein released the claimant for full duties.

On approximately August 17 the claims examiner telephoned the second opinion physician's office and found that the claimant had not rescheduled the appointment. The claims examiner also tried to contact the claimant at work, but was told that the claimant was no longer working there.

On August 31, the Office issued a decision suspending compensation benefits due to obstruction of the medical evaluation.

The Board reversed the decision. They found that the Office had not followed its own procedures by leaving a message on the claimant's answering machine concerning the second appointment (rather than speaking with the claimant directly or writing a letter), and by not allowing the claimant the opportunity to present a written explanation as to why he failed to make a second appointment.

FECA CIRCULAR NO. 96-05 **July 9, 1996**

SUBJECT: Selected ECAB Decisions for July-September 1995

These decisions cover a variety of issues including use of Office guidelines in the development of medical evidence; refusal of suitable work; an employee's physical ability to perform a selected job; obstruction of medical examination; and the mailbox rule.

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)

Loss of Wage Earning Capacity - Refusal of Suitable Work

Earnestine Rowe, Docket No. 94-1850, Issued July 6, 1995

In this case, the Board ruled that the Office could not find that appellant refused suitable work by resigning her position before she filed her claim for injury.

On May 11, 1992 appellant filed a notice of occupational disease and claim for compensation alleging that she sustained an intractable plantar keratosis of the right foot causally related to factors of her federal employment. Appellant stopped work on December 11, 1991 and resigned effective March 2, 1992. Appellant's personnel record contained a statement regarding her resignation which indicated that, due to health problems with her foot, she was unable to perform the daily duties of her job at the present time.

Appellant received compensation benefits from December 31, 1991 through March 1, 1992. She was released to limited duty effective March 16, 1992. The employing establishment advised that it did have a mandatory light-duty policy, and that appellant took it upon herself to resign.

In January, 1994, appellant filed a notice of recurrence of disability beginning in December, 1992. The Office denied her claim for compensation after March 2, 1992, finding that she refused to seek suitable work under section 8106 of the Act by voluntarily resigning on March 2, 1992, and that she was not entitled to compensation after that date. In a subsequent reconsideration request, appellant contended that she had not received any offer of light-duty work prior to the date she resigned.

The Board found that the Office improperly invoked the penalty provision of 5 USC 8106(c). In order to do so, the Office must establish that a claimant refused an offer of suitable work. At the time she resigned, appellant's claim had not been accepted by the Office and no offer of suitable work had been provided by the agency. While she may have "jumped the gun" by resigning, her action cannot be characterized as a refusal of an offer of suitable work which presupposes that an offer has been made.

Reconsideration - Mailbox Rule

Michael W. Hardin, Docket No. 94-376, Issued July 14, 1995

By decision dated November 29, 1990, the Office denied appellant's claim for recurrent back disability, finding that the accepted injury had aggravated a pre-existing condition that resolved by November 24, 1986. The Office did a merit review and by decision of March 21, 1991, denied modification of the November 29, 1990 decision.

On May 11, 1993, the Office received a congressional inquiry with an attached undated letter from appellant referring to a pending request for reconsideration. On June 23, 1993, appellant's attorney called the Office to discuss a previously filed request for reconsideration and was advised that no further request for reconsideration had been received, and that he could resubmit the request. The Office received a letter dated June 23, 1993 which stated that he had previously filed a request for reconsideration on November 22, 1991, evidenced by an attached two page request for additional compensation signed by the attorney and dated November 22, 1991.

The Office denied the request for reconsideration because it was filed more than one year after the March 21, 1991 decision, and that clear evidence of error was not shown.

The Board found that the Office improperly refused to reopen the claim, stating that:

> The Board has consistently held that in the absence of evidence to the contrary, it is presumed that a notice mailed in the ordinary course of business was received. This presumption, known as the mailbox rule arises when it appears from the record that the notice was properly addressed and duly mailed. The Board has held that the mailbox rule, which has often worked in favor of the Office, applies equally in favor of a claimant.

The Board accepted the June 23, 1993 statement from the attorney, as an officer of the court, and the attached legal pleading and the signature of the attorney, to be sufficient to raise the presumption that the Office received the November 22, 1991 request for reconsideration within one year of the March 21, 1991 decision.

The Board also found that the Office's refusal to reopen the claim constituted harmless error, since the evidence submitted with the request for reconsideration was cumulative. Thus, even though the Board found the refusal to reopen the claim to be improper, it did not require the Office to reopen the claim because the evidence submitted with the request was insufficient to require a merit review.

Medical Referral - Obstruction

Daniel F. O,Donnell, Docket No. 94-428, Issued July 19, 1995

In this case, the Board found that unreliable hearing test results did not, alone, support a finding that appellant had obstructed a medical examination.

The Office referred appellant to an otolaryngologist for a rationalized opinion on the cause and extent of his hearing loss. Results of two audiometric exams, conducted by different audiologists in separate

rooms were considered inconsistent and unreliable. The physician stated his opinion that "hearing is certainly better than audiometric responses furnished to use..." He found that hearing was adequate for conversational purposes, but that hearing testing could not be carried out with reliability.

The DMA stated that the audiograms of record could not be used as a basis for a schedule award.

The Office notified the claimant that his claim was accepted for an employment related hearing loss, and that his right to a schedule award was suspended because he did not adhere to the examination scheduled by the Office, rendering the test results inconsistent and unreliable. The Office concluded that appellant had obstructed the exam scheduled by the Office and suspended his right to compensation under 5 USC 8123(d).

The Board found that the Office improperly determined that appellant obstructed a medical examination. The Office did not state reasons for its conclusion that appellant had obstructed the exam, but apparently based the finding on the fact that the test results were considered inconsistent and unreliable by the otolaryngologist and the DMA. It was therefore unreasonable to make that conclusion and to suspend compensation benefits.

Carpal Tunnel Syndrome - Use of Office Guidelines

Patricia Tompkins, Docket No. 94-702, Issued August 25, 1995

The Office denied appellant's claim for right carpal tunnel syndrome on the basis of the lack of diagnostic studies to demonstrate carpal tunnel syndrome.

In support of a request for reconsideration, reports were submitted showing that both Tinel's sign and Phalen's test were positive, but that EMG or NCV studies had not been performed, because the attending physician did not believe that they were warranted for early carpal tunnel symptoms. The Office denied reconsideration on the basis that the new evidence was insufficient to warrant modification of the previous decision. The Office stated that EMG/NCV tests were needed to establish a diagnosis of carpal tunnel syndrome.

The Board found that the case was not in posture for a decision. It noted that the Office had issued guidelines to be used by claims examiners in determining whether a claimant had demonstrated carpal tunnel syndrome (currently found in Federal [FECA] Procedure Manual Chapter 3-600.8), and that those guidelines listed Phalen's and Tinel's tests, NCV, EMG, and neurological abnormalities as determined by evaluation as appropriate diagnostic tools. In this case, the physician noted neurological abnormalities, as well as positive Phalen's and Tinel's tests. He did not perform EMG or NCV studies, but explained why he did not. The Board found that his reports constituted sufficient evidence to warrant further development by the Office, and remanded the case.

The Office should not be so rigid in following procedures that it neglects to assess the weight of the evidence.

LWEC - Claims Examiner's Responsibility to Determine Whether Appellant Physically Able to Perform Selected Job

Leon Vasquez, Docket No. 94-1219, Issued September 7, 1995

The issue is whether the Office of Workers' Compensation Programs properly determined that the position of an estimator fairly and reasonably represented appellant's wage-earning capacity effective February 6, 1994, the date the Office reduced his compensation.

Appellant's employment-related back condition prevented him from returning to his date of injury job of inspector, and the employing establishment had no positions within his work restrictions. He successfully completed Office-sponsored rehabilitation training as a construction estimator in October 1989. Appellant worked briefly following completion of his training but was too slow to perform the work to the satisfaction of the employer.

In a December 4, 1992 report, appellant's vocational rehabilitation counselor stated that appellant was qualified to work as a construction estimator and that jobs were reasonably available within his commuting area which were medically suitable. The Office reduced appellant's compensation effective February 6, 1994, finding that the medical evidence of record established he was partially disabled and the selected position of estimator fairly and reasonably represented his wage-earning capacity.

The Board found this determination to be improper and reversed the Office's decision, stating:

> Although a claims examiner may rely upon a rehabilitation counselor's opinion as to whether a job is reasonably available and vocationally suitable, the claims examiner has the responsibility to determine whether the medical evidence establishes that appellant is able to perform the job, taking into consideration medical conditions due to the accepted work-related injury and any preexisting medical conditions. At the time of the Office's loss of wage-earning capacity determination in this case, there was evidence of record that appellant suffered from chronic, acute low back pain and radiculopathy between April and November 1993. In fact, appellant was hospitalized for, among other things, chronic low back pain syndrome from April 6 to May 21, 1993.
>
> The Office relied upon an August 3, 1992 work restriction evaluation completed by Dr. Waldman, a Board-certified orthopedic surgeon, to determine the suitability of the selected position in this case despite the fact that there was evidence since August 1992 that appellant continued to suffer from acute low back pain and radiculopathy. The Office modified appellant's compensation effective February 6, 1994 without determining whether appellant's acute low back pain and radiculopathy since August 1992 affected his ability to perform duties of the selected position. The medical evidence of record, therefore, does not establish that the duties of an estimator fairly and reasonably represented appellant's wage earning capacity on February 6, 1994 -- the effective date of the Office's loss of wage-earning capacity determination. The Office found that appellant was capable of performing the duties of an estimator without determining whether appellant's chronic, acute low back pain and radiculopathy prevented him from performing the duties of the selected position. Thus, the Board finds that the Office improperly determined that the position of an estimator mechanic fairly and reasonably represented appellant's wage-earning capacity effective February 6, 1994.

When making a determination of an employee's wage-earning capacity, the claims examiner must consider all of the medical evidence of record and may not select that which best supports the final determination to the exclusion of all other pertinent medical evidence.

Loss of Wage-Earning Capacity - Probative Value of Medical Evidence in Modifying LWEC

Rosenaldo Dean, Docket No. 94-424; Issued September 28, 1995

Appellant, a former nursing assistant, was receiving compensation for temporary total disability due to a work-related herniated nucleus pulposis at L5-S1. The Office determined that he could work at the selected position of video store rental clerk and reduced his compensation accordingly. His attending orthopedic surgeon approved of the selected position including the physical demands of 20 pounds maximum lifting as set forth in the Dictionary of Occupational Titles.

Appellant submitted a series of requests for reconsideration all of which were denied on the grounds that the evidence was insufficient to warrant modification. He included with his requests, reports from his attending physician and a physician specializing in occupational medicine, which indicated that he was physically unable to perform the job of video store clerk. A functional capacity assessment indicated that appellant could lift up to 14 pounds occasionally and 12.5 pounds frequently.

The attending physician reported that appellant had an increase in his symptoms of low back and leg pain which prevented him from working as a video store clerk. The occupational medicine specialist stated that, because the lifting capacity for the video clerk position was 20 pounds, and the functional capacity assessment showed an ability to lift 14 pounds, this alone prevented him from doing the job.

Based on a report from a rehabilitation counselor who visited a video store and was told by the assistant manager that lifting never exceeded 10 pounds, the Office found in one of its reconsideration decisions, that the position of video store clerk met appellant's requirement of not lifting more than 14 pounds.

The Board found that the Office properly reduced appellant's compensation to reflect his wage-earning capacity as a video store rental clerk and properly refused to modify its determination. However, the Board pointed out that the denial of modification on the grounds that the selected position was within the lifting restrictions found in the functional capacity evaluation was incorrect. The physical requirements of a selected position contained in the Dictionary of Occupational Titles cannot be modified based on information from a single employer.

With regard to the medical evidence, the Board stated:

> The deficiency of the reports from [appellant's physicians] is not the failure to explain how the functional capacity evaluation showed that appellant could not perform the position, but rather it is the failure of each physician to explain how appellant's employment-related condition has changed such that he is no longer able to perform the selected position. A general statement that appellant is unable to perform the selected position is of little probative value in modifying a loss of wage-earning capacity determination without a full explanation as to the contribution from a employment-related condition.

FECA CIRCULAR NO. 96-06 **July 9, 1996**

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

The interest rate to be assessed for the prompt payment bills is 7.0 percent for the period July 1, 1996 through December 31, 1996.

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, 1996.

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

7/1/96 - 12/31/96	7.0%
1/1/96 - 06/30/96	5 7/8%
7/1/95 - 12/31/95	6 3/8%
1/1/95 - 06/30/95	8 1/8%
7/1/94 - 12/31/94	7.0%
1/1/94 - 06/30/94	5 1/2%
7/1/93 - 12/31/93	5 5/8%
1/1/93 - 06/30/93	6 1/2%
7/1/92 - 12/31/92	7.0%
1/1/92 - 06/30/92	6 7/8%
7/1/91 - 12/31/91	8 1/2%
1/1/91 - 06/30/91	8 3/8%
7/1/90 - 12/31/90	9.0%
1/1/90 - 06/30/90	8 1/2%
7/1/89 - 12/31/89	9 1/8%
1/1/89 - 06/30/89	9 3/4%
7/1/88 - 12/31/88	9 1/4%
1/1/88 - 06/30/88	9 3/8%
7/1/87 - 12/31/87	8 7/8%
1/1/87 - 06/30/87	7 5/8%
7/1/86 - 12/31/86	8 1/2%
1/1/86 - 06/30/86	9 3/4%
7/1/85 - 12/31/85	10 3/8%
1/1/85 - 06/30/85	12 1/8%

ATTACHMENT TO FECA CIRCULAR NO. 96-06
DMS INTEREST RATES

1/1/96 - 12/31/96	5%
7/1/95 - 12/31/95	5%

1/1/95 - 06/30/95	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. 96-06

FECA CIRCULAR NO. 96-07 **July 29, 1996**

SUBJECT: Computation of Compensation for Rural Letter Carriers

Recent revisions to Chapters 2-900 and 2-901 provide procedures for paying compensation to Rural Letter Carriers. This circular is provided to help resolve some of the questions and confusion regarding various compensation payment issues unique to Rural Letter Carriers. Most of the guidance provided here simply follows principals already outlined in the law and the procedure manual, but covers areas that have been problematic in one document for easy reference.

EVALUATED PAY

As stated in PM 2-900, the salaries for rural carriers are based on the evaluation of their routes. The carrier's grade and step determines their hourly rate of pay. The route may be evaluated at between 36 and 48 hours per week. The hourly pay is multiplied by a formula corresponding to the route evaluation to derive their salary. They are paid the same salary whether they actually work more or less than the route evaluation. Salaries for routes which are evaluated at more than 40 hours per week are not considered to include overtime. They are only paid overtime if they work more than the number of hours established by the contract for overtime for their route. The evaluated pay, therefore, is the pay rate for compensation purposes.

For the sake of illustration, the examples in this circular will calculate hours over 40 hours per week at 1 1/2 times the hourly rate. The actual formula, however, is more complicated than that.

The salary of a rural carrier may vary over the life of the claim due to reevaluations of their route. 5 U.S.C. 8101 states that the pay rate for compensation purposes is the pay rate in effect on the date of injury, the date disability begins, or the date of recurrence, whichever is greater. There is no provision for adjusting compensation benefits because of a pay adjustment that occurs after the injury, where the disability is continuous. If a route is adjusted while an injured employee continues to be totally disabled, their compensation continues based on the date of injury pay rate.

Example: Rural carrier, John Smith, is injured on January 20, 1994, while assigned to a route evaluated at 42 hours. As a grade 10 step 1, His hourly rate of pay is $15.00, which equates to a salary of $645.00 per week for a 42 hour route. He is totally disabled from the date of injury through his return to full duty on July 2, 1995.

On March 15, 1994, his route is reevaluated for 45 hours. His salary is increased to $712.50 accordingly. Then, on December 1, 1994, his route evaluation is reduced to 38 hours, resulting in a decrease in his salary to $570 per week. His compensation continues based on a date of injury pay rate of $645.00 for the entire period through July 1, 1995. Of course he would be entitled to the 3/1/95 CPI increase.

When a route evaluation is reduced while a carrier is disabled, there is no continuing entitlement to compensation after the carrier is fit to return to full duty. The reduced evaluation is not due to injury related disability.

When John Smith returns to full duty on July 2, 1995, there is no continuing entitlement to compensation benefits, even though his salary was reduced while he was disabled.

RECURRENCES

If a rural carrier suffers a recurrence of total disability after returning to full duty, and their rate of pay is lower at the time of the recurrence, their compensation will be based on the date of injury pay rate.

Example: John Smith suffers a recurrence on February 1, 1996. He is now a grade 10, step 3, earning $16.50 per hour. His route is still evaluated at 38 hours, which equates to a salary of $627.00 per week. As this is less than his date of injury pay rate of $645.00, compensation is paid based on the DOI pay rate plus the CPI.

LOSS OF WAGE EARNING CAPACITY

Like all other Federal employees, rural carriers are entitled to any Loss of Wage Earning Capacity (LWEC) when they return to part time or light (limited) duty due to a job related injury. In applying the Shadrick formula, the claims examiner has to determine the "current pay for the job held when injured" (item 2 of the formula). This can be confusing where the rural carrier's route evaluation has changed since the injury.

Route evaluations can increase or decrease because of a mail count, without the geographic boundaries changing. Also, the geographic boundaries can be changed resulting in either an increase or decrease. In order to determine the "current pay for the job held when injured", the claims examiner must ask the Post Office whether the rural carrier's route has been reevaluated since the injury, and if so, whether the geographic boundaries have changed. Then proceed as follows:

If the route boundaries have NOT changed, ask the Post Office to use the current evaluation of the route (number of hours) and the current hourly rate for the grade and step of the carrier when injured to derive the current weekly pay for the job held when injured.

On April 1, 1996, John Smith's route evaluation was changed again to 43 hours. He is still a grade 10, step 3, and his hourly rate of pay is still $16.50. Based on a 43 hour route, his weekly pay is $734.25. John Smith returns to partial duty on 5/1/96. Let's say that the changes described to his route evaluation were all based on mail counts, and the geographic boundaries have not changed.

The pay for a grade 10, step 1 (the grade and step when injured) is $16.00 per hour as of 5/1/96. Ask the USPS to provide the current salary for a grade 10, step 1, working a 43 hour route. This is the "current pay for the job held when injured". It will be approximately $712.00, (($16 X 40) + ($24 X 3)) but remember, the formula is a bit more complicated, so you must get this from the Post Office.

If the route boundaries HAVE changed, the job held when injured no longer exists. Take the current pay for the grade and step when injured multiplied by the number of hours of the route evaluation at the time of injury.

If ANY of the reevaluations of John Smith's route were due to a change in the geographic boundaries, his job when injured no longer exists. Ask the Post Office to provide the current salary for a grade 10, step 1 working a 42 hour route. (It will be approximately $688, but again, you must obtain it from the Post Office.)

Once you have determined the "current pay for the job held when injured", you can proceed to apply the Shadrick formula to compensation payments for partial disability. Use the guidance provided above for the pay rate as of the date of injury, date disability began, or date of recurrence (item 1 of the formula).

Changes in route evaluations which occur after a final LWEC decision is issued do not alter that decision.

RURAL CARRIER ASSOCIATES (RCAs)

The rural letter carrier craft includes many Rural Carrier Associates (RCAs), who are employed irregularly and paid When Actually Employed (WAE). It can be confusing to the RCA that COP and the pay rate for compensation purposes are determined differently.

COP for all WAE employees is determined under 20 CFR 10.205 (c). The average weekly earnings for COP is computed by dividing the total earnings during the year prior by the number of weeks worked during the year.

The pay rate for compensation purposes for all WAEs is determined under 5 U.S.C. 8114, taking the total earnings for the year prior divided by 52. As a result, the pay rate for compensation purposes can be lower than the pay rate for COP.

It is hoped that this guidance will help you resolve most questions regarding computation of pay for rural letter carriers. Any additional questions in this regard should be addressed to Cecile Moran on (202)219-8461, email cmf@fenix2.

Sincerely,

Thomas M. Markey
Director for
Federal Employees' Compensation

Distribution: Folioviews Groups A and D
(Claims Examiners, All Supervisors, District Medical Advisors, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

FECA CIRCULAR NO. 96-08 **September 25, 1996**

SUBJECT: SELECTED ECAB DECISIONS FOR APRIL - JUNE 1996

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

A number of topics are covered, including Form CA-17 as authorization for medical treatment, forfeiture of compensation for failure to report earnings, use of affirmative defense in Peace Corps cases, overpayment findings of fault, performance of duty/compensable employment factors, and sending copies of correspondence to authorized representatives.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

AUTHORIZATION FOR MEDICAL TREATMENT - FORM CA-17

John B. Pettersen, Docket No. 94-2133, Issued June 12, 1996

A number of issues were addressed in this decision, but only the matter of Form CA-17 being considered authorization for medical treatment will be discussed in detail in this summary.

The claimant injured his back in the performance of duty. He was treated by a chiropractor, and was also examined by two medical doctors. No Form CA-16 was issued for treatment by the chiropractor, and the file showed no evidence that a CA-16 was issued for treatment by any other practitioner. However, several CA-17 forms were issued to the chiropractor. The Office denied payment of the chiropractor's bills on the basis that he did not qualify as a physician under the FECA, since he did not take x-rays at the time of injury to establish a subluxation. The Board found that the chiropractor should have been considered a physician, because subluxation was found on x-rays taken several months after the injury. They also found that the office should have considered whether the CA-17s issued to the chiropractor were issued under "an emergency" or "unusual circumstances," which would require the Office to exercise its discretion on whether to authorize the chiropractor's treatment, even though a CA-16 had not been completed. Because the Office had not exercised its discretion and made such a determination, the case was remanded.

FORFEITURE OF COMPENSATION FOR FAILURE TO REPORT EARNINGS

Janine M. Bernerth, Docket No. 94-1290, Issued April 5, 1996

The claimant sustained a right ankle fracture, which was accepted by the office. She returned to work part-time, then was totally disabled again due to a consequential injury. She submitted CA-8 forms to claim continuing compensation for the periods April 18 through May 1, 1992, and May 2 through May 15, 1992. On both forms, she indicated that she had not been employed. On May 20, 1992 she completed another CA-8 form, and attached a letter which stated that checks had been issued to her for work actually performed by her sons and fiance. The work involved delivery of telephone books. She stated that she signed delivery contracts in her name so that her sons and fiance could fulfill more than one contract, because the delivery company would allow only one contract at a time. The payments to her totalled $700.00.

The employer conducted an investigation. The claimant admitted that she sometimes drove the truck to pick up and transport telephone books, and that she also made notations indicating who received how many telephone books. She estimated that she helped 25% of the time.

The Office declared that compensation paid to the claimant for the period April 18 through May 15, 1992 was forfeited because she worked and did not report her earnings on the CA-8 forms. A $1,854.00 overpayment was declared, and the claimant was found to be with fault.

The claimant responded that no one ever explained to her the information she needed to submit on a CA-8 form, and that her sons and fiance earned the money, not her. She requested a hearing, during which she testified that after she received the checks in payment for the deliveries, she tried to telephone the office concerning what to do, and when she received no satisfactory answer, she wrote the May 20 letter. Her representative stated that the first check did not arrive until after one of the CA-8 forms had been sent to the Office. The hearing representative upheld the forfeiture decision.

The Board found that the Office improperly found that the claimant had forfeited compensation for the period April 18 through May 15, 1992. The Office has the burden of establishing that the claimant knowingly failed to report employment or earnings. It is not sufficient simply to establish that there were unreported earnings from employment. The term "knowingly"
is not defined in the Act or its implementing regulations, but the Board had held that it included such concepts as "with knowledge," "consciously," "intelligently," "willfully," or "intentionally." The office gave no evaluation or explanation of how the claimant "knowingly" omitted to report earnings, and therefore did not meet its burden to declare forfeiture.

HEARING LOSS - REPORT REQUIREMENTS; TINNITUS

Carmel J. Dalfonso, Docket No. 94-2015, Issued May 28, 1996

This decision is being included not because of the outcome, but because it contained some interesting discussion concerning hearing loss cases.

Claims examiners are often required to determine which of several audiograms to use in determining the extent of a claimant's hearing loss. A complete evaluation should include results of speech reception thresholds, auditory discrimination scores, and bone conduction thresholds. The audiological examination should be conducted separately from the otological examination, to ensure reliability.

With respect to tinnitus, the A.M.A. Guides to the Evaluation of Permanent Impairment does not assign impairment, except to the extent that tinnitus causes an inner ear disturbance, which produces vestibular disequilibrium or vertigo. In addition, a five percent impairment can be assigned where tinnitus impairs speech discrimination.

INTOXICATION - USE OF AFFIRMATIVE DEFENSE IN PEACE CORPS CASES

Kurt R. Ellis, Docket No. 94-969, Issued April 1, 1996

The claimant was a Peace Corps volunteer who sustained a psychotic episode while serving in the Peace Corps in Senegal, West Africa. He was taken to the United States for treatment and was separated from the Peace Corps shortly thereafter. He claimed that the stressful living conditions in Senegal, including different culture, customs, and language, had caused his condition.

The claimant had a twelve-year history of smoking marijuana several times a week, and had smoked marijuana and drank alcohol two to three times a week while in Senegal. He had been smoking marijuana and drinking at the time when he first started exhibiting psychotic delusions. The claimant also had a strong family history of mental illness.

The Office denied the claim on the basis that the emotional condition did not occur in the performance of duty, and that the claimant was in violation of the statutory exclusions of section 8102 involving intoxication or substance abuse. The claimant requested reconsideration and submitted additional medical evidence, which included an unrationalized medical opinion that the brief reactive psychosis was caused by job stress, rather than use of alcohol and marijuana. The Office denied modification, finding that the new evidence was insufficient to warrant modification of the prior decision.

The Board affirmed the office's decision, but pointed out that the statutory exclusion provisions for Peace Corps volunteers were found at section 8142(c)(3) rather than section 8102. Title 20 C.F.R. Section 10.605 provides that any injury suffered by a Peace Corps volunteer while the volunteer is located abroad is presumed to have been sustained in the performance of duty, and any disease or illness contracted during that time is presumed to be proximately caused by the employment, except when the injury or disease is caused by the volunteer's willful misconduct, intent to bring about the injury of self or another, or intoxication by alcohol or illegal drugs. If a presumption of causal relationship cannot be made because of these factors, then the volunteer has the burden of proving that the injury was sustained in the performance of duty. The Office raised the statutory exclusion issue, and the claimant failed to submit rationalized medical evidence establishing that his condition was related to his employment, rather than the intoxication and drug use.

OVERPAYMENT - FINDING OF FAULT

Charolette P. Sanders, Docket No. 94-65, Issued May 9, 1996

Several issues were being appealed in this case. The only issue being addressed in this summary is that of the finding with respect to an overpayment of compensation.

The claimant was receiving compensation on the periodic roll. She was informed that she should advise the Office if she received an offer of a position from her employer. By telephone call dated February 26, 1992, the Office was informed that the claimant returned to work on January 21, 1992. The claimant was informed on February 26 that she might have an overpayment. The claimant was paid compensation through March 6, 1992. An overpayment was calculated for the period January 21 through March 6, 1992. The claimant was informed that she was found to be with fault with respect to the overpayment, as she should have reasonably been aware that she was not entitled to compensation for lost wages after her return to duty.

The Board agreed with the amount of the overpayment, but found that the claimant was without fault for the portion of the overpayment that she received prior to the February 26 telephone call (a periodic roll check dated February 8, covering the period from January 12 through February 8, 1992). They reiterated the principle that the content of a form letter such as the one sent in this case cannot be used to establish what a claimant knew or didn't know with regard to the receipt of a subsequent payment, because it contains no specific information concerning the specific check. The Board also found that the finding of fault for the next check, dated March 7, 1992, was correct because after the February 26 telephone call, the claimant should have known that she was not entitled to the check.

This serves as a reminder that the circumstances of the individual case must be fully considered when making fault determinations.

OVERPAYMENT - FINDING OF FAULT

Thomas Ray, Docket No. 94-1356, Issued April 19, 1996

The claimant in this decision sustained a wrist injury which was accepted by the Office, and for which he received total disability benefits for approximately three years. When he was placed on the periodic roll, he was sent a letter CA-1049, which stated that he must notify the Office immediately upon any return to work and must return payments for periods that he worked. He was also sent CA-1032 letters, which also reiterated that employment should be reported immediately.

The claimant began to work full-time in a lower-paying job in August 1992, which was reported in an August rehabilitation report. The claimant continued to receive compensation for total disability through February 6, 1993, at which time compensation payments were reduced, based upon his loss of wage-earning capacity. The Office declared an overpayment of $4,443.22 for the period from August until February, based on the claimant having received benefits for total disability when he was only entitled to partial disability payments, due to his employment. The office found that the claimant was with fault in the matter of the overpayment, because he should have known that he was not entitled to compensation for total disability for this period.

The claimant requested a hearing on the issues of fault and waiver. He testified that he had tried to contact the Office after he returned to work, and received written information that the amount of compensation he was receiving was correct. The hearing representative affirmed the finding of fault and directed repayment based on financial information provided by the claimant.

The Board found that the amount of the overpayment was correct, but that the Office had improperly determined that the claimant was with fault. They found that the Office had not submitted sufficient evidence to establish that the claimant accepted payments that he knew or should have known were incorrect, since the record did not contain copies of the compensation payments or other evidence relating to the correctness of the payments. The CA-1049 letter in and of itself was not sufficient because it did not contain information regarding the period covered by a specific subsequent payment. The case was remanded for consideration of the claimant's eligibility for waiver.

PERFORMANCE OF DUTY - COMPENSABLE FACTORS OF EMPLOYMENT

Elmer G. Tardie, Docket No. 94-1107, Issued May 6, 1996

A significant number of ECAB Quarterly Summary Circulars issued during the past few years have included decisions which dealt with compensable factors of employment in claims for emotional conditions. In reviewing ECAB decisions over the past few years, it is noted that in general, claims examiners are becoming more skilled at differentiating between compensable and non-compensable employment factors. A larger proportion of decisions are being affirmed by the Board.

In this decision, the claimant stated that a few weeks after starting his new job, he became confused and depressed, and experienced headaches. He described the nature of his work as sorting materials into appropriate bins. He was required to work quickly and to make as few mistakes as possible. While working he would get anxious and confused, and he made some mistakes. He stated that he was not pushed to work faster, and that everyone at his employing establishment was friendly. His employer stated
that the claimant was a perfectionist, that he was consistently a top achiever, and that he became upset with himself when he made an error. The employer stated that they had reassured him that they were pleased with his performance, but that he was still self-critical.

The Office denied the claim on the basis that fact of injury was not established. They accepted that the described events occurred as stated, but found that the medical evidence did not support that a medical condition resulted from the work exposure.

A hearing was requested and conducted. The hearing representative found that the claim was based upon the claimant's anxiety over his ability to perform his duties, which was self-generated and therefore not compensable. The District Office's decision was affirmed.

The Board disagreed. They found that the claimant described the specific duties and requirements of his job to which he attributed his condition, and that these related to his assigned duties and were compensable. The Board also found that the claimant had submitted sufficient medical evidence to establish a prima facie claim. They remanded the case for additional development.

PERFORMANCE OF DUTY - COMPENSABLE FACTORS OF EMPLOYMENT

Leo Bumpus, Docket No. 94-1128, Issued April 19, 1996

The claimant in this decision was a mailhandler who claimed aggravation of asthma due to a conversation he had with his employer about union time.

The claimant was administrative vice president of the local union. On the Saturday of Labor Day weekend, after working about an hour, he asked his supervisor for union time for the remainder of the shift (about six hours). The supervisor told him that he could have one or two hours, but that he needed the claimant to work the rest of the time. After further discussion concerning whether the claimant was really needed to work, the claimant had an asthma attack. The employer submitted a statement that on most occasions, the claimant had in the past been given the total time requested for union affairs. On the date of injury, the staffing was reduced, and the mail volume was heavy, so management's offer of one to two hours of union time was reasonable.

The Office denied the claim on the basis that the injury did not occur in the performance of duty. The claimant requested a hearing. At the hearing, the claimant's representative contended that the claimant was on the clock in the performance of his duties as a union representative at the time of his injury. The claimant stated that he had filed a grievance over the denial of union time, which was at Step 3 and had not been resolved. The claimant also submitted a copy of a decision of a labor relations specialist from his employing agency which was reportedly related to a grievance on a prior denial of union time. The decision stated that "steward time will not be unreasonably denied" , and "there may have been occasions when the grievant was not allowed to do union business for eight hours a day based on the needs of the service. The file indicates that the grievant has been allowed eight hours of union time on other occasions. No disclosure of discrimination has been demonstrated..." The claimant also submitted a copy of the union/agency agreement, which stated that requests for official time by union stewards should not be unreasonably denied. The hearing representative affirmed the district office's decision, finding that the denial of union time was an administrative action, and there was no evidence that the agency's action was abusive or in error.

The Board found that the claimant was not actually engaged in representational functions at the time of his asthma attack, and that determining whether or not to grant union time was an administrative function of the agency which would not be covered under the Act absent a showing of error or abuse. The decision was affirmed.

REFUSAL OF SUITABLE WORK

Lawrence T. Pisapio, Docket No. 95-25, Issued April 15, 1996

The claimant was a credit union examiner stationed in California at the time he injured his back. The claim was accepted for a lumbosacral strain and a herniated disc.

Approximately one year prior to his injury, the claimant had been detailed to the California office, received a temporary promotion shortly after that, and then was reassigned to a permanent auditor position. Prior to his injury, he had moved his family back to Massachusetts, which is where he lived prior to being detailed to the California Office. He had applied for a transfer back to Massachusetts, but was still employed in California at the time of his injury.

The claimant's physician submitted medical evidence supporting that the claimant could return to work with no heavy lifting or prolonged sitting. The employer offered him employment as an auditor in California. The office reviewed the job offer and informed the claimant that it was suitable. The claimant refused the job on the basis that commuting from Massachusetts to California was not compatible with his medical condition. The Office received information from the agency showing that a PCS move from Massachusetts to California had been authorized, and that the claimant had established a residence in California. After verifying that the California residence was within commuting distance of the California office, the Office informed the claimant that his reason for refusing the job offer was unacceptable, that the job would be held open an additional 15 days to allow him to accept it, and that failure to accept the offered employment would result in termination of compensation. The Office received no further response from the claimant, and compensation was terminated.

The claimant requested a hearing. He stated that he had been in the process of arranging for a transfer when the injury occurred, and that the suitable work position was not in his commuting area as his residence was in Massachusetts. The hearing representative affirmed the Office's decision, finding that his duty station was in California, and the issue of whether the claimant had moved his household back to Massachusetts was irrelevant. The claimant also requested reconsideration, for which the Office denied modification.

The Board affirmed the Office's decisions. They reiterated the principle that if a continuously employed individual moves away from the employer's commuting area, a refusal of suitable work on the basis that it is not within the commuting area will not be acceptable.

REPRESENTATIVES - SENDING COPIES OF CORRESPONDENCE

Ivan R. Sturdivant, Docket No. 94-1809, Issued May 10, 1996
Irene M. Williams, Docket No. 94-1831, Issued May 29, 1996

Both of these decisions involve failure of the district offices to send copies of correspondence to authorized representatives.

In Sturdivant, the Office accepted that the claimant's head injury resulted in a mild contusion. The claimant subsequently resigned from his job due to a nonemployment-related condition, retained an attorney, and filed a claim for an unspecified recurrence of disability. The Office acknowledged the representative, and sent him procedures with regard to representative's fee applications. In a separate letter, the claimant was advised of the information required to establish his claim for recurrence. No copy of the letter was sent to the authorized representative. After receiving no response from the claimant, the Office denied the claim for recurrence. No copy of the denial decision was sent to the representative.

The Board set aside the Office's decision because the Office failed to send the representative notice of the deficiencies of the claim, thereby depriving him of the opportunity to assist in remedying the deficiencies. The case was remanded for the Office to notify both the claimant and the representative of the deficiencies of the claim.

In Williams, after paying compensation and medical benefits, the Office terminated the claimant's compensation on the basis that she had no continuing work-related disability. The Office had obtained second and impartial medical opinions on the issue, and the termination was based upon the opinions of those examiners. The authorized representative had requested that he be made part of the selection of any impartial medical specialist, but did not state the reason for participation in the selection, until after the termination of benefits was made. The Office did not inform the representative of the appointment for the impartial examination. In response to the proposed termination of compensation, the representative objected on the basis that he had not been allowed to participate in the selection of the impartial examiner, and that the reason for the request was that the claimant preferred to be examined by a female physician. The Office finalized the termination.

The representative requested reconsideration, citing the procedural error made with respect to the selection of the impartial physician. The Office denied modification of the prior decision.

The Board found that the impartial physician's report was not sufficient to constitute the weight of the medical evidence because it did not provide medical rationale for the opinions expressed, and reversed the decisions on the basis that the Office had not met its burden of proof to terminate benefits. With respect to the impartial physician selection, the Board stated that since no valid reason for participating in the selection process was offered by the representative, the Office's failure to provide him with a copy of the referral letter constituted harmless error.

Although in the Williams decision, the Office's failure to send a copy of correspondence to the authorized representative was found to be harmless error, the importance of sending copies of all correspondence to the authorized representative cannot be emphasized too much.

REPRESENTATIVES' FEES - ABUSE OF DISCRETION

Charles Hufford, Docket No. 94-1551, Issued April 22, 1996

The representative in this case requested approval of a fee in the amount of $7,774.00, based upon 23.92 hours of work at an hourly rate of $325.00. The claimant objected to the fee request, and stated that the fees were "excessive and unconscionable". The Office approved a fee in the amount of $4,784.00, based upon the claimed number of hours and an hourly rate of $200.00 rather than $325.00. As justification for reducing the hourly rate, the Office stated that the rate appeared high when compared to what attorneys in northern California charge (the attorney was located in Los Angeles), that an attorney in Long Beach charged less for similar cases, that there were attorneys in northern California who charged less than $100.00 per hour, and that there could not be that much of a difference between northern and southern California.

The Board found that the Office had abused its discretion in approving the reduced fee. The sole area of dispute was the hourly rate. The Office had not provided probative evidence to support that $200.00 per hour was a "customary local charge for similar services". The Los Angeles Bar Association or a similar organization had not been contacted for information concerning customary local charges.

FECA TRANSMITTALS INDEX

	Part 2 - Claims, Federal (FECA) Procedure Manual
FT 96-13	**Revision to Part 5, Benefit Payments, Federal (FECA) Procedure Manual**
FT 96-14	**Revision to Chapter 2-1000, Dual Benefits, Part 2 - Claims, Federal (FECA) Procedure Manual**
FT 96-15	**Revision to Chapter 3-0201, Staff Nurse Services, Chapter 3-0300, Authorizing Examination and Treatment, and Chapter 3-0600, Requirements for Medical Reports (09/96B)**
FT 96-16	**Revision to Chapter 2-0814, Reemployment: Determining Wage-Earning Capacity, and 2-1700, Special Act Cases, Part 2 - Claims, Federal (FECA) Procedure Manual**
FT 96-17	**Revision to Chapter 2-0900, Determining Pay Rates, and Chapter 2-0901, Computing Compensation, Part 2 - Claims, Federal (FECA) Procedure Manual**
FT 96-18	**Revision to Chapter 2-1602, Reconsiderations, Part 2 - Claims, Federal (FECA) Procedure Manual**
FT 96-19	**Revision to Chapter 4-0600, Reserve Officers' Training Corps, Part 4 - Special Case Procedures, Federal (FECA)**
FT 96-20	**Revision to Chapter 2-0806, Occupational Illness, and Chapter 2-0814, Reemployment: Determining Wage-Earning Capacity, Part 2 - Claims, Federal (FECA) Procedure Manual**
FT 96-21	**Revisions to Chapter 5-0204, Principles of Bill Adjudication, Part 5 - Benefit Payments, Federal (FECA) Procedure Manual**
FT 96-22	**Revision to Chapter 2-0401, Automated System Support For Case Actions, and Chapter 2-1400, Disallowances,Part 2 - Claims, Federal (FECA) Procedure Manual**
FT 96-23	**Revision to Chapter 2-0814, Reemployment: Determining Wage-Earning Capacity, Part 2 - Claims, Federal (FECA) Procedure Manual**
FT 96-25	**Revision to Chapter 0-0100, Introduction to FECA and DFEC (07/96B)**
FT 96-26	**Revision to Chapter 2-0700, Death Claims, and Chapter 2-1400, Disallowances (07/96B)**
FT 96-27	**Revision to Chapter 2-1602, Reconsiderations (09/96A)**
FT 96-28	**Revision to Chapter 2-0802, Civil Employee, and to FECA Program Memorandum 249 (09/96B)**
FT 96-29	**Issuance of New Chapter 5-0700, Chargeback, Part 5 - Fiscal (09/96B)**
FT 96-30	**Revision to Chapter 2-0810, Developing and Evaluating Medical Evidence, and Chapter 2-0813, Reemployment: Vocational Rehabilitation Services (09/96B)**

FT 96-01 Revision to Chapter 2-0806, Occupational Illness, Chapter 2-0800, Development of Claims, and Chapter 2-0400, File Maintenance and Management, Part 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

RELEASE -REVISION TO CHAPTER 2-0806, OCCUPATIONAL ILLNESS, CHAPTER 2-0800, DEVELOPMENT OF CLAIMS, AND CHAPTER 2-0400, FILE MAINTENANCE AND MANAGEMENT, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-01 October 10, 1995

EXPLANATION OF MATERIAL TRANSMITTED:

In July, National Office personnel surveyed a statistically valid sample of occupational illness claims in two district offices to determine what proportion of cases were simple OD and what proportion required extensive development of the evidence. The reviewers also assessed how long it took to adjudicate these cases.

This survey showed that occupational illness claims fall into two strikingly different groups, depending on nature of injury:

The large majority of all occupational illness cases usually required far less than the 180 days allotted for adjudication. This group included most of the claims for orthopedic injury, skin diseases, and infectious diseases.

The rest of the occupational illness cases usually required extensive development of the evidence for adjudication. This group included claims for stress (whether manifested as an emotional, gastrointestinal, or cardiac condition); multiple chemical sensitivity and sick building syndrome; strokes and other vascular diseases; pulmonary conditions; and hearing loss.

The reviewers also noted that if a second inquiry was made to obtain requested evidence in either group of cases, this letter almost never resulted in receipt of the requested information.

These findings have led us to believe that adjudication time frames for occupational illness cases can be adjusted to reflect the nature of injury without imperiling the quality of adjudication or requiring more work from claims personnel.
The new time frames for adjudication will be as follows:

For claims requiring the basic period for development:

75% within 90 days
95% within 180 days

For claims requiring an extended period for development:

70% within 180 days
98% within 365 days

To allow for clear distinctions between these groups, the number of codes for nature of injury has been increased, and their use has been refined. Cases involving skin, musculoskeletal, and infectious disorders, as well as certain other conditions (nature of injury code beginning with S, M, V or O) are to be adjudicated within 90 days.

The revised codes are shown as Exhibit 21 (note that general code "D9" has been dropped). The codes have also been programmed into the adjudication screen on the Sequent system, so that claims staff will know what time frame applies to each individual case. If multiple conditions are claimed, and more than one time frame applies, the longer period will be allowed for adjudication. If the nature of injury is miscoded, the CE is authorized to change it effective the date of this transmittal.

The CE is encouraged to adjudicate rapidly any case where the five basic requirements are clearly met, either when the claim is first submitted or when basic missing evidence has been received, and the underlying factors of employment have obviously led to the condition claimed. The procedures for such claims remain basically unchanged.

The requirement that general requests for information be made twice in occupational illness claims is being eliminated.

Any time a claim for occupational illness is adjudicated within 90 days of submission and the claimant has not returned to work, the CE should refer it for nurse services. When the claim is adjudicated after 90 days of submission and the claimant has not returned to work, the CE should consider whether such referral would be useful. Such referrals assist the program's objectives of managing the medical aspects of the claim and returning claimants to work as early as possible.

PM 2-0806.5, Evaluating Evidence in Cases Not Classified as Simple OD, has been removed as duplicative of material appearing in PM 2-0804 and 2-0805. The rest of the chapter has been reorganized and streamlined.

PM 2-0800.11 is being changed to include material previously found in PM 2-0806 about obtaining information by telephone, as it applies to claims in general, not just those for occupational illness. (Former paragraphs 11 and 12 have been renumbered 12 and 13, respectively.)

PM 2-0400 has been revised to reflect adjudication time frames for both basic-development and extended-development occupational illness claims, and the third tier standards for traumatic injury cases have been removed. Also, standards in other categories
have been updated.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

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

2	2-0400	i, 3-6	2	2-0400	i, 3-6
	2-0800	i, 13-14		2-0800	i, 13-14
	2-0806	i, 1-16		2-0806	i, 1-15 Ex. 21

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)

FT 96-02 Revision to Chapter 2-900, Determining Pay Rates, and Release of New Chapter 2-0901, Computing Compensation, Part 2 - Claims, Federral (FECA) Procedure Manual

FECA TRANSMITTAL NO. 96-02 December 12, 1995

EXPLANATION OF MATERIAL TRANSMITTED:

The material which formerly appeared in Chapter 2-0900 has been revised and expanded into two chapters. Revised Chapter 2-0900 now focuses exclusively on determining pay rates, while Chapter 2-0901 addresses computation of compensation payments.

Changes to Chapter 2-0900 include the following:

Paragraph 2, Establishing a Pay Rate, describes in general how to determine a pay rate.

Paragraph 3, Kinds of Appointments and Tours of Duty, has been added to help claims personnel clarify employment status.

Paragraph 4, Average Annual Earnings, contains much of the information previously found in the discussion of setting weekly pay rates. The steps needed to identify situations requiring further investigation and to establish the pay rate have been clarified.

Paragraph 5, Effective Date of Pay Rate, discusses recurrent pay rates which are lower than date of injury pay rates.

Paragraph 6, Elements Excluded in Pay Rate, states explicitly that amounts received for unemployment compensation may not be included in the pay rate.

Paragraph 7, Elements Included in Pay Rate, addresses holiday pay for non-Postal employees and availability pay for criminal investigators.

Paragraph 8, Applying Increments of Pay, has been added to clarify when the reported increments may be used as given, and when further information must be obtained. A section concerning calculations of pay rates involving FLSA overtime has also been added.

Paragraph 9, Computing Daily Pay Rate, has been modified to reflect that a daily pay rate should not include any increment of pay (that is, the restriction is not limited to receipt of night differential).

Paragraph 10, Weekly Pay Rate, contains a step-by-step description of how to apply the provisions of section 5 U.S.C. 8114. The definition of career seasonal status which appears in this paragraph has also been clarified. (The "career seasonal" status of employees whose employment does not meet this test may be redetermined, though district offices need not undertake any special searches for such cases. Any claimant whose career seasonal status is redetermined should be found not with fault if an overpayment results.)

Paragraph 12, Special Determinations, contains a section on pay rate determination for rural carriers (paragraph 3 also discusses these employees).

The exhibit addressing night differential and the Table of Julian days have been removed as obsolete.

New Chapter 2-0901 includes the following changes and additions:

Paragraph 2, Related Topics, provides cross-references to other parts of the FECA Procedure Manual and other resources concerning various aspects of making compensation payments.

Paragraph 3, Responsibilities, recognizes that CEs are increasingly performing functions once reserved for fiscal personnel and describes the changes to the certification process which were published in FECA Bulletin No. 95-14. Also, the amount which may be certified by a Senior CE or designated CE has been raised to $50,000.

Paragraph 7, Work Days/Calendar Days, discusses the distinction between these two methods of calculation, and provides formulas for their use.

Paragraph 8, Basic Computations, includes a discussion of compressed work schedules ("flextime") and how pay rates should be computed for employees working such schedules.

Paragraphs 10 and 11 address minimum and maximum compensation respectively.

Paragraph 15, Loss of Wage-Earning Capacity (LWEC), includes a discussion of locality pay. It also addresses how reevaluation of routes affect the compensation entitlement of rural carriers.

Paragraph 17, Death Benefits, addresses entitlements payable in death cases in addition to compensation for survivors.

Paragraph 18, Other Payees, discusses additional parties who may receive compensation, including representative payees.

A new exhibit showing ACPS activity codes has been added.

Many cross-references to other parts of the Procedure Manual have been added to both chapters.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

Remove Old Pages			Insert New Pages		
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2	List of Chapters		2	List of Chapters	
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				Exs.	1-6

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FT 96-03 Revision to Chapter 0-0100, Introduction to FECA and DFEC, Part 0 - Overview, Federal (FECA) Procedure Manual

RELEASE -REVISION TO CHAPTER 0-0100, INTRODUCTION TO FECA AND DFEC, PART 0 - OVERVIEW, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-03 October 2, 1995

EXPLANATION OF MATERIAL TRANSMITTED:

Exhibit 2 has been revised to reflect new telephone and fax numbers for District 13.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
0	0-0100	i	0	0-0100	i

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

FT 96-04 Revision to Chapter 3-0201, Staff Nurse Services: Chapter 3-0400, Medical Services and Supplies; Chapter 3-0500, Medical Examinations; and Chapter 3-0700, Schedule Awards, Part 3 - Medical, Federal (FECA) Procedure Manual

RELEASE - REVISION TO CHAPTER 3-0201, STAFF NURSE SERVICES: CHAPTER 3-0400, MEDICAL SERVICES AND SUPPLIES; CHAPTER 3-0500, MEDICAL EXAMINATIONS; AND CHAPTER 3-0700, SCHEDULE AWARDS, PART 3 - MEDICAL, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-04 October 10, 1995

EXPLANATION OF MATERIAL TRANSMITTED:

Several chapters of PM Part 3, Medical, have been revised as follows:

3-0201: Paragraph 7c has been revised to state that, if the nurse arranges a second opinion examination and the physician selected is not listed in the Physicians' Directory System, the nurse should advise the Medical Management Assistant of the physician's name and address so that this information can be added to the system.

3-0400: Paragraph 3c has been changed to remove the statement that a motorized wheelchair may not be provided if the claimant has the services of a full-time attendant. Also, paragraph 7c has been revised to more closely define situations where experimental treatments may be considered. Such requests must continue to be referred to the OWCP Medical Director.

3-0500: Paragraph 4 has been modified to reflect that medical brokerage firms may arrange the mechanics of referrals for impartial examination without compromising the impartiality of the examination itself. This policy was first published in FECA Bulletin 95-01.

3-0700: Exhibit 4, which describes calculations of schedule awards according to the fourth edition of the AMA Guides to the Evaluation of Permanent Impairment, has been added to this chapter. This material was first published in FECA Bulletin Nos. 95-07 and 95-17. References to the new exhibit have been added to paragraphs 2 and 4.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
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	3-0700	i, 1-4		3-0700	i, 1-4
					Ex. 4

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

FT 96-05 Revision to Chapter 2-0805, Causal Relationship, and Chapter 2-0806, Occupational Illness, Part 2 - Claims, Federal (FECA) Procedure Manual

RELEASE - REVISION TO CHAPTER 2-0805, CAUSAL RELATIONSHIP, AND CHAPTER 2-0806, OCCUPATIONAL ILLNESS, PART 2 - CLAIMS FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-05 NOVEMBER 1, 1995

EXPLANATION OF MATERIAL TRANSMITTED:

A new paragraph 8, High-Risk Employment, has been added to PM 2-0805 to address determinations of causal relationship in cases arising from employment situations where exposure to specific diseases is common. This paragraph contains the material first published in FECA Bulletin 95-21. Also, the title of paragraph 7 has been changed to "Psychological Factors Affecting Medical Condition" to reflect the terminology of DSM-4, and the contents of the paragraph have been modified slightly in light of this change.

Exhibit 20 of PM 2-0806 has been changed to include the material first published in FECA Bulletin 95-20. Related material previously found in MEDGUIDE Chapter 4.6 has also been added. The material concerning carbon tetrachloride poisoning has been removed, as this substance is no longer used.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0805	i, 11-12	2	2-0805	i, 11-13
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FT 96-06 Revision to Chapter 2-0900, Determining Pay Rates, And Chapter 2-0901, Computing Compensation, Part 2 - Claims, Federal (FECA) Procedure Manual

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. 96-06 March 21, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

In PM 2-0900, the following changes have been made:

1. Paragraph 4a is ambiguous with respect to career seasonal pay rates. The true policy is contained in paragraph 2-900.4a(1)(a), which states that a career seasonal employee "is entitled to receive compensation on the same basis as an employee with the same grade and step who has worked the whole year". That is, a full-time career seasonal employee's pay rate would be based on a full-time year-round employee's earnings, while a part-time career seasonal employee's pay rate would be based on a part-time year-round employee's earnings, and so on. Subparagraph (d) directly below implies that a career seasonal employee would be paid at the full-time rate even if the employee worked a part-time or intermittent schedule. This language is being clarified to conform with the wording of the preceding paragraph.

2. Paragraph 4c(3)(b) concerns comparisons between the employee's earnings and the earnings of a similarly-situated employee. The paragraph is modified to state that if the "same or most similar class" contains more than one employee, the earnings of the employee who worked the "greatest number of

hours" should be used.

3. Paragraph 5a(3) states that if the pay rate on date of injury is the same as on the date of disability, the date of injury pay rate should be chosen. This is incorrect, and the paragraph is being modified accordingly. Section 5 U.S.C. 8146a provides that CPIs will be applied beginning one year after disability begins, and ACPS determines entitlement for a CPI from the effective date of pay rate. Unless the pay rate on date disability began is used, CPI increases will be awarded in error to some claimants whose disability has not exceeded one year.

In PM 2-0901, Exhibit 5 was partly obscured in the printing process. It is reissued with this transmittal.

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

FT 96-07 Revision to Chapter 2-814, Reemployment: Determining Wage Earning Capacity, Part 2 - Claims, Fedearl (FECA) Procedure Manual

RELEASE -REVISION TO CHAPTER 2-814, REEMPLOYMENT: DETERMINING WAGE-EARNING CAPACITY, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-07 November 29, 1995

EXPLANATION OF MATERIAL TRANSMITTED:

In two recent cases, the Employees' Compensation Appeals Board set aside decisions terminating compensation based on abandonment of suitable work because the claimants had not been provided with their due process rights. The following quotation from one of the cases summarizes the issue:

> It is well established that the termination of benefits under section 8106(c) raises due process and fairness considerations. These considerations arise because compensation benefits constitute a property interest that is protected by the due proces clause. The Supreme Court has held that the essential requirements of due process are "notice and an opportunity to respond." These essential due process principles require that an employee have "at least notice and an opportunity to respond in some manner" prior to the termination of compensation benefits. Accordingly, the Board finds that appellant's compensation may not be terminated under section 8106(c)(2) for neglecting suitable work without prior notification and an opportunity to respond. [Mary A. Howard, Docket No. 92-886, Issued May 19, 1994; footnotes omitted]

Therefore, new paragraph 10 has been added to this chapter to address the procedures which should be followed when a claimant abandons his or her job. The 8106(c)(2) provision should be invoked only if a retroactive LWEC determination cannot be done and only after a recurrence of total disability has been explored. These procedures parallel those already in place for refusing a job offer. Former paragraphs 10 and 11 have been renumbered 11 and 12 respectively, and paragraphs 9a and 9b have been revised slightly in light of this change.

Also, page 2 of Exhibit 2 has been revised to include deductions for basic life insurance and post-retirement basic life insurance, and Exhibit 4 has been updated to show revised Form CA-817. Exhibit 5 has been removed as superfluous.

Finally, citations in paragraphs 6d(2), 7e and 8e have been updated, and the sequence of paragraph 6, which contained two subparagraphs lettered "c", has 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	2-814	i	2	2-814	i
		9-10			9-10
		15-16			15-16
		19-26			19-27
		Ex. 2,			Ex. 2,
		p. 2			p. 2
		Ex. 3			Ex. 3
		Ex. 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)

FT 96-08 Revision to Chapter 4-0300, War Hazards, Part 4 - Special Case Procedures, Federal (FECA) Procedure Manual

RELEASE - REVISION TO CHAPTER 4-0300, WAR HAZARDS, PART 4 - SPECIAL CASE PROCEDURES, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-08 November 29, 1995

EXPLANATION OF MATERIAL TRANSMITTED:

Exhibit 3 is updated to show the 1994 and 1995 yearly increases under the Longshore and Harbor Workers' Compensation Act.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
4	4-0300	i Ex. 3-4	4	4-0300	i Ex. 3-4

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)

FT 96-09 Revision to Chapter 2-1100, Subrogation and Other Remedies; Chapter 2-1200, Fees for Representatives' Services; and Chapter 2-1500, Recurrences, Part 2 Claims, Federal (FECA) Procedure

RELEASE -REVISION TO CHAPTER 2-1100, SUBROGATION AND OTHER REMEDIES; CHAPTER

2-1200, FEES FOR REPRESENTATIVES' SERVICES; AND CHAPTER 2-1500, RECURRENCES, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-09 December 12, 1995

EXPLANATION OF MATERIAL TRANSMITTED:

The second page of the Table of Contents to PM 2-1100 was omitted in error from FECA Transmittal No. 95-36; it is included in this transmittal. The Table of Contents to PM 2-1200 has been updated to include the exhibit.

Paragraph 8a of PM 2-1500 has been modified to remove the references to regular duty with respect to use of COP after a recurrence. This change is in accordance with section 10.208(b)(3) of OWCP's regulations.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-1100	i	2	2-1100	i-ii
	2-1200	i		2-1200	i
	2-1500	i 9-10		2-1500	i 9-10

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

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

FT 96-10 Revisions to Chapters 5-0100, Introduction, and 5-0101, Security of the Fiscal Operaiton; Revisions to and Replacement of Chapters 5-0201, Authorizing Medical Payments, 5-0202, Processing Bills for Payment, 5-0203, Bill Coding Under Medical Fee Schedule, 5-0204, Appeals of Fee Schedule Determinations, and 5-1002, BPS Jobs and Keying Instructions, Part 5- Benefits Payments, Federal (FECA) Procedure Manual

RELEASE -REVISIONS TO CHAPTERS 5-0100, INTRODUCTION, AND 5-0101, SECURITY OF THE FISCAL OPERATION; REVISIONS TO AND REPLACEMENT OF CHAPTERS 5-0201,

AUTHORIZING MEDICAL PAYMENTS, 5-0202, PROCESSING BILLS FOR PAYMENT, 5-0203, BILL CODING UNDER MEDICAL FEE SCHEDULE, 5-0204, APPEALS OF FEE SCHEDULE DETERMINATIONS, AND 5-1002, BPS JOBS AND KEYING INSTRUCTIONS, PART 5 - BENEFIT PAYMENTS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-10 January 31, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

Procedure Manual chapters which deal with the DFEC Medical Bill Processing System (BPS) have been completely revised and reorganized. These changes are necessary because of the conversion of the BPS in 1992 from a bill payment system to a bill processing system.

The revised procedures retain the portions of the existing procedures which are still relevant to the enhanced BPS. However, these retained procedures will be found in different places. Procedures described in FECA Bulletins 93-3, New Procedure Code Modifiers, 93-9, System Enhancements, 94-8, Explanation of Benefits Letters, 94-9, Duplicate Checking and Bypass Codes, 94-23, Implementation of the New Fee Revised OWCP Medical Fee Schedule Effective June 14, 1994, 95-18, Discounts on Hospital Bills, and 96-3, Excluded Provider Changes, have been incorporated. Information has been reorganized to reflect major functional areas.

Chapters 5-0100 and 5-0101 have been updated. The new/revised chapters being issued which deal specifically with the BPS are:

Chapter 5-0200 - Overview of the BPS;

Chapter 5-0201 - BPS FECS001 Programs;

Chapter 5-0202 - BPS Jobs;

Chapter 5-0203 - BPS Codes;

Chapter 5-0204 - Principles of Bill Adjudication;

Chapter 5-0205 - Bill Resolution; and

Chapter 5-0206 - Appeals of EOB Denials and Fee Schedule Determinations.

The following additional chapters will be issued at a future date:

Chapter 5-0207 - BPS Reports, which describes the various BPS reports available, their uses, and how to run them; and

Chapter 5-0208 - Other BPS Activities, which provides information on other activities related to the BPS which are not addressed elsewhere, such as tracers, audits, controls, and supervisory/management review. FECA Bulletin 94-10, Supervisory Sampling of Bills, will be incorporated in this chapter.

All exhibits and tables of contents have been modified for inclusion in folioviews.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
5	5-100	i 1-2	5	5-0100	i 1-2
5	5-101	i 1-4	5	5-0101	i 1-4
5	5-201	i 1-29 Ex. 1, 2	5	5-0200	i 1-18 Ex. 1, 2
5	5-202	i 1-26 Ex. 1-6	5	5-0201	i 1-24
5	5-203	i 1-6	5	5-0202	i 1-5
5	5-204	i 1-10 Ex. 1-4	5	5-0203	i 1-13 Ex. 1, 2
5	5-1002	i 1-16	5	5-0204	i 1-22
-	-----	-	5	5-0205	i 1-9 Ex. 1-3
-	-----	-	5	5-0206	i 1-17 Ex. 1, 2

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

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

FT 96-11 Revision to Chapter 2-1000, Dual Benefits, and 2-0813, Reemployment: Vocational Rehabilitation Services, Part 2 - Claims, Federal (FECA) Procedure Manual

RELEASE -REVISION TO CHAPTERS 2-1000, DUAL BENEFITS, AND 2-0813, REEMPLOYMENT: VOCATIONAL REHABILITATION SERVICES,

PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-11 February 9, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

In PM 2-1000, a new subsection is added to paragraph 8b to address how to determine the percentage of election where the Department of Veterans Affairs has awarded percentages of disability for more than one impairment. The material following the new paragraph has been repaginated.

In PM 2-0813, a new subsection is added to paragraph 9a to state that subsidies to employers for assisted reemployment should cease if compensation payments to the claimant are terminated.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages		Insert New Pages	
Part	Chapter Pages	Part	Chapter Pages
2	2-0813 i, 9-10 2-1000 i, 17-22	2	2-0813 i, 9-10 2-1000 i, 17-22

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)

FT 96-12 Revision to Chapter 2-0814, Reemployment: Determining Wage-Earning Capacity, Part 2 - Claims, Federal (FECA) Procedure Manual

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

FECA TRANSMITTAL NO. 96-12 March 21, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

This transmittal conveys several changes involving refusal to accept suitable work, abandonment of a suitable job, and application of the penalty provisions of 5 U.S.C. 8106(c).

1. In Michael E. Moravec, Docket No. 93-1137, issued February 1, 1995, the ECAB addressed a case where the employing agency made a job offer after the claimant had returned to work elsewhere. The district office terminated compensation on the grounds that the claimant improperly refused an offer of suitable work.

In reversing this decision, the Board stated that: "It is well established that once the Office has accepted a claim, it has the burden of justifying termination or modification of compensation benefits". The Board also stated that, in relying on section 5 U.S.C. 8106(c)(2) to terminate benefits,

> the Office has impermissibly focused its attention on this portion of the Act without also giving appropriate consideration to section 8115 of the Act. The Board has previously discussed the need for the Act to be interpreted in its entirety in order to best arrive at its intended meaning. It is well established that the Act is a remedial statute and should be broadly and liberally construed in favor of the employee to effectuate its purpose and not in derogation of the employee's rights.

Noting the relationship between sections 8106 and 8115, the Board concludes that "a proper evaluation of appellant's continued entitlement to compensation cannot be made without also undertaking an evaluation of appellant's wage-earning capacity under section 8115 of the Act."

Because the claimant earned actual wages for several years before the Office terminated benefits, the Board found that the Office has an affirmative duty to decide whether the position actually worked fairly and reasonably represented the claimant's wage-earning capacity before determining that the position offered by the employing agency was suitable and terminating compensation. This position is consistent with PM 2-0814.5a(2).

Such job offers will usually come from the original employing agency. The issue of whether the claimant's actual earnings fairly and reasonably represent the loss of wage-earning capacity (LWEC) may already have been determined, or it may have to be addressed when the new position is offered. Either way, the Claims Examiner must make such a determination before considering termination based on refusal of a suitable job. We are modifying paragraph 5b(2) to state that refusal of a job offer by a claimant with actual earnings which fairly and reasonably represent his or her wage-earning capacity is acceptable.

Unlike a claimant with actual earnings, a claimant who has been rated for LWEC based on a constructed position and who is not working must accept a suitable job offer. If the claimant does not accept the position offered, compensation will be terminated under 5 U.S.C. 8106(c)(2). Paragraph 5c is modified accordingly.

This position may appear inconsistent with OWCP's long-standing policy that an LWEC decision may be disturbed only if the claimant's medical condition has changed, the claimant has been vocationally rehabilitated, or the original decision was in error. However, the Office's decision to terminate a claimant's compensation for a constructed LWEC under 5 U.S.C. 8106(c)(2) when he or she refuses an offer of suitable work has no effect on any underlying rating under 5 U.S.C. 8115. Rather, the previous determination of the claimant's WEC remains in place and is superseded by the Office's termination decision when the claimant later refuses the employing agency's offer of suitable work.

2. A prior version of this chapter stated that retirement was an acceptable reason for refusing suitable employment. This reason will henceforth again be considered acceptable, in spite of the ECAB's holding in Bankston. New subparagraphs 5a(6) and 10c(3) are added to effect this change, and the reference to Bankston is removed from paragraph 10a. A sample notification letter to the claimant with respect to his or her entitlement to benefits in this situation is shown as new Exhibit 5 (a reference to the old exhibit 5 is removed from paragraph 12c.)

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, 5-8 23-27	2	2-0814	i, 5-8 23-27 Ex. 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)

FT 96-13 Revision to Part 5, Benefit Payments, Federal (FECA) Procedure Manual

RELEASE -REVISION TO PART 5, BENEFIT PAYMENTS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-13 March 28, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

A new List of Chapters is issued for Part 5.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
5	----	Outline	5	----	Outline

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

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

FT 96-14 Revision to Chapter 2-1000, Dual Benefits, Part 2 - Claims, Federal (FECA) Procedure Manual

RELEASE -REVISION TO CHAPTER 2-1000, DUAL BENEFITS, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-14 April 3, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

A new paragraph 17 has been added to incorporate the material about severance and separation pay which was originally published in FECA Bulletin 96-02.

Paragraphs 3 and 4 of the bulletin stated that when separation pay was based on a period of time, an award for loss of wage-earning capacity (LWEC) would not be considered a dual benefit, but that when the separation pay was based on an amount of money, the LWEC would be considered a dual benefit. The latter conclusion is incorrect, and the addition to this chapter states that LWEC payments and separation payments are not dual benefits, regardless of the basis for the separation payment. Because of this change, the entitlement of employees receiving severance pay is identical to that of employees receiving separation pay.

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 27	2	2-1000	i 27-32

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)

FT 96-15 **Revision to Chapter 3-0201, Staff Nurse Services, Chapter 3-0300, Authorizing Examination and Treatment, and Chapter 3-0600, Requirements for Medical Reports (09/96B)**

RELEASE - REVISION TO CHAPTER 3-0201, STAFF NURSE SERVICES, CHAPTER 3-0300, AUTHORIZING EXAMINATION AND TREATMENT, AND CHAPTER 3-0600, REQUIREMENTS FOR MEDICAL REPORTS, PART 3 - MEDICAL, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-15 September 20, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

Paragraphs 7c(4) and 8 of Chapter 3-0201 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 2-0600). Paragraph 8 has been retitled "Extensions and Interruptions of Nurse Services". The balance of the chapter has been repaginated.

In paragraph 2 of Chapter 3-0300, subparagraphs "c" and "d" have been relettered "b" and "c" respectively.

Finally, Exhibit 4 of Chapter 3-0600 has been revised to include 3,000 Hz in item 1. This change conforms to the recent revision of Form CA-1087.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages		Insert New Pages	
Part	Chapter Pages	Part	Chapter Pages
3	3-0201 i, 11-20	3	3-0201 i, 11-22
	3-0300 i, 1-2		3-0300 i, 1-2
	3-0600 i, Ex. 4		3-0600 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)

RELEASE - REVISION TO CHAPTER 2-0814, REEMPLOYMENT: DETERMINING WAGE-EARNING CAPACITY, AND 2-1700, SPECIAL ACT CASES, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FT 96-16 Revision to Chapter 2-0814, Reemployment: Determining Wage-Earning Capacity, and 2-1700, Special Act Cases, Part 2 - Claims, Federal (FECA) Procedure Manual

RELEASE -REVISION TO CHAPTER 2-0814, REEMPLOYMENT: DETERMINING WAGE-EARNING CAPACITY, AND 2-1700, SPECIAL ACT CASES, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-16 May 1, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

In paragraphs 5a and 10a of PM 2-0814, a sentence has been added to state that pre-termination notice is not required when terminating benefits to a claimant who has retired.

In PM 2-1700, the exhibit has been updated to show new payrates effective January 1996.

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, 5-6 25-26	2	2-0814	i, 5-6 25-26
	2-1700	i, Ex. 1		2-1700	i, Ex. 1

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)

FT 96-17 Revision to Chapter 2-0900, Determining Pay Rates, and Chapter 2-0901, Computing Compensation, Part 2 - Claims, Federal (FECA) Procedure Manual

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. 96-17 July 9, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

Paragraphs 12f of Chapter 2-0900 and paragraph 15f(2) of Chapter 2-0901 are revised to make clear that changes in a rural carrier's route evaluation do not result in a change in the pay rate for compensation purposes unless the pay rate otherwise qualifies as a date of injury, date disability begins or date of recurrence pay rate.

Also, paragraph 3b of Chapter 2-0901 is revised to add a definition of certification, which is to include initialing the payment setup both before and after the payment is keyed. In addition, delegation of authority to designated GS-11 Claims Examiners to certify initial death and schedule award payments has been eliminated. Such payments must be certified by Senior Claims Examiners or managers at the GS-12 level or above, as stated in new subparagraph (1). Subsequent subparagraphs have been renumbered.

Finally, Exhibits 1, 2, and 3 to Chapter 2-0901 are updated to include the new minimum, maximum, and CPI rates as first published in FECA Bulletins 96-07 and 96-08. Exhibit 5, the Percentage Table of Schedule Awards, has been updated to include the female reproductive organs, and Exhibit 6, Activity Codes, has been slightly edited.

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, 25-26	2	2-0900	i, 25-26
	2-0901	i, 3-4 23-24 Exs. 1-6		2-0901	i, 3-4 23-24 Exs. 1-6

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)

FT 96-18 Revision to Chapter 2-1602, Reconsiderations, Part 2 - Claims, Federal (FECA) Procedure Manual

RELEASE -REVISION TO CHAPTER 2-1602, RECONSIDERATIONS, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-18 May 20, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

The ECAB has recently remanded a number of cases in which requests for reconsideration were denied because they were not timely filed. The remands occurred because the OWCP did not address whether the evidence or argument submitted by the claimant constituted clear evidence of error. Paragraph 3 and Exhibit 2 have been revised to indicate that such a statement must be included in any denial of a reconsideration request based on untimely filing.

A new paragraph 6 addresses prima facie denials. Former paragraphs 8 and 9, which addressed reconsiderations following suspension of compensation and reconsiderations of schedule awards, have been combined into a new paragraph 5.

The chapter as a whole has been streamlined and updated.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-1602	i, 1-8 Ex. 2	2	2-1602	i, 1-8 Ex. 2

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)

FT 96-19 Revision to Chapter 4-0600, Reserve Officers' Training Corps, Part 4 - Special Case

RELEASE -REVISION TO CHAPTER 4-0600, RESERVE OFFICERS' TRAINING CORPS, PART 4 - SPECIAL CASE PROCEDURES, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-19 May 20, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

Paragraphs 5 and 6 are expanded to clarify the difference between ROTC "line of duty" determinations and "performance of duty" as usually interpreted under the FECA. The balance of the chapter is repaginated.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
4	4-0600	i-6	4	4-0600	i-6

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)

FT 96-20 Revision to Chapter 2-0806, Occupational Illness, and Chapter 2-0814, Reemployment: Determining Wage-Earning Capacity, Part 2 - CLaims, Federal (FECA) Procedure Manual

RELEASE -REVISION TO CHAPTER 2-0806, OCCUPATIONAL ILLNESS,AND CHAPTER 2-0814, REEMPLOYMENT: DETERMINING WAGE-EARNING CAPACITY, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-20 June 12, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

In Chapter 2-0806, paragraph 3a(3)(b) is modified to state that preparation of a statement of accepted facts and certain medical development actions are not needed where surgery is contemplated in cases accepted for carpal tunnel syndrome, since surgery is often the recommended treatment for this condition.

In Chapter 2-0814, the following three changes have been made:

Paragraph 4a is changed to include Claims Examiners in the list of those who can solicit job offers from employing agencies.

Paragraph 7d(2) is modified to state that when a career seasonal employee is rated in a career seasonal job, the salary of the current job should be annualized before the Shadrick formula is applied.

Paragraph 11 is expanded to address modifications of LWEC ratings where claimants rated at part-time work increase their hours to full-time duty.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0806	i, 3-4	2	2-0806	i, 3-4
	2-0814	i, 1-2 15-16 25-27	2	2-0814	i, 1-2 15-16 25-27

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)

FT 96-21 Revisions to Chapter 5-0204, Principles of Bill Adjudication, Part 5 - Benefit Payments, Federal (FECA) Procedure Manual

RELEASE -REVISIONS TO CHAPTER 5-0204, PRINCIPLES OF BILL ADJUDICATION, PART 5 - BENEFIT PAYMENTS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-21 June 1, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

Paragraph 6g concerning reimbursements has been revised to state that insurance companies applying for reimbursement of work-related medical payments may attach a signed certification of the payments made by the insurance company as proof of payment (rather than copies of cancelled checks). The National Association of Letter Carriers Health Benefit Plan's revised Form NALC-200 (April 1996) contains certification of the payments made, and no further verification of payment is needed. Charges and providers should be itemized on the HCFA-1500, NALC-200, or facsimile, and photocopies of the original bills are no longer required.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
5	5-0204	i 3-4	5	5-0204	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 and D
(Claims Examiners, All Supervisors, Systems Managers, District Medical Advisers, Technical Assistants, Rehabilitation Specialists, and Fiscal and Bill Pay Personnel)

FT 96-22 Revision to Chapter 2-0401, Automated System Support for Case Actions, and Chapter 2-1400, Disallowances, Part 2 - Claims, Federal (FECA) Procedure Manual

RELEASE -REVISION TO CHAPTER 2-0401, AUTOMATED SYSTEM SUPPORT FOR CASE ACTIONS, AND CHAPTER 2-1400, DISALLOWANCES, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-22 June 10, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

A new paragraph 13 is added to PM 2-0401 to address ICD-9 codes. This material was first published in FECA Bulletin No. 93-12.

In PM 2-1400, the second paragraph of Exhibit 11 is revised to reflect that the authority to declare forfeiture in cases involving fraud against the FECA program is 5 U.S.C. 8148. The rest of the paragraph is reworded accordingly.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0401	i	2	2-0401	i, 21
	2-1400	i-ii		2-1400	i-ii
		Ex. 10-11			Ex. 10-11

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)

FT 96-23 Revision to Chapter 2-0814, Reemployment: Determining Wage Earning Capacity, Part 2 - Claims, Federal (FECA) Procedure Manual

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

FECA TRANSMITTAL NO. 96-23 July 9, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

Action item 2 of FECA Transmittal No. 96-12 stated that retirement would once again be considered an acceptable reason for refusing or abandoning suitable employment. However, since the release of this transmittal, various arguments against this position have been raised, and we have been persuaded that it is unwise to counter the precedent which the Employees' Compensation Appeals Board set in the case of Roy Bankston, 38 ECAB 380.

Therefore, we are returning to the position affirmed by the Board, and paragraphs 5a, 5c, 10a, and 10d are modified to state that retirement is not a valid reason for refusing or abandoning suitable employment. Exhibit 5 is removed.

Finally, the citation to Maggie Moore in paragraph 5d has been updated.

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, 5-8 23-26 Ex. 5	2	2-0814	i, 5-8 23-26

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)

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FT 96-25 Revision to Chapter 0-0100, Introduction to FECA and DFEC (07/96B)

RELEASE - REVISION TO CHAPTER 0-0100, INTRODUCTION TO FECA AND DFEC, PART 0 - OVERVIEW, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-25 August 1, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

Exhibit 2 is modified to reflect the new address for the Boston District Office.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages		Insert New Pages	
Part	ChapterPages	Part	ChapterPages
0	0-0100 i, Ex. 2	0	0-0100 i, Ex. 2

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

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

FT 96-26 Revision to Chapter 2-0700, Death Claims, and Chapter 2-1400, Disallowances (07/96B)

RELEASE - REVISION TO CHAPTER 2-0700, DEATH CLAIMS, AND CHAPTER 2-1400, DISALLOWANCES, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-26 August 2, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

Paragraph 5f of PM 2-0700 is modified to remove the requirement that copies of certificates submitted to support payment of death benefits bear the raised seal of the custodian of records.

Paragraph 11(f)(1) of PM 2-1400 has been clarified with respect to the amount of compensation payable to the dependents of convicted felons.

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, 5-6	2	2-0700 i, 5-6
	2-1400 i-ii		2-1400 i-ii
	21-22		21-22

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)

FT 96-27 Revision to Chapter 2-1602, Reconsiderations (09/96A)

RELEASE - REVISION TO CHAPTER 2-1602, RECONSIDERATIONS, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-27 August 1, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

Exhibits 2, 3, and 4 are modified to reflect the new address for the Employees' Compensation Appeals Board.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-1602	i Exs. 2-4	2	2-1602	i Exs. 2-4

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)

FT 96-28 **Revision to Chapter 2-0802, Civil Employee, and to FECA Program Memorandum 249 (09/96B)**

RELEASE - REVISION TO CHAPTER 2-0802, CIVIL EMPLOYEE, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL, AND TO FECA PROGRAM MEMORANDUM 249

FECA TRANSMITTAL NO. 96-28 September 10, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

New Paragraph 32 is added to describe coverage for emergency workers performing services at the direction of the Federal Emergency Management Agency (FEMA).

A question recently arose concerning coverage of workers in the Green Thumb program. This program was authorized as part of the Older American Community Service Employment Act, which is addressed in FECA Program Memorandums 249 and 267. However, these issuances do not mention the Green Thumb program explicitly. Therefore, the following pen-and-ink change should be made to Program Memorandum 249: "Coverage includes workers in the Green Thumb program."

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages		Insert New Pages	
Part	Chapter Pages	Part	Chapter Pages
2	2-0802 i-ii 19	2	2-0802 i-ii 19

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)

FT 96-29 Issuance of New Chapter 5-0700, Chargeback, Part 5 - Fiscal (09/96B)

RELEASE - ISSUANCE OF NEW CHAPTER 5-0700, CHARGEBACK, PART 5 - FISCAL, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 96-29 September 30, 1996

EXPLANATION OF MATERIAL TRANSMITTED:

This chapter formerly appeared as Chapter 5-0900. It has been completely revised and updated.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages		Insert New Pages	
Part	ChapterPages	Part	ChapterPages
5	List of Chapters	5	List of Chapters
	5-0900 i, 1-7		5-0700 i, 1-6

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

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

FT 96-30 **Revision to Chapter 2-0810, Developing and Evaluating Medical Evidence, and Chapter 2-0813, Reemployment: Vocational Rehabilitation Services (09/96B)**

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. 96-30 September 30, 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 is changed to state that cases referred for vocational rehabilitation services should have stable, well-defined work limitations which allow the claimant to work at least four hours per day. However, where an occupational rehabilitation program (ORP) may be of benefit, these requirements need not be met. The criteria for referral are expanded to include those applicable where an ORP has been recommended or appears to be warranted.

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 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:

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	2-0813	i, 3-4		2-0813	i, 3-4
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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
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