PART 2 - CLAIMS

(Issued 04/95; Trans. No. 95-19)

LIST OF CHAPTERS

2-0100 .... Introduction
2-0200 .... General Provisions of the Federal Employees Compensation Act
2-0300 .... Communications
2-0400 .... File Maintenance and Management
2-0401 .... Automated System Support for Case Actions
2-0402 .... Security and Prevention of Fraud and Abuse
2-0500 .... Conferencing
2-0600 .... Case Management
2-0601 .... Disability Tracking and QCM Tracking Systems
2-0700 .... Death Claims
2-0800 .... Development of Claims
2-0801 .... Time
2-0802 .... Civil Employee
2-0803 .... Fact of Injury
2-0804 .... Performance of Duty
2-0805 .... Causal Relationship
2-0806 .... Occupational Illness
2-0807 .... Continuation of Pay and Initial Payments
2-0808 .... Schedule Awards and Permanent Disability Claims
2-0809 .... Statements of Accepted Facts
2-0810 .... Developing and Evaluating Medical Evidence
2-0811 .... Early Management of Disability Claims
2-0812 .... Periodic Review of Disability Claims
2-0813 .... Reemployment: Vocational Rehabilitation Services
2-0814 .... Reemployment: Determining Wage-Earning Capacity
2-0900 .... Determining Pay Rates
2-0901 .... Computing Compensation
2-1000 .... Dual Benefits
2-1100 .... Feca Third Party Subrogation Guidelines
2-1200 .... Fees for Representatives' Services
2-1300 .... Lump Sum Payments
2-1400 .... Disallowances
2-1500 .... Recurrences
2-1600 .... Review Process

2-1601 .... Hearings and Reviews of the Written Record
2-1602 .... Reconsiderations
2-1603 .... Appeals
2-1700 .... Special Act Cases
2-1800 .... Housing and Vehicle Modifications

2-0100 INTRODUCTION

Paragraph	Subject	Date	Trans. No.
	Table of Contents	07/04	04-05
1	Purpose and Scope	04/93	93-20
2	Organization of Material in FECA PM Part 2	07/04	04-05
3	Related Material	08/91	91-36

2-0100-1 Purpose and Scope

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

a. This chapter describes the structure of FECA PM Part 2.

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

2-0100-2 Organization of Material in FECA PM Part 2

2. Organization of Material in FECA PM Part 2.

a. Chapter 2-200 summarizes the major provisions of the FECA; identifies rules, regulations, FECA Program Memorandums, and other standing instructions that govern the actions and decisions of the Claims Examiner (CE); and provides a list of reference materials, decisions, and other guides which may be useful to the CE.

b. Chapters 2-400 through 2-500 present the "ground rules" for applying this body of knowledge to claims processing. They describe the rules for organizing and maintaining

the documents in a case record; the recording of the status and location of the case record; the procedures for safeguarding case records and arranging for investigations; and the rules for holding informal conferences.

c. Chapters 2-600 through 2-814 describe the rules for developing and managing claims. Included are discussions of the five basic requirements for accepting claims; occupational illness; continuation of pay; computation of compensation payments; development and evaluation of medical evidence; reemployment; and review of claims where continuing benefits are being paid.

d. The remaining chapters in FECA PM Part 2 address specialized issues which pertain only to certain claims. These issues include computation of pay, dual benefits, involvement of third parties, representatives' fees, lump sum payments, reopening closed cases, disallowances, appeals, special act cases, and housing and vehicle modifications.

2-0100-3 Related Material

3. Related Material. Other instructions affecting claims processing may be found in FECA Bulletins, where new procedures are first published pending
inclusion in the PM, and FECA Circulars, which transmit information but do not require specific action. FECA Program Memorandums contain legal
and medical policy determinations applicable to the adjudication and management of claims. These resources are described in detail in FECA PM 2-200.

Other parts of the FECA PM which the CE may consult include part 0, Overview; Part 1, Communications and Records; Part 3, Medical; Part 4, Special Case Procedures; Part 5, Benefit Payments; and Part 6, Debt Management. OWCP PM Chapter 1-400 addresses requests for information under the Privacy Act and the Freedom of Information Act. Most of this information is available in Folioviews, the program's automated reference system. A resource entitled "Medical Management of Claims under the FECA", abbreviated as "MEDGUIDE", can also be found in Folioviews.

2-0200 GENERAL PROVISIONS OF THE FECA

Paragraph	Subject	Date	Trans. No.
	Table of Contents	07/04	04-05
1	Purpose and Scope	08/91	91-36
2	General Provisions of the FECA	07/04	04-05
3	Responsibilities of the Claims Examiner	07/04	04-05
4	Reference Materials for Claims Examiners	07/04	04-05

2-0200-1 Purpose and Scope

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

2-0200-2 General Provisions of the FECA

2. General Provisions of the FECA.

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

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

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

d. Continuation of Pay. An employee who sustains a disabling job-related traumatic injury is entitled to continuation of regular pay (COP) for a period not to exceed 45 calendar days. To qualify for COP, the injured employee must file written notice of injury and claim for COP within 30 days of the injury. COP is not considered compensation and is subject to taxes and other payroll deductions. The employee must make separate claim for monetary compensation if the disability exceeds 45 days or results in any permanent disability. See FECA PM 2-807.

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

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

g. Attendant Allowances. 20 C.F.R. 10.312 allows payment for services of an attendant where it is medically documented that the claimant requires assistance to care for personal needs such as bathing, dressing, eating, etc. Such services are paid as a medical expense under 5 U.S.C. 8103; are limited to $1500 per month under 5 U.S.C. 8111; and are paid directly to the provider of the services. See FECA PM 2-812.

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

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

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

k. Survivor Benefits. In the event of death due to employment, the Act provides for funeral and burial expenses up to $800, and up to $200 for the administrative costs of terminating a decedent's status as a Federal employee. The law provides compensation for widows or widowers with no eligible children at the rate of 50 percent of the deceased employee's monthly salary, and for widows or widowers with eligible children at 45 percent. If a spouse survives, each child receives 15 percent, up to total of 30 percent. Where no spouse survives, the rate for the first child is 40 percent, plus 15 percent for each additional child, shared equally among all children. Monthly payments for all beneficiaries generally cannot exceed 75 percent of the employee's monthly pay rate. Other persons who may also qualify for benefits are dependent parents, brothers, sisters, grandparents, and grandchildren. See FECA PM 2-700.

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

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

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

o. Review of OWCP Decisions. Under 5 U.S.C. 8116(c) the FECA is a beneficiary's exclusive remedy for injury or death of a Federal civil employee in performance of duty. Although aggrieved parties on occasion do seek remedies outside the FECA through a Federal tort suit or other litigation, the existence of such litigation is not considered in adjudicating claims or taking other case actions. If an employee or the survivors disagree with a final determination of the OWCP, a hearing may be requested, where the claimant may present evidence in further support of the claim. Also, the claimant has the right to appeal to the Employees' Compensation Appeals Board, a separate entity of the U. S. Department of Labor, and OWCP may review a case on its own initiative. See FECA PM 2-1600 through 2-1602.2-1602.

2-0200-3 Responsibilities of the Claims Examiner

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

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

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

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

2-0200-4 Reference Materials for the Claims Examiners

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

a. Federal Employees' Compensation Act, 5 U.S.C. 8101 et seq., as amended.

b. 20 C.F.R. Part 10 (Title 20, Code of Federal Regulations, 1.1 et seq.); US GPO.

c. FECA Procedure Manual, Part 0, Overview; Part 1, Communications and Records; Part 2, Claims; Part 3, Medical; Part 4, Special Case Procedures; Part 5, Benefit Payments; and Part 6, Debt Management.

d. FECA Program Memorandums, Bulletins, and Circulars.

e. Decisions of the Employees' Compensation Appeals Board, with Index (issued annually), including floppy discs containing published ECAB decisions, volumes 39 and following.

f. Summaries of ECAB decisions issued periodically by the National Office.

g. Black's Law Dictionary, West Publishing Co., St. Paul.

h. Workmen's Compensation Law, Arthur Larson, Matthew Bender Publishing Co., Washington, with all updates.

i. Dorland's Illustrated Medical Dictionary, W.B. Saunders Co., Philadelphia.

j. Current edition of the AMA Guides to the Evaluation of Permanent Impairment. A copy of prior editions should also be retained.

k. Current edition of The Merck Manual, Merck & Co., Rahway, N. J.

l. Current Directory of Medical Specialists, published by Marquis Who's Who, Chicago (hard copy for reference, in addition to the version contained in the automated Physician Directory System).

m. Current directory of the American Medical Association for each state within the district office's jurisdiction.

n. Current directory of the American Psychological Association.

o. Current directory of the American Chiropractic Association.

p. Current edition of the Dictionary of Occupational Titles, and supplements.

q. The most recent accountability review report.

r. Road maps or a road atlas covering the district office's geographical jurisdiction.

s. Telephone directories for prominent areas in the district office's jurisdiction.

2-0300 COMMUNICATIONS

Paragraph and Subject	Date	Trans. No.

	Table of Contents	02/00	00-03
1	Purpose and Scope	02/00	00-03
2	Policy	02/00	00-03
3	Responsibilities	02/00	00-03
4	Regular Correspondence	02/00	00-03
5	Priority Correspondence	02/00	00-03
6	Controlled Correspondence	02/00	00-03
7	Telephone Calls	02/00	00-03
8	Translations	02/00	00-03

2-0300-1 Purpose and Scope

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

2-0300-2 Policy

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

2-0300-3 Responsibilities

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

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

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

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

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

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

2-0300-4 Regular Correspondence

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

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

(1) The Forms Correspondence (FC) option in the Sequent system allows the user to generate many form letters, and to obtain sample copies of these letters. The LETTERS infobase in FolioViews contains a list of FC letters.

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

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

b Signature Level. Claims Examiners (CEs) may release routine correspondence over their own signatures, and they may sign some formal decisions (see FECA PM 2-1400). Most other formal decisions are signed by Senior Claims Examiners. Controlled correspondence is prepared for the signature of the DD or Regional Director (RD).

c. Signature Format. Both a given and family name should appear. For example, June Smith, John M. Smith and J. Milton Smith are all correct. Also, J. Smith or J. M. Smith may be used if the signer notes "Mr." or "Ms." before the name. Signature stamps may be used only by their owners.

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

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

It is not necessary to send the agency copies of material which does not bear on the overall payment status of the claim. For instance, agencies need not be sent copies of letters returning medical bills for additional information, two-way

memos asking for one or two items of information as a follow-up to a previous request, or copies of letters transmitting information contained in the case file.

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

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

(1) Supplemental Name File. Upon receipt of a signed statement from a claimant appointing a representative, the CE will add the person's name and address to the supplemental name file in the Sequent system. These entries are made through option 13 of the Case Management subsystem, using code A for attorneys and code R for other legal representatives.

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

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

2-0300-5 Priority Correspondence

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

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

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

(2) A case in another DO. The letter should be sent to the DO that has jurisdiction.

b. Preparation of Responses.

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

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

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

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

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

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

c. Decisions and Other Case Actions.

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

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

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

2-0300-6 Controlled Correspondence

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

a Definition. Controlled correspondence includes letters addressed to the Secretary of Labor or Assistant Secretary for ESA which require responses according to DOL policy (see DLMS Handbook 1-200). It also includes any letter so designated by the Office of the Assistant Secretary for the Employment Standards Administration or the Office of the

Director for Workers' Compensation. Most letters from Congressional offices are referred to the DO for a direct response, while letters from other parties are sent to the DO with a request that a draft reply be sent to the NO.

b. Letters with Direct Responses.

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

(2) Copies. When the reply is released:

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

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

The DO is to maintain a separate reading file of responses.

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

2-0300-7 Telephone Calls

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

a. Received in DO.

(1) Priority Inquiries. These inquiries are defined in paragraph 5 above. A response is required within two work days. If a full reply cannot be given within that time, the call should be acknowledged and a full reply must be provided within 10 work days.

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

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

b. Received in NO.

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

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

2-0300-8 Translations

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

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

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

Or, the request may be faxed. The original request will be returned to the DO for inclusion in the case file when the translation is completed.

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

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

2-0400 FILE MAINTENANCE & MANAGEMENT

Paragraph and Subject		Date	Trans. No.
Table of Contents		10/98	99-02
1	Purpose and Scope	02/00	00-03
2	Jurisdiction of Cases	02/00	00-03
3	Material Loaned from Other Agencies	02/00	00-03
4	Filing Material in Cases	02/00	00-03
5	Maintaining Files	02/00	00-03
6	Requesting Files	02/00	00-03
7	Incoming and Outgoing Cases	02/00	00-03
8	Doubling Case Files	02/00	00-03
9	Custody and Storage of Files	02/00	00-03
10	Case Transfers and Loans	02/00	00-03

2-0400-1 Purpose and Scope

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

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

2-0400-2 Jurisdiction of Files

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

a. General Jurisdiction Cases. The district offices (DOs) adjudicate all cases where the employee's duty station is located within the geographical area served by the DO. The boundaries of the DOs are defined in FECA PM 1-0200.

After adjudication, the claimant's home address determines where further processing will occur. The only exception to this policy is where the claimant lives much closer to the DO serving the area of the duty station than to the DO serving the area of residence.

b. Special Jurisdiction Cases. Certain kinds of cases are developed and adjudicated only in the National Operations Office (NOO), District 25, and most of them remain there for management (see FECA PM Chapter 1-0200a and b). Also, a few types of cases are developed in the DO and referred to the NOO for adjudication (see FECA PM Chapter 1-0200c).

Cases listed in FECA PM Chapter 1-0200a and b are to be sent without processing (other than notices of transfer) to the NOO, and inquiries about these cases should be referred to the NOO.

2-0400-3 Material Loaned from Other Agencies

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

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

b. Refusal of Permission by Agency. An agency which initially refuses permission to copy will often grant it if the CE explains the need for documentation in a letter. If the agency does not allow its material to be copied, the CE may not use it, since the case file must contain full documentation for any decision.

2-0400-4 Filing Material in Cases

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

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

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

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

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

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

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

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

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

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

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

2-0400-5 Maintaining Files

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

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

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

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

2-0400-6 Requesting Files

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

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

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

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

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

2-0400-7 Incoming and Outgoing Cases

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

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

b. Outgoing Cases.

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

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

completed.

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

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

2-0400-8 Doubling Case Files

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

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

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

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

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

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

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

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

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

(1) Cases of this nature include those where:

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

(b) Periods of disability overlap; and

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

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

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

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

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

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

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

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

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

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

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

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

2-0400-9 Custody and Storage of Files

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

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

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

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

2-0400-10 Case Transfers and Loans

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2-0401 AUTOMATED SYSTEM SUPPORT FOR CASE ACTIONS

Paragraph	Subject	Date	Trans. No.
Table of Contents		01/01	01-03

1	Purpose and Scope	01/98	98-04
2	Responsibilities	06/92	92-26
3	System Components	06/92	92-26
4	System Capabilities	06/92	92-26
		06/94	94-26
5	Call-Ups	06/92	92-26
6	Status Changes	06/92	92-26
7	Definitions of Pay Status Codes	12/97	98-03
8	Definitions of Adjudication Status Codes	06/92	92-26
9	Assignment of Status Codes	06/92	92-26
		12/97	98-03
10	TPCUP Codes	06/92	92-26
		12/97	98-03
		01/01	01-03
11	Reports	06/92	92-26
12	Inquiries	06/92	92-26
13	ICD-9 Codes	06/96	96-22

2-0401-1 Purpose and Scope

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

2-0401-2 Responsibilities

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

2-0401-3 System Components

3. System Components. The FECS has four major subsystems with which CEs interact:

a. The Automated Compensation Payment System (ACPS). The CE's responsibilities include providing accurate and detailed payment set-ups for entry into the system, ensuring that payee addresses are kept current and periodically reviewing ACPS case file reports to verify accuracy of payments.

b. The Bill Payment System (BPS). The CE is responsible for including proper authorization of payable medical charges and reviewing history reports to ensure accuracy.

c. Forms Correspondence. The CE uses this program to generate letters to claimants, employing agencies, and other interested parties.

d. The Case Management System, including the CMF. This program includes a Query function, which allows CEs to obtain information about specific cases from the screen, and it includes sub-functions which allow CEs to enter new data.

2-0401-4 System Capabilities

4. System Capabilities.

a. When an injury report or claim for occupational disease is received in a district office, a record is built for the case in the CMF, from which a CA-800 Case Summary and Form CA-801 post card acknowledgement to the agency and the claimant are generated automatically. The system controls number assignments and edits entries for duplication of date and other identifiable errors. The data elements which are built into the file at time of case creation are shown in the FEC Case Management Users Manual.

b. CEs are required to record their adjudicatory actions in the CMF, which should contain the current status of each case and the effective date of that status. Other data recorded in the CMF include third party status and rehabilitation indicators. Definitions of adjudication and pay status codes appear in paragraphs 7 and 8 below, while definitions of third party and rehabilitation indicators are found in the FEC Case Management Users Manual.

c. Call-ups may be set, allowing CEs to diary cases for future review.

d. Notes may also be entered, enabling the CE to review the status of the case without requesting it from file. Notes are especially useful in monitoring continuing entitlement to physical therapy and compensation as well as health benefit information.

e. Location of the physical file in the office is tracked through the system, using a set of specifically defined location codes. The maintenance of this information on a daily or more frequent basis is extremely important to the efficient administration of the district office.

f. Incoming and pending mail may be identified by type using the queuing capability of the system, which assigns a priority to documents according to their

character and urgency.

g. Information about case processing is summarized monthly and quarterly in Management Information System reports. District office managers use these reports to monitor timeliness of adjudication and payment action and the movement of files in the office. Reports for the use of CEs and fiscal personnel in managing their case assignments are produced more often.

h. Addresses for frequent correspondents other than the claimant or beneficiary are maintained in a "Supplemental Name File" in the CMF. Entry of names and addresses of authorized attorneys and other legal representatives is required; entry of other names and addresses is optional. These names and addresses are then available when letters are issued through the WP Letters program. Supplemental name codes are defined as follows:

A	Attorney
D	Dependent
L	Legislative Representative
M	Medical (Physician)
O	Other
R	Representative (Legal)
S	Supervisor
V	Vocational Rehabilitation Agency
W	Widow, widower

Of these, addresses coded A, D, M, R, V and W can be accessed through the automated letter system. Claimant and employer addresses are available elsewhere in the CMF and are not drawn from the supplemental name file.

2-0401-5 Call-Ups

5. Call-Ups. At least one current call-up should be maintained on any active case. For convenience of data recovery and for reference, call-ups are assigned as follows:

A	Adjudication Control	Q	Quick (Timely) Payment
C	Claimant Evidence	R	Rehabilitation
E	Employer Evidence	S	SSA Data
M	Medical Evidence	T	Training Facility
O	Other Evidence	2	Second Opinion (Early Referral)
P	OPM Data	3	Third Party Actions

All call-ups carry a due date, usually the date on which the case should be reviewed if the

information has not been received on the date on which action should be taken. Two lines are available through the note capability for entry of a reminder of next action or information about case status. For example, a CE may have written a letter asking for pay rate information to establish a schedule award. The CE would set a call-up with code E indicating that employer information is needed, and might enter "pay rate" in the note field as a reminder.

In this case, the CE would establish a call-up due in 15 to 30 days and plan to send a second request or make a phone call if the information has not been provided. If the information arrives before the expiration date, the CE deletes the call-up from the system since it is no longer needed to prompt action. If the information has not arrived by the call-up expiration date, the case will appear on report FEC 190 for that date. The CE may be able to take action without the case file if the call-up note contains sufficient information. Otherwise, the CE calls for the file, takes the next action, and sets a new call-up if further monitoring is required.

Call-ups may be used to diary cases for periodic roll review, to identify cases which should be closed after a certain period of inactivity, to bring cases back to the CE for adjudicatory decisions within program time frames, and to monitor third party actions, OPM actions, etc.

2-0401-6 Status Changes

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

2-0401-7 Definitions of Pay Status Codes

7. Definitions of Pay Status Codes. Every case file acquires a pay status code (or case status code) when it is created and retains such a status throughout its existence. Before the case is adjudicated, the pay status code reflects whether it has been reviewed, and afterwards it reflects whether and what benefits are being paid or are payable. Of the 22 two-character pay status codes in the system, 21 are still in use. Only certain codes are compatible with payment through ACPS and BPS. Brief definitions are indicated below.

> UN: Case created, not reviewed. This status is automatically generated at the time of case create, and should not be changed unless the case has been reviewed by a CE or a bill for treatment authorized by Form CA-16 has been filed. UN changed to any status generates "review date."

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

MC: Entitled for the time being to medical treatment only. (May be used temporarily to ensure payment of an authorized procedure on a denied or unadjudicated case.) Only used in combination with "A_" adjudication code.

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

PR: Entitled to payment on periodic roll; re-employment or earning capacity not yet determined. Used with "AP" in early stages of extending disability.

PS: Entitled to payment for schedule award, whether periodic or lump sum. Assigned with "AP" to effect payment through ACPS.

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

PW: Entitled to reduced compensation reflecting a partial wage-earning capacity or actual earnings. Used with "AP."

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

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

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

RH: Should no longer be used.

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

C2: Closed, accepted, no further payments anticipated, time lost covered by leave,

leave not repurchased. Used with "AL" adjudication code.

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

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

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

CL: Administrative closure.

RT: Retired or awaiting retirement.

XX: Awaits destruction.

2-0401-8 Definitions of Adjudication Status Codes

8. Definitions of Adjudication Status Codes. With the exception of noncontroverted no-time-lost cases discussed in paragraph 9, the adjudication status code field may not be filled until the initial acceptance or denial of the case by the responsible CE, with action on the CA-800 summary. Assignment of any of the codes beginning with "A" should reflect acceptance of a medical condition as work-related, with entries in Boxes 20, 21 and 22 of Form CA-800. The reported/accepted condition flag must be set to "Y" before an ICD-9 code can be entered. Assignment of any of the codes beginning with "D" should reflect a formal decision with appeal rights.

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

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

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

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

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

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

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

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

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

Denials--Any denial code prevents entry of payment data in the medical and compensation automated payment system.
DO: Disallowed pending.

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

D2: Denied; claimant not a civil employee.

D3: Denied; fact of injury not established.

D4: Denied; not in performance of duty.

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

D7: Remanded by ECAB.

D8: Remanded by the H&R.

D9: Request for reconsideration pending.

SU: Consideration for benefits suspended for failure to report for an Office-directed medical exam.

2-0401-9 Assignment of Status Codes

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

a Primary Adjudication.

(1) Creation. Each case received is placed in status UN at time of case create. The change from "UN" to any other status sets Review Date in CMF.

No adjudication code is used with UN, and bills cannot be entered in BPS while case is in this status. Cases move from UN to UD when reviewed by a CE who makes that disposition. Cases may be placed in UD status prior to CE review to pay a bill when treatment was authorized by Form CA-16.

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

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

(3) Acceptance. If the CE is able to accept a condition, either on first review or after development, the condition is entered on the CA-800 summary and an appropriate adjudication status and pay status are set for the case. The adjudication code will depend on whether the CE accepts any period of disability as supported by medical evidence. All approval (A_) codes must reflect true adjudication, which includes acceptance of the five basic requirements and approval of a condition, and the status code date should be the date on which the case was approved.

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

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

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

AC/MC: Condition accepted as injury-related. Continued pay was elected and is supported for some period. Further bills accepted and

payable.

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

(4) Closure (in minor cases). With the exception of noncontroverted no-time-lost cases, all cases must be adjudicated, with acceptance of condition on Form CA-800, or formal denial, and an appropriate status code entered into the CMF.

The BPS permits the processing of bills in closed status, except for C3 (denied), and the bill screening job will not flag bills where date of service is within 90 days of closure date. The CE may lose credit for prompt adjudications if an adjudicated case is closed early and then readjudicated on the basis of further information. Repeated reopenings also distort MIS statistics on the number of reopened and readjudicated cases.

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

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

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

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

(a) The total amount of medical bills exceeds $1500;

(b) Evidence is received to show that the injured employee was disabled for work after the date of injury;

(c) Evidence is received to show that a schedule award may be payable for permanent impairment.

Prior to releasing cases to the claims units, the District Office will identify the non-controverted, no-time-lost traumatic injury cases. Item #35 on Form CA-1 will show whether a case is controverted. If there is no entry in item #35 it should be assumed that the case is not controverted. However, if the "yes" box is

checked but there is no explanation for the controversion, it should be assumed that the case is controverted and that the no-time-lost procedures will not apply. Items #23-26 and #38 on Form CA-1 will show whether the case is no-lost-time. If items #23-#26 are blank, it can be assumed that the case is no-lost-time.

These no-lost-time cases can be closed without review by a CE. Closing these cases will involve different keying requirements in the reported/accepted condition data fields. Because a formal adjudication has not been made in the cases, "C" (for closed no-lost-time) should be entered in the data field which asks whether the case has been accepted, instead of "Y" or "N". The reported condition entered during the case create process should be retained by using the "Enter" key to skip through the reported condition field. Entry of "C" in the reported/accepted condition field will result in the system assigning a "C1" case status code and an "AM" adjudication code with no additional keying. Form CA-800 should be initialed in item #58, indicating that the case is being closed no-lost-time. No accepted condition should be entered on the CA-800.

The closed no-lost-time cases without bills can be routed directly to the file room without CE review. Cases with bills can be processed for payment in accordance with individual office procedures.

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

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

b. Compensation Payment.

(1) Daily Roll. The codes for daily roll payment are AD/DR (accepted for daily roll compensation; compensation payable). If continuing Forms CA-8 are expected the case should remain in that status and should not be placed in a closed or medical pay status, since these will not permit payment through ACPS.

Lump sum schedule awards must be in AP/PS status to be properly entered in ACPS. Therefore, even if a one- time payment of a schedule award is being made, the CE should not use AD/DR. The CE may use the routing grid on the front of the case file folder as a reminder to change the status after the payment is made. The appropriate status after the payment is made would be AP/C5 or, if medical care continues, AM/MC.

When the claimant returns to work (or ceases to claim compensation) and medical bills are still coming in, the codes should be AM/MC. If the claimant is discharged from treatment, the case is closed AM/C5. This closure allows a 90-day window for bill payment before the screening program will require a CE review.

Cases in AL/__ status in which a claim for leave repurchase is filed should remain "AL" until a completed Form CA-1207 is returned and payment is set up, at which time the status changes to AD/DR.

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

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

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

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

(3) Schedule Awards. If a schedule award is being paid, the case should have status AP/PS whether it is being paid on the periodic or the daily roll. After a lump sum payment of a schedule award, the case status should be changed as indicated above, under AD.

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

(4) Closures Without Denial. When a claimant who has been receiving compensation on the daily roll returns to work and is discharged from medical

care, the case is closed AD/C5. A periodic roll case, when the entitlement to medical and compensation ends, becomes AP/C5. However, if expenses for medical treatment are expected to continue after wage loss compensation ends (the claimant is working or elected an OPM annuity), the case may be held in AM/MC status and eventually closed AM/C5.

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

c. Denials.

(1) Use of Denial Codes. A denial adjudication code should reflect a compensation order or notice of decision with full appeal rights, and the adjudication status date should be the date of release of the formal decision by the authorized person. Denial codes should not be used following issuance of Form CA-1041. Denied cases are always closed, except on remand from H&R or the ECAB. The codes are shown in paragraph 8 above.

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

(a) Claimant has X-ray evidence of asbestos-related disease, but no disability for work and is entitled to yearly medical examinations.
(b) Claimant was denied monetary benefits due to lack of timeliness but is entitled to medical care.

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

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

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

d. Reconsideration, Hearings, Appeal. Code D7 or D8 is used when a remanded case is not in a payment status and a de novo decision has not been issued. The pay status is UD. D9 is used while an application for reconsideration on a denied case is being processed. Cases in pay status (LWEC, SA) which are remanded or under

reconsideration will retain the adjudication and pay status appropriate to their benefit status (e.g. AP/PW).

e. Reopening Closed Cases.

(1) Accepted cases should not be reopened merely to pay medical bills. The screening program flags only those bills for which the billed date of service is 90 days or more after the date of closure. These are routed for approval to the CE.

(2) Denied cases on which a medical bill is payable must be given a payable status. Code AM/MC may be used. Efforts should be made to ensure that cases are promptly restored to closed status after payment.

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

(4) Remands and reconsiderations on denied cases should prompt the assignment of adjudication code D7, D8 or D9, as appropriate, and pay status UD.

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

(a) Manual Reopening. Menu item REOPEN LT/NLT CLOSURE (not STATUS/ACCEPTED CONDITION) should be used. Any of the following may be chosen as the reason for reopening the case: 1--Medical bills exceed $1500; 2--Compensation claim received;
3--Case controverted; 4--Other. Any choice will generate an expired call-up and call-up note showing the reason for reopening the case.

The CE should enter "UD" in the case status field. The date that the evidence requiring reopening of the case is received in the office should be used for the "UD" date in the system. The "C" entry should remain until the case is adjudicated, at which time the CE must enter either "Y" or "N" in place of "C" to show whether or not the case was accepted. If so, the ICD-9 code should be entered into the system. If the case is denied, medical payments will not be denied retroactively.

(b) Reopening by System. Cases closed short form will automatically be reopened if the medical bills exceed $1500, a wage loss claim is entered into TPCUP, or the controverted indicator in the CMF record is changed to "Y". The system will remove the adjudication status code and accepted flag, set the case status to UD and generate a call-up note reflecting the triggering event.

Payment of medical bills approaching or exceeding the $1500 short-form limit ("edit 109 failure") is addressed in the Expanded Bill Resolution Job Aid available to claims and bill resolution staff.

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

2-0401-10 TPCUP Codes

10. TPCUP Codes. Form CA-7 is entered into the Timely Payment of Compensation Program (TPCUP) upon receipt in the office, and the date when the claim form is placed with the responsible CE is also recorded. Unless otherwise specified, the codes below apply to both traumatic and occupational claims:

a. Resolution on Initial Processing. Where the claim is resolved on initial processing, the CE or certifier enters one of the following codes: Where the payment has to be re-entered or revised for any reason, the certifier must update the coding and date in the system as appropriate.

A1 Certified for Payment
B1 Denied (formal decision released)
C1 Claimant on Periodic Roll
D1 LBB, CA-1207 Released
E1 No Wage Loss (COP entitlement, lease used, 3-day waiting period, returned to work, etc.)
F1 Duplicate, Already Paid
G1 Other

H1 Schedule Award
I1 Recurrence
X1 Occupational Disease, Paid (Claim Received Prior to Acceptance of Case)
Y1 Occupational Disease, Other

Entry of one of these codes moves the claim from the Claims Tracking Report to the Completed Claims Report.

b. Deferral of Decision. Where the CE cannot pay the claim on initial processing because clarification or development is needed, one of the following codes is entered to denote the reason for deferral of payment:

30 Medical Evidence Required (case adjudicated)
31 Unadjudicated (this would include unadjudicated case, unadjudicated recurrence, etc.)
32 Case File Out of Office (e.g., for medical review, for hearing or appeal, etc.)
33 Need Information from Agency (case adjudicated)
34 Awaiting Election
35 SA Development
36 Other
37 Recurrence
38 Leave Buy-Back

Entry of one of the above codes moves the claim from the Claims Tracking Report to the Outstanding Claims Report, which calls for supervisory review of unresolved claims at 30 and 60 days from the date of receipt. CEs are responsible for establishing call-ups appropriate to the circumstances of the case.

c. Resolution of Claim. When a decision has been made on a claim which was previously deferred, the certifier enters one of the following codes to denote final claims action:

A2 Certified for payment
B2 Denied (formal decision released)
C2 Claimant Placed on Periodic Roll)
D2 LBB, CA-1207 Released
E2 No Wage Loss

F2 Duplicate, Already Paid
G2 Other
H2 Schedule Award Paid
I2 Recurrence Accepted
X2 Occupational Disease, Paid (Claim Received Prior to Acceptance of Case)
Y2 Occupational Disease, Other

The entry moves the claim from the Outstanding Claims Report to the Completed Claims Report. Where the data entered by the CE is revised or re-entered by the certifier, the certifier must update the coding and dates in the system.

11. Reports. Four reports are available for use by individual CEs in managing case loads. They are the FEC 180, the FEC 190, the FEC 200, and the Outstanding Claims Report. The FEC 200 is useful only in offices which employ the system's mail queuing capability.

a. FEC 180 is generated weekly and on demand. The occupant of each computer location receives an inventory of cases charged to that location, the date it entered that location, and its pay status code. The 180 also includes a code which categorizes cases by age in location. The report enables CEs to work oldest cases first, and to make sure that all cases receive prompt attention. The SCE may review a FEC 180 for all CE and clerical locations in the unit.

b. FEC 190 may be generated each day for each CE. It lists all expired call-ups for that CE's cases which have not been deleted from the system. The report gives the expiration date of the call-up, the call-up category, the case location, pay and adjudication status, nature of injury and claimant's name. CEs may renew or extend the call-up based on other information in the system, or may request the case, take the indicated action, and delete old call-up, setting a new one for the next review date or indicated action.

c. The FEC 200 is used in offices which assign queue codes to mail prior to case attachment. The report lists all cases which have mail in the various queues. Queue codes are defined as follows:

QQ 1	Case in file, contains priority mail
QQ 2	Case in file, contains pending medical bill
QQ 3	Case in file, contains unreviewed medical report
QQ 4 - 9	(district office defined)

The queuing report enables a CE to schedule work so that items are reviewed in order of importance. Cases may remain in file until the CE is ready to work them, and may be called for when needed.

d. Outstanding Claims Report. This report addresses claims (Forms CA-7 and CA-8) under development pending final resolution. Claims appear on this report when the CE, on initial processing, determines that the claim cannot be resolved without further development, initiates action to obtain the needed evidence, and enters a code denoting the reason for deferring resolution of the claim.

(Two other TPCUP reports are available for use by office managers: the Claims Tracking Report, which tracks incoming claims until the responsible CE or certifier takes action, and the Completed Claims Report, which records final decisions on incoming claims and identifies the elapsed days from date of receipt to the date keyed into ACPS.)

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

13. ICD-9 Codes. When conditions are accepted as work-related, the CE should enter the corresponding ICD-9 codes into the system as well as to item 22 of Form CA-800. The codes are found in Volume 3 of the ICD-9 code manuals. As additional conditions are accepted, the ICD-9 codes must be added to the system. Up to six such codes may be entered for each case.

a. Severity of Condition. The ICD-9 code should accurately reflect the severity of the condition accepted. For instance, if the OWCP has accepted a herniated lumbar disc (code 722.10), the code for lumbar strain (847.2) should not be used instead.

b. Surgery. When a surgical procedure has been accepted as work-related, the CE should enter the ICD-9 procedure code into the system along with the condition to be treated by surgery.

c. Psychiatric Conditions. When a claimant who has a physical work-related condition requires treatment for a related psychiatric condition (e.g., depressive reaction), the CE must add the psychiatric diagnosis to the system. Failure to do so may result in denial of bills for psychiatric care other than the initial evaluation.

d. Specific Identifiers. One-character identifiers unique to the FECA system are used to add more specificity to ICD-9 codes. These identifiers, which are entered in the sixth position of the ICD-9 code field, are as follows:

R Right
L Left
B Both
A Aggravation
D Denied

e. Coding Priorities. If more than six conditions have been accepted in a given case, those which most fully reflect the nature and severity of the claimant's current disabilities should appear on the system. Each body part or function affected should be represented on the system, if possible. Diagnoses take priority over procedure codes, and conditions currently requiring treatment take priority over those which have resolved.

2-0401-11 Reports

11. Reports. Four reports are available for use by individual CEs in managing case loads. They are the FEC 180, the FEC 190, the FEC 200, and the Outstanding Claims Report. The FEC 200 is useful only in offices which employ the system's mail queuing capability.

a. FEC 180 is generated weekly and on demand. The occupant of each computer location receives an inventory of cases charged to that location, the date it entered that location, and its pay status code. The 180 also includes a code which categorizes cases by age in location. The report enables CEs to work oldest cases first, and to make sure that all cases receive prompt attention. The SCE may review a FEC 180 for all CE and clerical locations in the unit.

b. FEC 190 may be generated each day for each CE. It lists all expired call-ups for

that CE's cases which have not been deleted from the system. The report gives the expiration date of the call-up, the call-up category, the case location, pay and adjudication status, nature of injury and claimant's name. CEs may renew or extend the call-up based on other information in the system, or may request the case, take the indicated action, and delete old call-up, setting a new one for the next review date or indicated action.

c. The FEC 200 is used in offices which assign queue codes to mail prior to case attachment. The report lists all cases which have mail in the various queues. Queue codes are defined as follows:

QQ 1	Case in file, contains priority mail
QQ 2	Case in file, contains pending medical bill
QQ 3	Case in file, contains unreviewed medical report
QQ 4 - 9	(district office defined)

The queuing report enables a CE to schedule work so that items are reviewed in order of importance. Cases may remain in file until the CE is ready to work them, and may be called for when needed.

d. Outstanding Claims Report. This report addresses claims (Forms CA-7 and CA-8) under development pending final resolution. Claims appear on this report when the CE, on initial processing, determines that the claim cannot be resolved without further development, initiates action to obtain the needed evidence, and enters a code denoting the reason for deferring resolution of the claim.

(Two other TPCUP reports are available for use by office managers: the Claims Tracking Report, which tracks incoming claims until the responsible CE or certifier takes action, and the Completed Claims Report, which records final decisions on incoming claims and identifies the elapsed days from date of receipt to the date keyed into ACPS.)

2-0401-12 Inquiries

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

2-0401-13 ICD-9 Codes

13. ICD-9 Codes. When conditions are accepted as work-related, the CE should enter the corresponding ICD-9 codes into the system as well as to item 22 of Form CA-800. The codes are found in Volume 3 of the ICD-9 code manuals. As additional conditions are accepted, the ICD-9 codes must be added to the system. Up to six such codes may be entered for each case.

a. Severity of Condition. The ICD-9 code should accurately reflect the severity of the condition accepted. For instance, if the OWCP has accepted a herniated lumbar disc (code 722.10), the code for lumbar strain (847.2) should not be used instead.

b. Surgery. When a surgical procedure has been accepted as work-related, the CE should enter the ICD-9 procedure code into the system along with the condition to be treated by surgery.

c. Psychiatric Conditions. When a claimant who has a physical work-related condition requires treatment for a related psychiatric condition (e.g., depressive reaction), the CE must add the psychiatric diagnosis to the system. Failure to do so may result in denial of bills for psychiatric care other than the initial evaluation.

d. Specific Identifiers. One-character identifiers unique to the FECA system are used to add more specificity to ICD-9 codes. These identifiers, which are entered in the sixth position of the ICD-9 code field, are as follows:

R Right
L Left
B Both
A Aggravation
D Denied

e. Coding Priorities. If more than six conditions have been accepted in a given case, those which most fully reflect the nature and severity of the claimant's current disabilities should appear on the system. Each body part or function affected should be represented on the system, if possible. Diagnoses take priority over procedure codes, and conditions currently requiring treatment take priority over those which have resolved.

2-0402 SECURITY & PREVENTION OF FRAUD & ABUSE

Paragraph and Subject		Date	Trans. No.
Table of Contents		10/98	99-02
1	Purpose and Scope	03/91	91-22
2	Monitoring Files and Documents	03/91	91-22
3	Payments	03/91	91-22
4	Information from Outside Sources	03/91	91-22
5	Unreported Earnings	03/91	91-22
6	Action Where Fraud is Not Involved	03/91	91-22
		04/95	95-19
7	Action Where Fraud is Involved	10/98	99-02
8	Action upon Identifying Possible Fraud	03/91	91-22
		08/95	95-33
		01/92	92-12

9	**Physical Security**	**01/92**	**92-12**

Exhibits

1	**Worksheet for Investigation of FEC Claimant**	**04/95**	**95-19**
2	**Incident Report, Form DL-156**		
	Page 1 (Link to Image)	**04/95**	**95-19**
	Page 2 (Link to Image)	**04/95**	**95-19**
3	**Referral of FEC Case to the OIG, Form CA-503 (Link to Image)**	**04/95**	**95-19**

2-0402-1 Purpose and Scope

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

2-0402-2 Monitoring Files and Documents

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

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

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

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

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

2-0402-3 Payments

3. Payments.

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

b. CEs should obtain ACPS and BPS reports periodically to determine if improper payments are being made on cases under their jurisdiction. In addition, payment histories

on missing cases should also be reviewed. Any evidence of medical or compensation payments made on a case which are not clearly supported by the evidence of record or otherwise explained should be brought to the attention of the Assistant District Director (ADD).

2-0402-4 Information from Outside Sources

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

2-0402-5 Unreported Earnings

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

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

2-0402-6 Action Where Fraud is Not Involved

6. Action Where Fraud is Not Involved. Investigation by a Compliance Officer of the Wage and Hour Division, an OWCP investigator, or by claims personnel may be requested as a routine

matter in situations which present no clear indication of fraud. For example, such an investigator may check on the activities of a person receiving periodic roll benefits to obtain specific evidence of the kinds of physical movement (lifting, climbing) the claimant is able to engage in, or visit a workplace to determine the factors of employment to which the claimant is exposed.

a. Recommending Cases for Investigation.

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

(a) The particular issues about which additional evidence is required; it is the CE's responsibility to give a clear and concise description of the specific problem so that the need for the investigation will be apparent.

(b) A resume of the relevant evidence appearing in the record.

(c) A brief explanation of the reason this evidence is not sufficient to permit a proper determination.

(d) A brief outline for the kind of evidence which the investigator should seek, including the names of any persons the CE believes should be contacted.

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

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

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

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

c. After Assignment for Investigation.

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

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

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

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

2-0402-7 Action Where Fraud is Involved

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

2-0402-8 Action Upon Identifying Possible Fraud

8. Action Upon Identifying Possible Fraud.

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

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

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

b. Actions by ADD. Upon receipt, the ADD will review the information or evidence (including the case file) and will arrange for the preparation of Forms DL-1-156 and CA-503 (in triplicate) for the signature of the Regional Director (RD) (see subparagraph g below). The ADD, will make any pertinent comments on the Form DL-1-156 (Block 14) and will forward the forms and the case file to the DD as quickly as possible. Whether the ADD agrees or disagrees with the recommendation for referral to the OIG, the forms and the case file must be forwarded to the DD. In National Office (NO) cases, NO staff will prepare the forms in duplicate for the signature of the Director for FEC, and forward the forms directly to him.

c. Review by DD. Upon receipt of the Forms DL-1-156 and CA-503, the DD will review the forms and attachments, and the case file, and will make any pertinent comments on the Form DL-1-156 (Block 14). The original and copies of the forms, with attachments, will then be forwarded to the RD, regardless of whether the DD agrees with the recommendation for referral to the OIG.

d. Review by RD. The RD will review the forms and their attachments upon receipt. Any pertinent comments will be made in Block 14 of form DL-1-156. After dating and signing the form, the RD will ensure that the originals, with attachments, are forwarded to the appropriate regional office of the OIG. A copy of each of the completed forms will be mailed to the Office of the Inspector General, Division of Compensation Fraud Investigation, P.O. Box 1924, Washington, D.C. 20012. One copy of each of the forms will be maintained in a locked file in the office of the RD. In the National Operations Office, the DD will be responsible for the files. In NO cases, the file will be maintained by the Chief, Branch of Regulations and Procedures.
Whether the RD agrees or disagrees with the recommendation for referral to the OIG, the

forms must be forwarded to the OIG for a determination of whether investigation/action is warranted.

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

f. Reports of Fraud. Whenever an OWCP employee is contacted by someone outside of ESA, whether a private citizen or government official, with allegations or information regarding suspected fraud in an FECA claim, the individual will be referred immediately to the ADD or the DD, who will report such contact to the OIG by arranging for the completion and submission of Form DL-1-156 through the RD.

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

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

Block 2. Enter the FECA case file number.

Block 3. For use by the OIG only.

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

Block 5. Check as appropriate.

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

Block 7. Enter district office address.

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

Block 9. Check as appropriate.

Block 10. Identify the law enforcement agency (such as FBI, U.S. Postal

Inspector, Naval
Intelligence, etc.) and furnish the agent's full name and address. Results of the contact, including information requested or provided, should be shown in Block 14.

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

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

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

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

Block 15. The responsible official for the purposes of this procedure is the RD.

Block 16. Self-explanatory.

Block 17. Self-explanatory.

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

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

Any case where action has been delayed for more than 60 days pending OIG disposition should be reported to the Director for FEC by memorandum, enclosing copies of the Forms CA-503 and DL-1-156. In those cases where action by the OWCP has not been held in abeyance awaiting OIG disposition, a report, enclosing the Forms CA-503, and DL-1-56, should be made to the Director for FEC if no disposition has been made by the end of six months following the submission of the documents. When information is received that the OIG has disposed of a case, the Director for FEC should be advised

immediately if a report concerning a delay had previously been made. The Director for FEC will advise the RD whether continued monitoring by the district office will be necessary in those cases where reports have been submitted to him.

i. Tracking. Any request for information, especially an investigative memorandum, in connection with an investigation of an FECA claimant should be tracked on a local PC system. Initial and follow-up actions should be monitored until a resolution is reached, and the Regional Director should sign any correspondence. The Office should retain tracking reports on the PC or in hard copy form.

2-0402-9 Physical Security

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

2-0402 Exhibit 1: Worksheet For Investigation Of FEC Claimant

Name of Claimant or Beneficiary:________________________________
OWCP Case File No.______________________ SSN____________________
Address:____
____

Telephone Number:_____________________________
Date of Injury:_______________________________
Condition(s) for Which Benefits are Claimed/Paid:_______________
____
Claimant's Occupation:____
Employment Address:____
____
Has case been accepted? Yes___ No___ If so, is compensation being paid? Yes___ No___ If so, at what rate? $________ each four weeks

Purpose of Investigation:

____Determine facts surrounding injury or exposure
____Periodic roll employment check
____Periodic roll activity surveillance
____Overpayment financial questionnaire
____Other (explain below)

Reasons investigation is requested:________________________________
____
____
____

Specific actions requested (interview, observation, etc.)________
____
____
____

Claims Examiner:_______________________________ Date:______________
Telephone Number:__________________________

2-0402 Exhibit 2: Incident Report, Form DL-156 Page 1 (Link to Image)

2-0402 Exhibit 2: Incident Report, Form DL-156 Page 2 (Link to Image)

2-0402 Exhibit 3: Referral of FEC Case to the OIG Form CA-503 (Link to Image)

2-0500 CONFERENCING

Paragraph	Subject	Date	Trans. No.
Table of Contents		06/98	98-05
1	Purpose	07/95	95-28
2	Responsibilities	07/95	95-28
3	Cases Suitable for Conferencing	07/95	95-28
4	Preparation for Conferencing	07/95	95-28
5	Elements of Conference	07/95	95-28
6	Senior CE Actions	07/95	95-28
7	Memorandum of Conference	07/97	97-19
		06/98	98-05
8	Comments	07/95	95-28

		07/97	97-19
9	Due Process	07/95	95-28

2-0500-1 Purpose

1. Purpose. The purpose of this chapter is to provide specific instructions for holding conferences with claimants, employing agency personnel, or other parties to resolve complex issues, and to facilitate the claimant's early return to work. The issues commonly addressed through conferencing include controversions, disputed facts or occurrences, and overpayments. In such situations, the conference is employed as a means of fact- finding, following which a decision is made.

The return-to-work (RTW) conference is different from other kinds of conferencing in that its goal is to assist the claimant's return to the work force, and as such is a form of principled negotiation. If the objective of the RTW conference is reached, all parties to the negotiation will experience a positive result.

Although conferences will sometimes be held in person with several parties in attendance, most conferences will be held by telephone and with only one party at a time. However, a typical RTW conference by telephone will involve several parties--the Senior Claims Examiner (SrCE), the Field Nurse, the Staff Nurse, the claimant and/or a representative of the employing agency (though not physicians). On occasion the Claims Examiner (CE) assigned to the case will also take part.

2-0500-2 Responsibilities

2. Responsibilities. The SrCE is responsible for conferencing cases where an issue is in dispute, where detailed technical evidence is required to decide an issue, or to facilitate return to employment. Except in overpayment cases and those involving return to work, the Supervisory Claims Examiner (SCE) is responsible for identifying cases for conferencing and will refer them to the SrCE. The District Director will keep a file containing all Memorandums of Conference.

2-0500-3 Cases Suitable for Conferencing

3. Cases Suitable for Conferencing. Conferencing should be considered in the following situations:

a. Fact of injury or performance of duty has been controverted.

b. The claimant's disability has resolved to the point that a return to work effort,

using nurse intervention and/or vocational rehabilitation, is appropriate. The RTW conference will generally be used:

(1) Early in the nurse intervention process, so that the efforts of the various parties involved in the claim (e.g., the SrCE, Field Nurse, claimant and agency representative) may be coordinated;

(2) Near closure of the RTW effort through nurse intervention, when placement with the previous employer is appropriate and feasible.

c. A disputed issue has arisen, whether or not the case is controverted. Typical disputes or questions may involve:

(1) Fact of injury.

(2) Performance of duty (e.g., recreational injuries, assault cases).

(3) Vehicle or housing purchase and/or modification.

d. Overpayments have been identified and:

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

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

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

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

2-0500-4 Preparation for Conferencing

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

For conferences involving more than one party, a pre-conference call may be needed to schedule the call, provide the phone number, and explain the use of the conference line. For RTW conferences, it may be necessary to identify the official(s) at the employing agency who can

arrange the return to work (e.g., by confirming the availability of light duty). Or, at district office option, the CE may identify this individual before the case is referred for conferencing. As part of the preparation for the call, the SrCE should:

a. Give the participant a clear picture of the purpose and process of the conference call, and the obligations of all parties in it.

b. Explain the issues to be discussed.

c. Describe the criteria used to make key decisions in the case, including due process (see paragraph 9 below).

d. Describe any evidence the participant needs to have for the conference call.

e. If the only participant is the claimant, advise him or her that all non-medical information obtained in the conference will be shared with the employing agency.

f. Give the participant a chance to ask questions.

2-0500-5 Elements of Conference

5. Elements of Conference. All conferences are to be non-adversarial in nature and should include the following:

a. Identification of caller.

b. Statement of the purpose of the call.

c. Statement that notes will be taken, and for this reason periodic pauses will occur.

d. If the claimant is the only participant, advice that information gained during the call will be shared with the employing agency.

e. A description of the specific focus of the call.

f. An acknowledgement from the participant(s) that he or she understands the nature of the issues and the purpose of the conference.

2-0500-6 Senior CE Actions

6. Senior CE Actions. During the discussion, the SrCE should:

a. Address the issues in ascending order of difficulty and listen carefully to what is being said.

b. Take notes complete enough to capture necessary information.

c. Probe responses which are too general or not credible, or which conflict with other statements given or other evidence in the file.

d. Confirm the accuracy of the statements recorded by reading them back to the participant(s) for confirmation.

e. In a RTW conference, encourage both the injured worker and the employing agency to reach a RTW decision, and move quickly to remove any roadblocks to that end.

2-0500-7 Memorandum of Conference

7. Memorandum of Conference. After the conference is completed, the SrCE should complete a neutral Memorandum of Conference (that is, one which does not contain findings). It should describes what each party said in the conference in clear, non-technical language. A sound Memorandum of Conference should:

a. Identify and describe the issues which were discussed.

b. Identify the SrCE who conducted the conference and the participants to the conference.

c. Describe each party's position before the conference.

d. Describe the explanations provided in the conference to protect the parties' right to due process.

e. Describe what each party said in the conference that is relevant to the issue.

f. Describe the method used to confirm the accuracy of the information collected during the conference and recorded in the Memorandum of Conference.

g. Describe any agreements reached in the conference.

The format of the Memorandum of Conference should include the following elements: Name of Claimant; File Number; Date of Conference; Participants; Issue; Background; and Discussion.

2-0500-8 Comments

8. Comments. In most cases, the SrCE must obtain comments on the Memorandum of Conference from each party.

a. Comments Not Required. In the following two situations, it is not necessary to request comments from any of the parties to the conference:

(1) When it is clear that the decision will benefit the claimant and that the basis of any objection from the employing agency will be addressed in the ensuing decision. For instance, a controverted case which will be resolved in the claimant's favor as a result of a conference will be the subject of a Form CA-1038 or other correspondence which will advise the agency of the basis for continuing pay.

(2) When return to work is at issue, since due process issues are usually not a consideration in conferences which address this issue. While it is appropriate for all parties to receive copies of the Memorandum of Conference, the SrCE need not postpone any post-conference actions in these cases to confirm the accuracy of the memorandum.

b. Comments Required. In all other cases, comments from each party must be requested, especially where a conference held with the claimant results in new allegations that need to be shared with the agency for confirmation or rebuttal. Each participant should be sent a copy of the Memorandum of Conference and asked to provide any comments within 15 days. The requests may be sent to all parties simultaneously, rather than serially. (However, if comments from one or more parties result in a material change to the Memorandum of Conference, the SrCE will need to request comments from the other party(ies) again.)

At the end of the 15-day period, the SrCE should make findings on the issue for resolution. These findings need not be the subject of a separate memorandum, but they will need to be documented in the formal decision. Any decision to deny benefits should be made in accordance with 5 U.S.C. 8124. Where a controversion is not upheld, rationale for OWCP's action must be provided in accordance with 20 C.F.R. Section 10.140.

2-0500-9 Due Process

9. Due Process. Claimants must be informed about due process in cases where conferences are held. To this end, the SrCE should explain, in clear language, the criteria being used to make the various decisions and the implications of those decisions. Such explanations are especially

important in overpayment cases. The meaning of "at fault" should be explained, as well as the criteria upon which it is determined. The SrCE should state that a preliminary finding of fault was made and show how it was reached; state the implications of this finding; and invite the claimant to provide any information that could affect the finding.

Discussion of due process issues is not as vital in RTW conferences because they are less formal and their goal is to facilitate an early return to work, before the employing agency makes any written offer of "suitable work". Where the goal of the RTW conference is not reached, it may be necessary for the employing agency to make a formal job offer. In such cases, the CE should consult PM Chapter 2-814.5, which describes the due process requirements, before invoking the sanctions of 8106(c) of the FECA.

2-0600 CASE MANAGEMENT

Paragraph	Subject	Date	Trans. No.
Table of Contents		09/97	97-16
1	Purpose and Scope	11/96	97-04
2	Policy	11/96	97-04
3	Responsibilities of Claims Examiners	11/96	97-04
4	Initial Actions	11/96	97-04
		09/97	97-16
5	Nurse Services	11/96	97-04
6	Medical Management	11/96	97-04
7	Referrals for Vocational Rehabilitation Services	11/96	97-04
		09/97	97-16
8	Return to Work with Previous Employer	11/96	97-04
9	Ten-Month Letter	11/96	97-04
10	Plan Development	11/96	97-04
11	Return to Work with New Employer	11/96	97-04
12	Case Resolution	11/96	97-04
		09/97	97-16

Exhibits

1	Sample of Letter to be Sent to Claimant at Ten Months After Disability Began	10/94	95-02
2	Sample of Letter to be Sent to Claimant when		

	Vocational Rehabilitation Plan is Approved	**10/94**	**95-02**
3	**Sample of Letter to be Sent to Claimant at Beginning of Placement New Employer Phase**	**10/94**	**95-02**
4	**Request for Extension of Field RN Services**	**11/96**	**97-04**
5	**Planning Chart for QCM Cases (Link to Image)**	**11/96**	**97-04**

2-0600-1 Purpose and Scope

1. Purpose and Scope. The Office of Workers' Compensation Programs (OWCP) is responsible for ensuring that benefits are promptly paid and that they do not continue after the effects of the work-related condition have ceased. The OWCP is also obligated to help claimants return to duty as soon as possible.

This chapter outlines the major steps in helping claimants to return to work. The procedures address only adjudicated claims. Except for catastrophic injuries, they do not apply to cases where only continuation of pay (COP) is at issue. (Procedures for COP cases are found in PM Chapter 2-0807).

2-0600-2 Policy

2. Policy. The purpose of this paragraph is to describe the projected outcomes of claims and the time frames for accomplishing them.

a. Outcomes. The most likely outcomes are as follows (all but the first assume disabling injury-related residuals):

(1) Complete recovery from employment-related disability without wage loss;

(2) Return to modified work with the previous employer and without wage loss;

(3) Return to work with a new employer and without wage loss, or with the previous or new employer and with a loss of wage-earning capacity (LWEC);

(4) Determination of LWEC without actual job placement, after OWCP has made reasonable efforts to return the claimant to work and has advised the claimant of his or her rights and responsibilities;

(5) Application of sanctions for non-cooperation with the OWCP's rehabilitation and reemployment efforts, with eventual reduction or termination of

benefits where necessary;

(6) Determination that the claimant has no current wage-earning capacity (assignment of case status PN).

Paragraphs 3-12 below address how CEs, OWCP nurses, and vocational rehabilitation personnel help claimants return to work.

b. Time Frames. Each step in the re-employment process has a time frame.

(1) Within one year of the date wage loss began, the OWCP will have issued a decision to most claimants with a disabling job-related injury or occupational illness. This decision will state that the claimant has:

(a) Completely recovered from employment-related disability and thus has no ongoing entitlement to compensation for wage loss;

(b) Returned to work with the previous employer, either at full duty, full-time light duty, or part-time light duty. Such a decision will include an LWEC determination;

(c) Returned to work with a private employer or another Federal agency, and include an LWEC decision; or

(d) Been notified that OWCP will provide vocational rehabilitation assistance leading to re-employment, either in the private sector or with another government agency. Because the claimant will be able to return to work, benefits will be adjusted to reflect an LWEC.

(2) The importance of issuing this decision within one year stems from Section 5 U.S.C. 8151(b)(1) of the Federal Employees' Compensation Act, which provides that:

the department or agency which was the last employer shall immediately and unconditionally accord the employee, if the injury or disability has been overcome within one year after the date of commencement of compensation or from the time compensable disability recurs if the recurrence begins after the injured employee resumes regular full-time employment with the United States, the right to resume his former or an equivalent position....

It is therefore critical that re-employment with the original agency, or a finding of capability for such re-employment, be made within one year of the date that wage loss begins, after the expiration of any COP. The same policy applies to recurrences of compensable wage-loss disability. PM Chapter 2-0813 contains further information about the one-year time limit.

(3) Within two years of the date wage loss began, most claimants who did not return to work with their employing agencies will either be:

(a) Receiving the assistance which will allow them to take other employment. OWCP will make entitlement decisions based on the

selected jobs, regardless of actual employment status; or

(b) Issued decisions stating that they have no wage-earning capacity.

2-0600-3 Responsibilities of Claims Examines (CEs)

3. Responsibilities of Claims Examiners (CEs). This paragraph addresses CEs' responsibilities in managing cases. Brief but timely inquiries and reminders to physicians, employing agencies, and RNs are often very effective. CEs are to:

a. Focus on Return to Work. Each contact with the claimant, employing agency, attending physician, and any second opinion physician should be used to inform the party about the need for return to work or ask for information which will further this goal. This approach will minimize handling early in the life of the case.

b. Initiate Interventions and Services. [Sometimes, however, automated selection criteria are used to identify cases for attention from the OWCP nurse (RN) or Rehabilitation Specialist (RS)].

c. Request Medical Information. The CE will need to ask for supplemental reports from attending physicians, arrange referrals for second opinion or referee examinations when needed, and obtain clarification of these reports when required. (Procedures for developing and evaluating medical

evidence are found in PM Chapter 2-0810.) During nurse intervention or vocational rehabilitation, the CE may ask the RN, RS or Rehabilitation Counselor (RC) to obtain medical evidence from the treating physician.

d. Follow Up With the RN and the RS. The CE will need to ensure that the RN and RS have acted within the stated time frames and critically evaluate their reports. The CE may find it useful to meet with the RN or the RS to plan a course of action.

e. Bring the Case to Resolution. The CE must actively manage the case until the claimant returns to work, an LWEC decision is issued, or a finding of no wage-earning capacity is made. Where the medical evidence establishes that no continuing injury-related disability exists, the CE needs to terminate benefits even if nurse or rehabilitation services are under way, and where the claimant does not cooperate with vocational rehabilitation and re-employment efforts, the CE must apply sanctions.

2-0600-4 Initial Actions

4. Initial Actions. This paragraph describes the actions required as soon as it is clear that the employee will not return to duty within the time specified by the attending physician or the medical matrix (see MEDGUIDE in Folioviews). PM Chapter 2-0811 addresses early management of disability claims in detail. Except for catastrophic injury, case management should begin with receipt of the first claim for wage loss (as opposed to a claim for leave repurchase, a schedule award, etc.) The CE should take the following steps whether the period claimed is continuous or intermittent:

a Adjudication. The CE should adjudicate the case if necessary and possible. The evidence needed to adjudicate a traumatic injury case which was closed short form (accepted condition code "C") may appear in file already. If not, request it promptly.

It is recognized that adjudication and payment of occupational illness claims may need to await additional development of the evidence (see PM Chapter 2-0806 for a development of occupational illness claims, and PM Chapter 2-0401 concerning deferral of payments).

b. First Payment of Compensation. The CE should then set up a compensation payment for the period supported by evidence from the attending physician or the medical matrix (see MEDGUIDE in Folioviews). This payment may be made on the daily roll. The only cases which may be placed on the periodic roll right away are those involving severe injury (e.g., multiple fractures or paralysis), and where the projected return to duty date (if any) is over 90 days away. Enter the projected return to duty date (whether light or full) in the QCM Tracking System.

c. Inquiry About Return to Work. The CE should call the claimant to advise that a

payment is being made, and find out whether he or she has returned to work. If not, ask whether he or she has a plan to do so. Document the claimant's responses on Form CA-110. (At district office option, the Staff RN may make this call using a list of cases where a first payment of compensation for wage loss has just been made. The nurse should record the results on Form CA-110.)

(1) If the claimant has returned to full duty, enter the return to work date in the QCM Tracking System. No further case management action is needed unless a claim for recurrence is filed (see paragraph 6g below).

(2) If the claimant has returned to modified and/or part-time duty, refer the claimant to an OWCP Staff RN as described in paragraph 5 below.

(3) If the claimant states a plan to return to duty, and the date appears to be realistic according to the medical evidence, the medical matrix, or information contained in MEDGUIDE, set a call-up for the date specified. Call the employing agency on that date to find out if the claimant has in fact returned to work.

(a) If so, see subparagraphs (1) and (2) directly above.

(b) If not, refer the claimant to an OWCP Staff RN as described in paragraph 5 below.

For a date more than six months in the future, set an interim call-up to contact the claimant and ensure that the specified date remains viable.

(4) If the claimant does not state a plan to return to duty, or if the date offered is inconsistent with the nature and severity of the injury, refer the case to a Staff RN (see paragraph 5 below).

(5) If the medical evidence, the medical matrix, and MEDGUIDE do not provide a return to work date, the CE will need to call the attending physician to obtain a return to duty date, or arrange for the RN to do so.

Note the date of this telephone call and the date of referral to the RN in the CMF, and on the Case Management Form CA-674.

d. Actions if Claimant Has No Return to Work Plan. If the claimant has not returned to duty, or has no plan to do so, the CE should:

(1) Advise the claimant in writing that he or she:

(a) Will continue to receive compensation only through the specified date (from the attending physician, the medical matrix, or the guidance in

MEDGUIDE) without submission of another claim.(a)

b) Is expected to contact the employing agency to find out if light duty is available and advise the attending physician of the light duty requirements;

(c) Is expected to return to work as soon as medically able to do so.

Forms CA-1650 or CA-1651 may be used for this purpose.

(2) Release Form CA-1656 to the employing agency. This letter requests the position description, including the physical requirements of the job.

e. Further Compensation Payments. Depending on the projected recovery date and other medical developments, the CE may need to authorize further compensation payments.

f. Conferencing. Depending on district office practice, the CE may wish to arrange a conference to coordinate with the various parties involved in the claim (PM Chapter 2-0500 addresses procedures for conferencing.)

2-0600-5 Nurse Services

5. Nurse Services. This paragraph addresses the use of OWCP RNs to assist claimants in returning to work.

a. Definitions. The Staff Nurse (SN) is an OWCP employee who assigns cases to and coordinates the work of Field Nurses (FNs), who meet with claimants, employing agencies and physicians, and CAP nurses, who interact with these parties by telephone. (See PM Chapters 2-0810, 2-0813, and 3-0201 for a fuller discussion of RNs and their duties.)

b. Scope of RN Services. As noted in paragraph 4c above, the SN may make the "return to work" telephone call at district office option, using a computer-generated report. The SN will document the results on Form CA-110, which the CE will review. The SN will take no further action on the case without a specific referral from the CE, but the SN may begin this process by using the nurse referral Form OWCP-57.

(1) Continuing Interventions. The CE may ask that the FN contact the claimant, attending physician, and/or employing agency to address the claimant's questions concerning medical care; to obtain treatment plans, return to work dates, and descriptions of work limitations; and to arrange return to work.

The CE may also ask if more active treatment or more active participation by the claimant in the recovery process appears to be needed. Also, the CE may want the RN to address surgery, prolonged treatments such as physical therapy without clear goals or direction, and multiple concurrent medical/psychological issues.

(2) Advice. The CE may ask the SN for advice where the claimant has sustained a catastrophic injury or has undergone surgery. Likewise, a brief consultation with the SN may be in order to assess whether a particular treatment is appropriate, to help the claimant explore treatment centers, or understand the purpose of particular diagnostic tests.

c. Time Frames. Continuing interventions should usually not exceed 120 days. They may be shorter if the claimant's medical situation stabilizes quickly, or if the FN cannot obtain a return to work date from the physician.

(1) Reasons for Extensions. The CE may authorize extensions for the reasons noted below, all of which apply to the work-related condition. If a non-work-related condition is responsible for a delay in recovery or return to work, the CE should consider an interruption of services (see paragraph 6e below).

(a) Up to 60 more days may be authorized for follow-up with the claimant after return to work. After this period ends, the FN may continue to work toward full-time full duty by pursuing increases in work tolerance limitations and obtaining descriptions of them on Form OWCP-5 at periodic intervals if the medical evidence shows that such an outcome is likely.

The CE must assess the medical evidence carefully 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, the CE should terminate nurse services.

(b) Up to 30 more days may be allowed for other good cause, such as follow-up with a new attending physician.

(c) A variable period, depending on how severe the condition is, may be allowed for work-related surgery [see PM Chapter 3-0201.8a(3)].

(2) Authorization for Extensions. The CE must authorize each extension on Form CA-110 or another form such as the one shown in Exhibit 4. The CE should also advise the SN of the extension (see Exhibit 5 (Link to Image) for a sample tracking sheet to be kept in the case file).

The CE should note 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 given time frame.

d. Kinds of Nurse Intervention.

(1) Telephone Call. A telephone intervention may be the most effective first step where the medical evidence does not clearly establish disability. It may also be the intervention of choice where the claimant lives in a remote area. The SN may assign the case to a CAP RN, who will contact the claimant, the attending physician, and/or the employing agency to try to determine the severity of the injury, the appropriateness of treatment, and the possibilities for return to regular or light duty.

(2) Personal Visit. Such visits are most appropriate with severe injuries, or if a phone intervention has not proven successful. Issues may include explanation of medical treatment to claimants and their families, and monitoring such treatment. In addition to addressing the kinds of issues noted in the preceding paragraph, the FN may more easily assess the claimant's environment and job situation in a personal visit.

e. Criteria for Referral. The best time for nurse intervention is from 45-90 days after the date of injury.

(1) Traumatic injury cases should be referred to an OWCP RN, regardless of the time elapsed since the injury, if:

(a) The medical evidence does not state a return to work date;

(b) The return to work date stated is not in keeping with the severity of the original injury);

(c) The return to work date is extended without clear medical reasons; or

(d) The claimant is partially disabled but the file contains no description of work limitations.

The RN may initiate the referral where she or he makes the return to work telephone call (see paragraph 5b above).

(2) Occupational illness cases ordinarily require at least 90 days to adjudicate, which places them outside the optimum time frame for nurse intervention. Therefore, they will not routinely be referred for continuing assistance from an OWCP RN as described in paragraph 5a(1) above. They may, however, be referred for advice and assistance with specific issues. Referral for vocational rehabilitation services is more appropriate in most occupational illness cases.

f. Communication Between the CE and RN.

(1) To refer the case, the CE should:

(a) Note on Form OWCP-57 the goals of the intervention (e.g., obtaining a description of work limitations from the attending physician); the issues which the RN should address with the physician; and any pending adjudicatory actions (e.g., an imminent second opinion referral);

(b) Flag the pertinent medical reports in file and any statement of accepted facts (one need not be prepared just for this purpose); and

(c) Note the date of referral in the CMF.

(2) The RN will report to the CE either by telephone, in writing, or both (written reports are usually required each 30 days). The RN may note such information as the attending physician's opinion concerning length of disability, work limitations, etc. The CE may use this information as the basis for questions to the physician (see paragraph 6 below) but should not base adjudicatory actions on it, as it is not medical evidence. Of course, if the RN arranges for submission of a medical report from the physician, it may be used for adjudicatory purposes.

(3) Periodically during the RN's intervention, or at the end of 120 days, the RN and the CE will confer, either by telephone, written memorandum, or face-to-face meeting, to determine the next actions. The CE should ensure that any recommendations are consistent with the medical findings.

(a) The RN may recommend a second opinion examination and/or identify physicians who can perform such examinations on an expedited basis. The RN may also recommend medical or vocational rehabilitation services, or other kinds of evaluation.

(b) The CE should promptly make any indicated referral. For second opinion examinations, the CE may ask the RN to help formulate questions. For vocational rehabilitation services, the RN may complete Form OWCP-14, but the CE must sign it. The CE should document any reason for disregarding the RN's recommendations in a memo to the file.

(c) The SN should note the date of closure for nurse services in the CMF.

(4) Timely responses to telephone calls from FNs are crucial to successful case management.

g. Other Issues.

(1) If the claimant declines nurse services, the RN will so advise the CE, who may then determine whether medical intervention or referral for vocational rehabilitation services is appropriate.

(2) The RN may want to address problems not directly related to the claimant's accepted medical conditions. A broader scope is perfectly acceptable as long as the RN focuses on issues contributing to the claimant's disability and/or absence from work. The RN may not authorize tests for unrelated conditions.

(3) The RN may want to coordinate care with an employing agency nurse. This approach may be useful when the claimant is located in a remote area and the employing agency can offer sophisticated medical assistance. As a rule, however, employing agency nurses are discouraged from working with claimants simultaneously with OWCP RNs.

(4) If the claimant returns to work during the RN's intervention, the RN will follow up with the claimant for 60 days. If the claimant has significant problems readjusting to work, or claims a recurrence, the CE may want to talk with the RN and/or the RS to decide whether to ask the RN to intervene further or to refer the case for vocational rehabilitation services.

(5) Nurse and vocational rehabilitation services will not routinely be used at the same time. However, some cases may require such dual action (e.g., the claimant has sustained a catastrophic injury, or has significant difficulties in readjusting to work).

(a) Where the RN identifies the need for RS intervention, she or he will request it by preparing Form OWCP-14 for the RS and CE.

(b) Where the CE identifies the need for both RN and RS intervention, he or she will communicate via OWCP-57 to the RN and OWCP-14 to the RS.

[See FECA PM Chapter 3-201 (for nurse services) and OWCP PM Chapter 3-201 (for rehabilitation services) for a fuller discussion.]

(6) If the CE has begun to terminate compensation, the RN may continue to work with the claimant until the date benefits terminate.

(7) Nurses providing direct care as authorized in PM Chapter 3-0400.6 may, of course, continue to perform those services.

(8) In a case transferred to the Branch of Hearings and Review (H&R) or the Employees' Compensation Appeals Board, the RN should continue to provide services. When the case is in H&R, a Hearing Examiner will make copies of significant medical evidence and forward them to the district office.

2-0600-6 Medical Management

6. Medical Management. The purpose of this paragraph is to describe the CE's responsibility for attending to medical issues, regardless of whether nurse or rehabilitation personnel are providing services to the claimant.

a. Advice to Attending Physician. Where an RN is involved in the case, the CE should so advise the attending physician in the first letter requesting further information.

b. Treatment Plans. Unless the file states that the claimant has returned to work, any inquiry to the attending physician should include a request for a treatment plan. If a position description is in file, the request should include a statement of accepted facts which contains a description of the claimant's job duties. The request should:

(1) Note the previously specified return to duty date;

(2) Ask the doctor's cooperation in returning the claimant to duty;

(3) Inquire about the reasons and objective findings that support continuing injury-related disability. Has the condition worsened? If so, state the new objective findings to support the deterioration;

(4) Inquire as to the reasons for continuing absence from work. If the condition is unchanged, why has the claimant not recovered? Does the disability

continue to be due to the employment-related injury, or is it due to an underlying, non-work-related process?; and

(5) Request a specific treatment plan, with time frames, which will improve the claimant's physical status and promote his or her ability to return to work.

For example: "With respect to this patient's injury-related disability, please outline all the medical measures you think will be necessary to return him (or her) to work, and describe your medical reasons for your statements and the amount of time each step will take." Send the physician Form OWCP-5.

c. Further Medical Opinion. If a second opinion or referee examination (see PM Chapter 2-810) is arranged during the RN's or RS/RC's work with the claimant, the CE should so advise the RN or RS. Also, the CE should immediately advise the RS of any change in the weight of medical evidence as it affects work limitations.

The CE should continue to ask about the nature and extent of injury-related disability and request a treatment plan, either from the attending physician or a second opinion specialist, until one is obtained. Formulation of direct, incisive medical questions is crucial to this effort (see MEDGUIDE for guidance in composing such questions).

e. Other Medical Developments. From medical reports, the RN, RS, or RC, the CE may learn of other medical factors affecting the claimant's recovery. These include pregnancy; prescription of a course of physical therapy or medical rehabilitation; the emergence of a non-work-related condition; or the need for surgery (work-related or not).

If the situation will materially affect the time needed to recover from the work-related injury, the CE may advise the RN or RS to modify the intervention or interrupt efforts until the projected recovery date, if less than six months away. (Interrupted status, rather than an extension, is appropriate since the claimant would require little or no active involvement by the FN during this time.)

f. Transfer of Care. If the attending physician is repeatedly unresponsive to requests from the Office for a treatment plan, the CE may consider transfer of care to another physician (see PM Chapter 2-810 or 3-300).

g. Recurrences. If the employee claims a recurrence of total disability or a relapse which returns him or her to light duty status or fewer hours of work per day, the CE will need to follow the procedures outlined in PM Chapter 2-1500. The CE will need to decide whether the RN or RS should continue to work with the claimant. 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. If nurse or rehabilitation services are under way:

(1) The RN or RS must refer the case to the CE for a decision on the recurrence before services are interrupted or terminated.

(2) The RS may wish to refer the case, through the CE, to an OWCP RN for assessment of the claimant's medical situation. The CE may authorize such a referral.

h. Work Limitations. The CE may ask the RN to obtain a description of work limitations from the attending physician, or the CE may request them directly from the attending physician or a second opinion specialist. Ordinarily, Form OWCP-5 should be used for this purpose. A description of these limitations should appear in file before any referral for vocational rehabilitation services is made.

2-0600-7 Referrals for Vocational Rehabilitation Services

7. Referrals for Vocational Rehabilitation Services. This paragraph addresses the criteria and procedures for referring cases for vocational rehabilitation services. Further information about vocational rehabilitation may be found in FECA PM Chapter 2-0813 and OWCP PM Part 3.

a Criteria for Referral. If the claimant has stable, well-defined work limitations which allow him or her to work eight hours per day, the case should be referred for rehabilitation services. (A limited referral may be made for placement services with the previous employer when the claimant can work at least four hours per day and the

previous employer may be able to offer a modified job. The CE should note on Form OWCP-14 that the referral is limited to placement with the previous employer.)

(1) The RN may recommend such referral at the end of RN services, and such a referral may be desirable if the claimant has declined nursing services or has not cooperated with the RN.

Also, the RS may identify a case for referral based on an ADP report and so notify the CE on Form OWCP-3. The CE should concur unless there is a reason based on the medical evidence for not doing so.

(2) For claimants who cannot work eight hours per day, the CE must attempt to establish the claimant's ability to work a full day by one or more of the following: referral for an Occupational Rehabilitation Program (ORP), monitoring the attending physician's reports until the physician can release the claimant to work an eight-hour day, or second opinion evaluation.

(3) An ORP is also appropriate when the specific work limitations are unknown. The CE may refer the claimant to the RS for an ORP when:

(a) Intervention by the FN has ended but the claimant has moderate to severe physical limitations or deconditioning, or has not had an assessment of physical limitations, and has not returned to work; or

(b) A health care provider has recommended rehabilitation or an ORP, unless the claimant has already returned to full-time regular duty.

(4) Only if the CE has taken these actions and documented them in a Memorandum to the File may he or she refer a claimant who can work less than eight hours per day for other vocational services.

(5) Cases in which rehabilitation services were previously terminated for reasons which are either unclear or no longer pertinent may be referred as long as the claimant is able to work eight hours, or the inability to do so is properly documented.

b. Making the Referral. The CE refers cases for vocational rehabilitation services using Form OWCP-14, which should state:

(1) The name of the attending physician;

(2) The opinion and date of opinion which represents the weight of medical evidence, if the file contains varying descriptions of work limitations;

(3) The date on which wage loss or recurrence of wage- loss disability began, to identify the one-year time frame for placement with the previous employer;

(4) Any medical or adjudicatory action (e.g., second opinion examination or referral for investigation) which is in process or imminent;

(5) Whether or not the CE authorizes the RS or RC to contact the attending physician directly. The CE may authorize such contact when it will not potentially disturb the weight of medical evidence concerning work limitations. However, the CE should not authorize such contact when work tolerance limitations have been established by a second opinion or referee examination;

(6) Where the claimant is employed at less than full capacity based on work limitations, the CE's assessment of the situation and the desired action from the RC.

(7) The gross amount of compensation the claimant is awarded each four weeks and the pay rate on which this amount is based.

c. Other Actions.

(1) If varying descriptions of work limitations appear in file, the CE may wish to ask the physicians who submitted them to comment on each other's descriptions.

(2) When the referral is made, the CE should advise the claimant by letter which opinion represents the weight of medical evidence, and why.

(3) The CE should note the date of referral to the RS in the CMF.

(4) The CE may need to provide new information to the RS after the referral is made. Specifically, the CE should inform the RS when:

(a) Changes in work limitations, weight of the medical evidence, entitlement to benefits, and/or accepted condition have occurred, or that a second opinion or referee examination is scheduled; or

(b) The RS and RC should no longer communicate directly with the attending physician to resolve nuances in work limitations.

Form OWCP-14 may be used for this purpose. The CE may send a copy of the pertinent letter, pre-termination notice, formal decision, etc. to the RS for use by the RS and the RC.

(5) The CE must act within five days on any issues identified on a Rehabilitation Action Report, as follows:

(a) The claimant fails to cooperate with rehabilitation efforts;

(b) The medical situation appears to have changed significantly;

(c) A job offer is made, refused, or accepted; or

(d) The previous employer is not cooperating in a re-employment effort.

2-0600-8 Return to Work with Previous Employer

8. Return to Work with Previous Employer. This paragraph addresses actions needed to return the claimant to work with his or her Federal employing agency.

a Placement Services. After screening and initial interview (see PM Chapter 2-0813 and OWCP PM 3-0300), most candidates for vocational rehabilitation, except those who were employed by now-defunct agencies, will receive services leading toward placement with the previous employer (PPE) even when nursing intervention has occurred.

(1) RS Actions. If the claimant agrees to vocational rehabilitation services, the RS will, within five days of receiving the referral:

(a) Refer the claimant to an RC to address PPE, ensuring that the RC understands the need to reach a decision concerning employability within one year after wage loss begins;

(b) Contact the previous employer to discuss prospects for re-employment; and

(c) Advise the CE that the case has been opened via copy of Form OWCP-35.

Where the claimant does not accept vocational rehabilitation services, the RS should so advise the CE, who will need to apply sanctions as described in PM Chapter 2-0813.

(2) RC Actions. The RC maintains regular contact with the claimant and the previous employer to elicit job offers compatible with the work limitations identified by the CE. As necessary, the RC also arranges for vocational testing and vocational evaluation.

In district offices which use conferencing in the rehabilitation process, the RC will be asked to contact the district office after the first visit with the claimant so that all pertinent parties can discuss the rehabilitation effort.

(3) Time Frames. The RS will approve PPE for up to 90 days, with a 30-day extension where necessary if the previous employer is making active good faith efforts to place the claimant.

(a) If the employer has shown no interest by the 30th day of PPE efforts, vocational testing and planning will begin while the RC continues contact with the employer.

(b) If no job offer is developed by the 85th day, the RC will make a final personal contact with the previous employer to assess its interest in extending a job offer. If none is forthcoming, the RC will so notify the RS by telephone.

(4) Interruptions. PPE may be interrupted or extended beyond 120 days only when surgery, the need for medical treatment, or a change in work limitations warrants. Either the CE or the RS may identify such situations. If the RS advises the CE that a delay or extension of PPE seems appropriate, the CE should promptly notify the RS whether he or she agrees with this assessment. The CE must also notify the RS when PPE efforts should resume.

b. Outcomes. The RC will follow the claimant for at least 60 days after placement and submit a final report. The RS will advise the CE by OWCP-3 of the outcome of PPE efforts:

(1) If PPE is successful, the CE should prepare a formal LWEC decision, even if the LWEC is 0%. If the job does not reflect the claimant's maximum capacity in terms of duties performed and hours worked, the CE must continue to monitor the case (see paragraph 12c below).

(2) If PPE is unsuccessful, the CE and RS or RC will need to take further actions, as described below.

c. Actions by RS and CE. If the claimant cannot work eight hours per day, the RS may interrupt services at this point until a full-time schedule is feasible. However, the RS and RC may not wish to disturb the momentum of a claimant who is actively involved in vocational rehabilitation services. In this instance, the RS and RC may proceed with vocational planning.

However, the CE may also need to obtain additional medical opinion, arrange for an occupational rehabilitation program, or take whatever other action is indicated to increase the claimant's level of readiness to seek work with a new employer. At this stage of the re-employment effort, it is not appropriate to refer the case back to an RN for additional action. The RS and RC should supervise any occupational rehabilitation program or similar effort.

2-0600-9 Ten-Month Letter

9. Ten-Month Letter. This paragraph addresses release of the 10-month letter to the claimant. The claimant's entitlement to the job held at date of injury, or its equivalent, continues for one year after wage loss began if disability is overcome within that time.

a. Contents of Letter. At least 30 days before the end of that period, or at the end of placement previous employer (PPE) status, whichever is sooner, the CE must advise the claimant in writing that:

(1) Despite the OWCP's best efforts, the previous employer has not identified a job meeting the claimant's work limitations, and contacts with the previous employer do not indicate that any such offer will be forthcoming.

(2) Only a total recovery (that is, the ability to return to regular work) within one year of the date that wage loss began will maintain the claimant's right to reclaim his or her date of injury job, or equivalent, under section 5 U.S.C. 8151. A claimant who has totally overcome his or her disability more than one year after the beginning of wage loss is, however, entitled to priority consideration for placement in the date of injury job or equivalent.

(3) Absent such a recovery, the OWCP will begin Plan Development. This stage will prepare the claimant for other work, possibly with another government agency, but probably with a private employer. This process will likely require training or development of skills.

(4) The OWCP will make every effort to identify the claimant's vocational strengths and aptitudes, prepare him or her for re-employment in a specified job, and aid in placement. The claimant's full cooperation is expected in returning to work, whether with another government agency or in the private sector. The OWCP will continue to monitor the claimant's medical status during this process.

(5) The new employment will likely involve some loss of pay. Whether or not the claimant is actually re-employed, the OWCP will determine his or her loss of wage-earning capacity and reduce compensation accordingly.

A sample letter is shown as Exhibit 1.

b. Actions Resulting from Letter. This letter will allow the claimant time to contact the previous employer and/or the attending physician, if there is any possibility of return to the job held on date of injury. On the other hand, where the medical limitations and/or the employment prospects with the previous employer render placement there extremely unlikely, the CE may need to clarify the medical situation to the claimant, or arrange for the RS to clarify the employment situation.

2-0600-10 Plan Development

10. Plan Development. The purpose of this paragraph is to describe the plan development (PD) phase of vocational rehabilitation services. PD is usually required to determine what services are best to re-employ the claimant. It includes testing, assessment of the labor market, and counseling to ascertain the claimant's interests and abilities. The plan will generally be aimed toward placement with a new employer, training, or placement with short-term assisted reemployment.

a. RS Actions. After the plan is submitted to the RS, he or she does the following:

(1) Reviews the vocational goals and identifies two jobs by DOT titles, provides time frames for successful completion, and states in general terms the expected wage-earning capacity resulting from the training plan (an LWEC calculation need not be performed at this point).

(2) If the plan involves placement with a new employer, specifies the anticipated placement outcome, the jobs determined to be suitable and available to the claimant, the length of the placement plan, and the expected wage-earning capacity following job placement. In most cases the RS will authorize the RC to offer employers a six-month (short term) Assisted Reemployment subsidy.

b. Time Frames. A plan should be produced within 90 days from the point testing begins. This period may be extended up to 60 days for medical reasons, or because the claimant is having trouble accepting a program leading to a new occupation. If the latter occurs, the RS will personally intervene with the claimant before the 90th day to discuss the need to agree on a plan.

The RS will advise the CE when an extension in PD is proper. The RS and CE will discuss any extension in PD which will affect notification of the claimant within one year. The CE should advise the RS when PD activity should resume (e.g., if suspended for medical reasons).

c. CE Actions. The RS will advise the CE once a viable plan is received.

(1) The CE must ensure that the medical requirements of the job are consistent with the weight of medical evidence and must be prepared to explain its suitability to the claimant (see paragraph c(2) below).

(a) If the CE has any questions, he or she should contact the RS. For instance, the CE may ask why a plan which seems very expensive or lengthy was chosen over other available alternatives, and discuss these alternatives with the RS. However, it is not the CE's role to assess the vocational aspect of the plan.

(b) The CE should address such issues to the RS within one week of receiving the plan. After that time, absent any questions, the RS will advise the RC to proceed.

(2) The RC may discuss the motivation of the claimant to undertake a training program. If the earnings of the job for which the claimant is being retrained will greatly increase his or her WEC, but the claimant is reluctant to undertake the program, the CE will need to remind him or her of the need to cooperate with vocational rehabilitation efforts.

(3) After reviewing the plan, the CE will advise the claimant that:

(a) Based on a thorough vocational evaluation and a survey of the local labor market, he or she has a wage-earning capacity of a specific dollar amount (as stated by the RC) which will determine future compensation entitlement;

(b) He or she is expected to return to work in a job similar to the one identified, and that only partial compensation based on the above-stated wage-earning capacity will be paid at the end of this effort;

(c) After any training or other preparation is completed, OWCP will provide 90 days of placement services using an Individual Placement Plan.

An example of this letter is shown as Exhibit 2.

(4) This letter should not be used as a pre-termination notice, since its intent is to encourage return to work. The letter should, however, state that the law provides sanctions for lack of cooperation with vocational rehabilitation efforts, without citing specific sanctions.

d. Pre-Training Activities. If the claimant needs remedial services (usually school-based academic training) to prepare for actual training, the RS will inform the CE of their nature and length and will identify the training goal. If remedial services are unsuccessful, the RS will so advise the CE and note the reasons. The RS will then attempt placement with a new employer based on an occupation for which retraining is unnecessary. In some cases the RC may recommend longer-term assisted reemployment or an ORP.

2-0600-11 Return to Work with New Employer

11. Return to Work with New Employer. This paragraph addresses actions needed to place the claimant with a new employer, or to reach a decision that the claimant is employable if PPE is not successful.

a. Placement with New Employer (PNE). When any training is completed, or when assisted reemployment is being arranged, the RS will approve PNE, which may include short term assisted reemployment services. PNE will normally take up to 90 days, but the RS may authorize extensions up to 90 more days if the claimant is making a good effort to obtain a job and if short-term assisted reemployment is authorized. The CE must remind the claimant in writing that placement services will be offered for a maximum of 90 days (see Exhibit 3). However, since actual reemployment is preferred to a constructed rating, extensions may be granted when the claimant is cooperating with the job search.

b. Outcomes. The RS will advise the CE of the outcome of PNE efforts:

(1) If PNE is successful, the RC will follow the claimant for at least 60 days, then submit a final report. At this time the CE should prepare a formal LWEC decision, even if the LWEC is 0%. If the job does not reflect the claimant's maximum capacity in terms of duties performed and hours worked, the CE must continue to monitor the case (see paragraph 12c below).

(2) If PNE is unsuccessful, the RS or RC will specify if the job titles and expected wages identified in plan development are still viable and state whether jobs are still reasonably available in the claimant's commuting area, so that the CE can consider an LWEC decision.

c. Other Issues.

(1) If the claimant obstructs or does not cooperate with vocational rehabilitation efforts at any stage, the RC will promptly so advise both the RS and the CE using a Rehabilitation Action Report.

After talking with the RS, the CE will advise the claimant of the consequences of non-cooperation with rehabilitation efforts, as outlined in PM Chapter 2-0813. Should the claimant later cooperate with rehabilitation efforts, the process should resume at the point where it was suspended.

Cases in the PNE/Assisted Reemployment stage are handled slightly differently, however. The claimant should be rated in the job for which he or she was trained at the end of the 90-day period, with no sanctions applied.

(2) Suspension of rehabilitation efforts for medical reasons, or any further extensions beyond the time frames stated above for plan development and placement, will require the CE's concurrence. The RS or RC should provide rationale for any such request, and after review by the RS, the CE should act promptly on it.

(3) If the severity of the injury and/or the job market in the claimant's commuting area prevents development of a vocational rehabilitation plan, the RS will specify the reasons so that the CE can decide whether the case should be placed in PN status. The RS should not close the rehabilitation file without evidence of jobs suitable to the claimant's medical limitations, or without the CE's concurrence that medical limitations make re-employment infeasible.

(4) A claimant who initially returns to work may later cease work before a formal LWEC decision is issued. If this occurs, the CE should decide, preferably together with the RS, whether to apply sanctions, resume the RC's efforts, or provide the services of an OWCP RN.

(5) Nurse and vocational rehabilitation services will not routinely be used at the same time, as noted in paragraph 5e(5) above. Sometimes, however, such dual action will be desirable, as for instance when the claimant undergoes surgery or sustains a consequential injury during the rehabilitation effort, or the claimant leaves a job after an apparently successful placement but before an LWEC decision is issued.

(a) Where the RS requests RN intervention, he or she will prepare OWCP-3 for the CE and RN.

(b) Where the CE believes that both RN and RS should intervene, he or she will so advise the RN via Form OWCP-57 and the RS via Form OWCP-14.

[For a fuller discussion, see FECA PM Chapter 3-201 (for nurse services) and OWCP PM Chapter 3-201 (for rehabilitation services).]

2-0600-12 Case Resolution

12. Case Resolution. This paragraph discusses how cases are usually resolved.

a. Termination with No Continuing Injury-Related Disability. Pre-termination notices and formal decisions are discussed in PM Chapter 2-1400. Where nurse or rehabilitation services are under way and the CE determines that injury-related disability has ceased, it is proper to issue a pre-termination notice. As the claimant's response may overcome the initial determination to terminate compensation, the OWCP will continue nurse and/or rehabilitation services during the notice period until a formal decision is issued.

b. Re-employment with No Loss of Wages. Unless the claimant has returned to the job held at time of injury, the CE must prepare a formal decision which includes a finding that the claimant's earnings fairly and reasonably represent his or her wage-earning capacity, even if the claimant has a 0% LWEC (see PM Chapter 2-0813).

c. Re-employment with LWEC. The CE should prepare a formal decision addressing whether the earnings fairly and reasonably represent the claimant's wage-earning capacity, even if the position represents modified duty with the previous employer.

(1) The CE should continue to monitor cases with LWEC decisions to assess whether injury-related disability continues and whether the claimant's work limitations have changed.

(2) Claimants who remain on light duty may claim recurrences of disability if the light duty is withdrawn. The CE should monitor the medical status of such claimants and set up compensation payments based on actual earnings until the claimants have reached their maximum wage-earning capacity. Claimants should not be rated in light duty positions unless the medical evidence clearly establishes that they cannot return to full duty.

(3) Employing agencies may be asked to perform fitness for duty examinations when they believe a claimant in a light duty position may be able to return to the date of injury job or to another regular position.

d. Finding of Employability. Even after provision of nurse and rehabilitation services, the claimant may not obtain employment during the 90-day placement period. In this event, the CE will prepare a pre-termination or pre-reduction notice addressing the claimant's loss of wage-earning capacity based on a suitable position for which the claimant received training and/or placement efforts.

e. Assignment of PN Status. If no rehabilitation plan can be developed due to the severity of the claimant's medical condition and/or the job market in the claimant's commuting area, assignment of status code PN may be appropriate. The CE will need to monitor these cases to determine if injury-related disability continues (see PM Chapter 2-0812).

2-0600 Exhibit 1: Sample Letter to be Sent to Claimant at 10 Months After Disability

Dear CLAIMANT NAME:

This is to advise you of the effect of your work-related injury on your employment status.

To date, your employing agency has not identified a job which meets your work limitations. The Registered Nurse [or Rehabilitation Counselor] who has been working with you on behalf of this Office has advised us that your agency does not appear likely to make you a job offer in the near future.

Under Section 5 U.S.C. 8151 of the Federal Employees' Compensation Act, only a total recovery (that is, the ability to return to regular work) within one year of the date that wage loss began will protect your right to reclaim the job you held at the time of injury, or an equivalent job. Without such a recovery, the Office of Workers' Compensation Programs (OWCP) will begin the next stage of the rehabilitation effort. This stage, called Plan Development, will prepare you for other employment. This work may be with another Federal agency, but it will probably be with a private employer. This process may require that you be retrained, or that skills you already have be further developed.

OWCP will make every effort to identify your vocational strengths and aptitudes, prepare you for employment in a specified job, and aid in placement. Your full cooperation is expected in returning to work, whether with another Federal agency or in the private sector. OWCP will continue to monitor your medical status throughout this process.

The new employment may involve some loss of pay. At the end of the placement services, OWCP will determine any loss of wage-earning capacity and reduce your compensation payments accordingly. In all likelihood, this reduction in

benefits will occur whether or not you are actually reemployed.
If you have any questions, please do not hesitate to contact me.

Sincerely,

CLAIMS EXAMINER

2-0600 Exhibit 2: Example of Letter to be Sent to Claimant When Vocational Rehabilitation Plan Is Approved

Dear CLAIMANT NAME:

I am writing in reference to the plan developed by you and your Rehabilitation Counselor for your return to work as a TITLE OF OCCUPATION.

We have reviewed this plan with respect to the medical reports in your file, and we have determined that the job duties are within your work limitations. DETAIL ANY MEDICAL INFORMATION REQUIRED BY THE CASE, ESPECIALLY IF THE WEIGHT OF EVIDENCE IS WITH A PHYSICIAN OTHER THAN THE ATTENDING.

Therefore, you are expected to cooperate fully so that you may return to work in the specified job, or one similar to it. After any necessary training or other preparation is completed, OWCP will provide 90 days of placement services so that you may reach this goal.

Based on a vocational evaluation and a survey of the local labor market, it appears that you have (or will have) a wage-earning capacity of $99,999 per year. At the end of the rehabilitation program, whether you are actually employed or not, the Office of Workers' Compensation Programs (OWCP) will in all likelihood reduce your compensation based on this amount.

OWCP will continue to help you return to work. You should note, however, that the Federal Employees' Compensation Act provides penalties for claimants who do not cooperate with vocational rehabilitation efforts.

If you have any questions, please do not hesitate to contact me.

Sincerely,

CLAIMS EXAMINER

2-0600 Exhibit 3: Example of Letter to be Sent to Claimant at Beginning of Placement New Employer Phase

Dear CLAIMANT NAME:

Your Rehabilitation Counselor has advised me that you have begun to look for

employment as a TITLE OF OCCUPATION.

As noted in our letters dated DATES OF TEN-MONTH AND DESCRIPTION OF VOCATIONAL REHABILITATION PLAN LETTERS, you will receive 90 days of assistance from the Office of Workers' Compensation Programs to help you meet this goal. At the end of the 90-day period, your compensation will be reduced based on the wage-earning capacity of $99,999 per year. Therefore, it is very important that you cooperate with your Rehabilitation Counselor in this effort.

If you have any questions, please do not hesitate to contact me.

Sincerely,

CLAIMS EXAMINER

2-0600 Exhibit 4: _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:___________________________

2-0600 Exhibit 5: Planning Chart for QCM Cases (Link to Image)

2-0601 Disability Tracking and QCM Tracking Systems

Paragraph	Subject	Date	Trans. No.
	Table of Contents	01/98	98-04
1	Purpose and Scope	01/98	98-04
2	Measurement of Performance	01/98	98-04
3	Disability Tracking System	01/98	98-04
4	QCM Tracking System	01/98	98-04
5	QCM Codes	01/98	98-04
6	Effect of RTW on QCM Status	01/98	98-04
7	Consistency in Coding	01/98	98-04
8	QCM Resolution	01/98	98-04

Exhibits

1 Disability Tracking and QCM

	Category Codes	01/98	98-04
2	Optional QCM Codes	01/98	98-04

2-0601-1 Purpose and Scope

1. Purpose and Scope. This chapter describes the Disability Tracking and QCM (Quality Case Management) Tracking Systems, through which periods of disability and QCM interventions are monitored. It also addresses codes and data entry for both of these systems and describes various edits and relationships between them. It does not, however, address reports produced from these systems. Procedures for QCM cases are found in FECA PM 2-0600, and other codes are discussed in FECA PM 2-0401.

2-0601-2 Measurement of Performance

2. Measurement of Performance. These two systems support OWCP's efforts to help injured workers return to full duty in their date-of-injury jobs wherever possible, and they assist employing agencies in reducing their light duty rolls. To measure performance, OWCP tracks all QCM cases for two years from the date the claimant stops work and enters a non-pay status (the date wage loss began). Performance reports are produced quarterly for each district office, with the emphasis on the percentage of QCM cases resolved successfully at the one and two year marks. For this reason, it is important that QCM coding be accurate and current.

2-0601-3 Disability Tracking System

3. Disability Tracking System. Case Management menu item 36 (Disability Tracking) in the Sequent system is used to create records for each period of disability, including those which occur during the COP period, and each new recurrence.

a. Disability Tracking Screen. The system creates an initial disability record (Disab# "00") whenever a TPCUP record is changed to a status of A1, A2, I1, I2, X1, or X2, and no "00" disability record already exists for that case. The system assigns a status of A (Accepted). The Claims Examiner (CE) can also create an initial disability record manually by selecting F1 (ADD STAT).

(1) Disability Number and Date. Each new record must be assigned a disability number (Disab#) from 00 to 99 and a disability beginning date (Disab Date). Disab# 00 is for the initial period of disability, while other numbers represent recurrences.

(2) Status Codes. For manually added records, the claim status (Status)

defaults to U (Undecided), and both the disability claim received date (Recv Date) and status date (Date) default to the current date. Status codes A (Accepted) and D (Denied) should be entered along with the new status date when a decision on the disability claim has been made. Status codes X (Error Record) and N (New Injury) should be entered where appropriate. If a QCM record is associated with the disability record, the QCM record must first be changed to category 0 (NOT A QCM CASE) before any update to the disability record is permitted.

For any record with a QCM record that has been "zeroed out", the CE may not change the status from A to another value without deleting the associated QCM record. A prompt "Status change will cause deletion of the associated QCM record. Proceed? Y/N" will be displayed, and N may be pressed to abort the change.

(3) Return-to-Work Codes. A pop-up window shows the return-to-work (RTW) codes, which are also listed in Exhibit 1. The CE should enter a code for the associated disability record whenever the claimant's work status changes, regardless of the status of the particular claim for wage loss.

(a) For non-QCM cases, RTW status codes must always be added directly.

(b) Once a case "drops in" to QCM, RTW codes cannot be entered in the Disability Tracking System. Instead, certain QCM status codes which reflect the claimant's work status automatically update the RTW code.

To avoid creating a QCM record in error, the RTW code should be entered as soon as possible after an initial wage-loss claim is approved in the TPCUP program or a recurrence claim is accepted. For example, when an initial wage-loss claim for a closed period is approved in TPCUP ("first and final payment"), the CE should update the "00" disability record resulting from the TPCUP action by entering a RTW code of FF. This will prevent the creation of an associated QCM record which would then have to be "zeroed out".

(4) Deletion of Records. Disability records may be removed using F5 (DELETE). If the record to be deleted includes a RTW code, the first deletion will remove only the RTW data and F5 (DELETE) must be selected again to remove the rest of the disability record.

b. Claims for Recurrence. The CE should review Form CA-2a in conjunction with the case record and any existing data in the Disability Tracking System. If the Form CA-2a in fact represents a recurrence of disability, and not a new injury or a duplicate recurrence claim, the CE should add a disability record to the Disability Tracking System. These steps also apply to any claim for a new recurrence submitted during the COP period, or received on Form CA-8 instead of Form CA-2a.

If necessary, the CE should also update any previous disability record(s) with the appropriate return to work code(s). After making a decision on the current claim, the CE should update the status code in the disability record. A new QCM record will be created for each disability record (again, including those during the COP period) with a status of A and a RTW code other than FF, NL or XX.

The screen includes a column that shows whether a particular recurrence record is associated with a QCM record. Also, each record in QCM shows the Track Date, which generally corresponds to the "Disab Date" from the recurrence record (see paragraph 4 below).

c. Leave Buy-Back Claims. Claims for leave repurchase should be entered into the Disability Tracking System unless they involve only intermittent periods of wage loss without ongoing disability. When a claim for leave buy-back is received after a new injury, the CE should manually enter a "00" disability record into the Disability Tracking System with an appropriate RTW code at the same time the claim is entered into the TPCUP program.

d. Wage Loss When No Claim Filed. If no claim for wage loss is filed (e.g., the return to light duty occurs during the COP period), the CE should enter a "00" disability record with the appropriate RTW code. The date of return to light duty should appear as both the disability date and the RTW date.

2-0601-4 QCM Tracking System

4. QCM Tracking System. Case Management menu item 35 (Quality Case Management) in the Sequent system is used to update the QCM status and add all other information for cases handled under QCM procedures.

If a case has a Disability Tracking record with a status code of A and a RTW code other than FF,

NL or XX, the system will create a QCM record and the QCM flag will be set to Y in the case management file (CMF). The QCM flag will remain Y as long as an active QCM record is associated with the case.

a. QCM Screen. When the QCM screen is displayed, the QCM record associated with the most recent accepted period of disability will appear. If more than one accepted period of disability exists, the CE may select an earlier period.

Below the standard header, the QCM screen is divided into the QCM header and STATUS areas. The F9 key allows the CE to toggle between these areas. Prompts appear at the bottom of the screen as the cursor is moved among data fields.

(1) QCM Header. The disability number, initial category, and date appear based on entries into the Disability Tracking System. The other QCM header fields are as follows:

(a) Track Dt/QCM Start Date. The Track Date usually reflects the "Disab Date" in the Disability Tracking record associated with the case. However, where the claimant returns to light duty before creation of the QCM record, the Track Date is the same as the QCM Start Date.

QCM performance is based on the Track Date. Therefore, where the claimant is already working in a light-duty job when the case "drops in" to QCM, the time needed to resolve the case will be measured from the date the case comes under QCM, not the date the claimant stopped work.

(b) QCM CE. This code reflects the responsible CE (RCE) associated with each QCM record. The initial entry for this field will come from the CMF when a QCM record is created. Unless changed manually, this code will remain on the QCM record even if the RCE code is later changed in the CMF. Likewise, entry of a different QCM CE code will not affect the RCE code in the CMF. This field may not be changed on closed QCM cases.

(c) Category Code. No entry of the category code is allowed except to "zero out" a QCM record. Also, no data entry is allowed on category 0 records except to enter a comment if desired. The entry of certain status codes will automatically change the category code, if necessary.

Those status codes with no category code listed may be added as the current status only if the record is already in category A or B, or if the most recent existing status is CSA or CPN. (In the latter case the category will be updated without regard to the existing CSA or CPN status code.)

For status codes with no associated RTW code listed, no updating of the Disability Tracking system will occur. Also, if a status code associated with a RTW code is later deleted, the corresponding RTW code in the Disability Tracking system will also be deleted.

(d) Field Nurse Last Name. Up to 20 characters may be typed in this field.

(e) Tax ID. The field nurse's 9-digit tax identification number should be noted here.

(f) Agency Name/Site. This field contains the first line of the employing agency's address as entered in the CMF. However, the CE may overwrite or add to the existing data.

(g) Light Duty. This field allows the CE to record whether or not the employing agency has light duty available (Y or N).

(h) Text. The CE may enter two lines of notes about the case.

If any changes have been made, the prompt "OK? (Y/N)" will appear. Typing N will move the cursor back to the QCM CE field so that changes may be made. Typing Y will save the new QCM header data and move the cursor down to the STATUS area.

(2) QCM Status Area. This area shows any existing QCM status codes, along with their narrative descriptions and effective dates. Mandatory QCM status codes are described in paragraph 5, and optional status codes are shown in Exhibit 2.

(a) Display of Codes. The mandatory status codes are listed in the pop-up window (ADD STATUS) under four activity headings. Any active optional codes appear under a fifth heading. The Page Up/Page Down keys are used to move quickly between the code groups while the Up/Down arrow keys are used to scroll through the entire list of codes.

(b) Entry of Codes. The CE may add a status code from the pop-up window by moving the cursor to highlight the desired code and pressing <Enter>. The status date defaults to the current date, which may be modified if needed to show the effective date of the indicated action.

(c) Confirmation of Data. After entering a date, the prompt "Confirm Status Update? (Y/N)" will appear. Entering Y will save the new QCM status data, while entering N will move the cursor back to the date field of the selected status. However, the CE may exit the update mode without saving changes by pressing the ESCape key twice again.

(d) Deletion of Data. The CE may delete a status code by highlighting the desired record and pressing F5 (DELETE). The prompt "Confirm Status

Delete? (Y/N)" will then appear. Any or all QCM status codes may be removed in this way.

(e) Modification of Data. To modify a QCM status record (e.g., to correct the effective date), the CE must first delete the record and then enter a new status code by pressing F1 (ADD STAT).

(f) Effect of Status Codes on Category Codes. Addition or deletion of a QCM status code will automatically update the category code, if a change is indicated.

(g) Effect of Status Codes on RTW Codes. The entry of a status code will update the RTW status in the Disability Tracking system.

(h) Prohibited Entries. The system prevents entry of a closed status code (CFF, CNL, CCO, CSA, CAE, CLW, CRN, or CPN) where no prior intervention code exists. The message "Status Not Valid Without Prior Intervention Code" is displayed.
(A similar edit prevents deletion of the only remaining intervention code if a closed code exists.)

b. Multiple Records. Only one open QCM record should exist for a case. If multiple records exist, either the new QCM record was created in error and should be changed to category 0, or the old QCM record should be changed to category 0 or updated with an appropriate status code.

For example, if a QCM record is added to reflect a newly accepted recurrence in a case with an existing QCM record, but no QCM intervention actually occurred, the existing QCM record should be changed to category 0. However, if QCM procedures had been used in connection with the prior disability, the CE should update the QCM status in the existing record with the "resolved" code reflecting the actual events in the case.

2-0601-5 QCM Codes

5. QCM Codes. While certain QCM status codes are mandatory, each district office may designate individual optional codes, which are listed in Exhibit 2, as "active" or "inactive" within that office. The mandatory codes are defined below; the nine codes with an asterisk (*) are the intervention codes.

a. CE Activity Status Codes.

(1) OIC*--Other Intervention by CE. Used when the CE or Senior CE

contacts the claimant, agency or physician to discuss a RTW date and the availability of limited duty. It may be used when any of the following occur:

(a) Discussion by telephone with the claimant about the anticipated RTW date (regular or light duty); current work limitations and why they preclude any work at all, or preclude return to the regular job; and whether the employer has been contacted about the availability of light duty. The conversation should be substantive and should serve to remind the claimant of his or her responsibility to return to work.

(b) Telephone or written contact with the employer to discuss work limitations or the availability of light duty, or to solicit a job offer. The description of work limitations should be available on the date of the conversation or letter.

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

If the use of OIC is based upon a telephone call, the CE must fully document the conversation and note OIC on the corner of the Form CA-110, letter or other document for easy identification. This code may be used more than once on a given QCM record, but it may not be used when the conversation concerns bill payment, compensation payments or other case issues.

(2) QAP*--Questions to Attending Physician. Used when the CE poses written questions to the attending physician about the extent and duration of disability. It may not be used when simply requesting a current report from the attending physician.

(3) CON*--Conference Held.

(4) MSI*--SECOP Initiated. The effective date of the status is defined as the date of the examination (a date in the future is allowed).

(5) MRI*--Referee Exam Initiated. The effective date of the status is defined as the date of the examination (a date in the future is allowed).

b. Nurse/Rehabilitation Activity Status Codes.

(1) NFN*--Referred to Field Nurse.

(2) NIN--Nurse Interrupt. Used where the services of the nurse are suspended but are expected to resume. For example, this code may be used where the claimant undergoes surgery that will require a period of recovery during which nurse services are inappropriate.

(3) RRC*--Referred to Rehabilitation Counselor.

(4) RCL--Rehab Case Closed - No RTW. Used in cases closed by the Rehabilitation Specialist without a RTW.

(5) RLT*--Eventual Reduction via Rehabilitation (Letter Sent by CE).

(6) RTR*--In Approved OWCP Vocational Training.

c. Work Status Codes.

(1) PLP--Pre-QCM RTW Light Duty/Part Time. Used when claimant returns to part-time work before the case "drops in" to QCM.

(2) PLF--Pre-QCM RTW Light Duty/Full Time.

(3) NLP--RTW via Nurse; Light Duty/Part Time. Used when the claimant returns to part-time work via nurse services. (It may also be used in cases that already have a PLP code, but only if the work hours actually increase due to intervention by the nurse.)

(4) NLF--RTW via Nurse; Light Duty/Full Time.

(5) RLP--RTW via Rehab; Light Duty/Part Time. Used when the claimant returns to part-time work via rehabilitation services. (It may also be used in cases that already have a PLP code, but only if the work hours actually increase due to intervention by the rehabilitation counselor.)

(6) RLF--RTW via Rehab; Light Duty/Full Time.

(7) MLP--RTW via CE; Light Duty/Part Time. Used when the claimant returns to part-time work by CE intervention rather than nurse or rehabilitation services. The CE's intervention must be readily identifiable (see subparagraph a(1) above) to justify using this code. (It may also be entered in cases that already have a PLP code, but only if the work hours actually increase through the CE's intervention.)

(8) MLF--RTW via CE; Light Duty/Full Time. Used when the claimant returns to light duty work on a full-time basis by CE intervention rather than nurse or rehabilitation services. The CE's intervention must be readily identifiable (see subparagraph a(1) above) to justify using this code.

d. Closure Status Codes.

(1) CFF--Closed, RTW (Date-of-Injury or Pre-established LWEC (Loss of Wage-Earning Capacity) Job). Used in all cases where the claimant returns to full duty under QCM.

(2) CNL--Closed, RTW (Not Date-of-injury Job; 0% LWEC Decision).

(3) CCO--Closed, Formal Decision Establishes No Disability.

(4) CSA--Closed, Sanctions Imposed (or Compensation Not Claimed). In addition to designating a sanction decision, this code is also used where the claimant elects benefits from the Office of Personnel Management (for otherwise stops claiming compensation benefits. All cases in this group may be reopened at the claimant's option.

CSA is the only closure code representing successful resolution where the case may be reopened by later entering a status code into the QCM record. With this mechanism in place, QCM activity may continue to be tracked in cases where the sanctions are lifted or the claimant otherwise receives compensation benefits again.

(5) CAE--Closed, Actual Earnings LWEC.

(6) CLW--Closed, Constructed LWEC.

(7) CRN--Recurrence/New Injury Following Return to Light Duty. Used when the claimant sustains a recurrence or a new injury while QCM procedures are being applied.

Cases closed with this code will be considered resolved successfully only if an earlier RTW occurred due to QCM intervention (as shown by status codes NLP, NLF, RLP, RLF, MLP, or MLF). Where no such code exists, the prompt "OK to zero out this QCM record? Y/N" will appear. If the CE presses Y, the CRN code will be added and the case will be set to category 0. Otherwise, the entry will be aborted.

(8) CPN--Closed, Unable to Work (PN memo).

2-0601-6 Effect of RTW on QCM Status

6. Effect of RTW on QCM Status. Except as specified in subparagraph c below, QCM procedures apply to any accepted case where the claimant returns to light-duty work, until the claimant returns to the job held on the date of injury (DOI) or OWCP issues a formal decision regarding the claimant's entitlement.

a. No Claim Filed. Manual entry of a record into the Disability Tracking System will be necessary if no claim for wage loss or recurrence has been filed (e.g., the return to

work occurs during the COP period). A "00" disability record should be created with the appropriate RTW code.
The date of the claimant's return to light duty should be entered as both the disability date and the RTW date.

b. Coding. If the claimant returns to full-duty work or OWCP issues a formal decision about the claimant's wage-earning capacity before any QCM intervention occurs, the QCM record should be coded category 0. For cases where such interventions have occurred, QCM status codes are used as follows:

(1) In a new QCM case, if the associated Disability Tracking record already has a RTW code of LP or LF, the QCM record will be created with a status code of PLP or PLF and a category code of B.

(2) In an existing QCM case where the claimant returned to work in other than the DOI job before QCM intervention, the CE should enter a status code of PLP or PLF, with a status date corresponding to the date of the claimant's RTW. If the claimant's work status improves due to application of QCM procedures, the QCM code reflecting this change should be entered.

c. Certain Recurrence Cases. If a claimant working in a light-duty job suffers a recurrence and then returns to the same light-duty job, the following rules govern whether QCM procedures apply:

(1) If an LWEC decision had not been issued (e.g., the RTW was for less than 60 days), the CE should apply QCM procedures and track them under the new recurrence. Status code CRN should be used to close out an existing QCM record.

(2) If an LWEC decision had been issued, the CE need not apply QCM procedures, and the QCM record should be changed to category 0. (However, if the claimant returns to work in a light-duty capacity other than the LWEC job, the CE should apply QCM procedures.)

2-0601-7 Consistency in Coding

7. Consistency in Coding. Consistent coding is essential to proper measurement of QCM actions. One aspect of consistency is ensuring that cases which do not actually undergo QCM procedures are "zeroed out". For instance, a new QCM record is created whenever an accepted recurrence claim is entered into the Disability Tracking System without a RTW code. If the claimant had already returned to full duty before the claim was accepted or before QCM procedures were applied, the CE should change the QCM record to category 0, so that case will be excluded from the QCM count.

Consistency also requires use of the same standards to define the actions which should be considered "interventions" under QCM. To be counted, the action must meet a certain threshold in prompting or helping the claimant return to full-time work in the DOI job. The following examples are intended to clarify when an action meets that threshold. They are based on acceptance and payment of a claim filed on Form CA-7, and creation of a new QCM record:

a. Example 1: When the claim is approved, the CE makes an initial call to the claimant, who states that he plans to return to work in two weeks. The CE does not intervene and, in fact, the claimant returns to his DOI job full-time.

At the time of the initial call, the RTW code for the disability record associated with this claim should be changed to AN and the anticipated return to work date should be entered. When the claimant actually returns to work, the associated QCM record should be coded as category 0 and the RTW code should be changed to FF. No QCM status code need be entered.

(While the CE did in fact call the claimant, this level of activity is not sufficient to be regarded as a QCM intervention, and it will not be included in the QCM performance measures.)

b. Example 2: The claimant states that she doesn't know when she will return to work. The CE prepares a Statement of Accepted Facts and refers the file to the Staff Nurse, who prepares a Field Nurse (FN) referral package. However, the CE learns that the claimant returned to full-time full-duty work before the referral takes place.

Again, the QCM record should be coded as category 0 and the RTW code in the Disability Tracking System should be changed to FF.

c. Example 3: The claimant returns to work after the referral letter is sent to the FN (with a copy to the claimant) but before the FN contacts the claimant.

Here the QCM status should be changed to NFN (Referred to Field Nurse) and then to CFF (QCM Case Closed - Return to Work DOI Job). This case will be counted in the QCM performance measures as successfully resolved.

(The distinction between this and the previous example is the level of intervention. Here, the claimant's receipt of a copy of the letter to the FN prompted the return to work.)

2-0601-8 QCM Resolution

8. QCM Resolution. A case with status code NLF or RLF will be considered successfully resolved within one year of the Track Date. After one year cases will not count as successfully resolved unless the claimant has returned to full-time full-duty work (status CFF) or a decision has been issued (status CNL, CCO, CAE, CSA or CLW).

Code CRN (Recurrence/New Injury Following RTW Light Duty) should be used where the claimant suffers a recurrence after returning to light duty work. Entry of CRN will automatically change the category to C, and the case will be counted as resolved successfully.

2-0601 Exhibit 1: Disability Tracking and QCM Category Codes

DISABILITY TRACKING AND QCM CATEGORY CODES

Disability Tracking Return to Work Codes

__ - (Blank) No Return to Work
AN - Anticipated RTW Date
FF - Returned to Full Duty on a Full-Time Basis
LP - Returned to Light Duty on a Part-Time Basis
LF - Returned to Light Duty on a Full-Time Basis
NL - No Lost Time with this Recurrence
PS - Returned to Work - Private Sector
XX - Final Decision with no RTW

QCM Category Codes

0 = NOT A QCM CASE
A = ACTIVE QCM CASE
B = LIGHT DUTY TRACKING
C = QCM PROCEDURES COMPLETE

2-0601 Exhibit 2: Optional QCM Codes

OPTIONAL QCM CODES

STATUS	DESCRIPTION
DEL	Delayed Development
IAE	Interim Actual Earnings (No Formal LWEC)
NFE	Field Nurse Extension Granted
JOL	Suitable Job Offer Letter Issued
MIN	Medical Interruption of QCM Activity
MRC	Referee Exam Completed
MRF	Referee Exam Follow-up
MSC	Secop Exam Completed
MSF	Secop Exam Follow-up
NCE	Discussion of Case Between CE and Nurse
NCN	Nurse Case Closed - Claimant Not Cooperative
NCO	Nurse Case Closed - Claimant Cooperative
NRC	Referred to CAP Nurse
NSN	Referred to Staff Nurse
OPM	OPM Elected (Use CSA Code to Close Case)

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

2-0700 DEATH CLAIMS

Paragraph	Subject	Date	Trans. No.
	Table of Contents	**04/02**	**02-08**
1	**Purpose and Scope**	**08/94**	**94-32**
2	**Policy**	**08/94**	**94-32**
		04/02	**02-08**

3	**Authority**	**08/94**	**94-32**
4	**Responsibilities**	**08/94**	**94-32**
5	**Initial Processing**	**08/94**	**94-32**
		09/95	**95-34**
		11/96	**97-02**
6	**Adjudication**	**08/94**	**94-32**
		07/97	**97-19**
7	**Compensation to Widow/Widower**	**08/94**	**94-32**
		11/96	**97-02**
8	**Compensation to Children**	**07/00**	**00-09**
		08/94	**94-32**
9	**Compensation to Parents**	**08/94**	**94-32**
		11-96	**97-02**
10	**Compensation to Siblings, Grandparents and Grandchildren**	**08/94**	**94-32**
		06/98	**98-05**
11	**Payments**	**08/94**	**94-32**
12	**Apportionment**	**08/94**	**94-32**
13	**Third-Party Cases**	**08/94**	**94-32**
14	**Burial Expenses**	**08/94**	**94-32**
15	**Termination of Employee Status**	**08/94**	**94-32**
16	**Disappearance Cases**	**08/94**	**94-32**
17	**Periodic Roll Review**	**08/94**	**94-32**
18	**Suspension of Benefits**	**08/94**	**94-32**
19	**Closure**	**08/94**	**94-32**
20	**Gratuity from Employing Agency**	**11/96**	**97-02**

Exhibits

1	**Percentages of Entitlement**		
	Page 1 (Link to Image)	**08/94**	**94-32**
	Page 2 (Link to Image)	**08/94**	**94-32**
2	**Entitlement of Multiple Payees (Link to Image)**	**08/94**	**94-32**
3	**Sample Letter Suspending Benefits When Report of Dependents is Not Received**	**08/94**	**94-32**

2-0700-1 Purpose and Scope

1. Purpose and Scope. This chapter describes procedures for developing and adjudicating death claims under the FECA. It discusses entitlement to monthly compensation benefits, funeral and burial expenses, and 24-month lump-sum payments.

2-0700-2 Policy

2. Policy. Death claims generally take precedence over other types of claims, and inquiries about them should be answered with speed and sensitivity. Great care must be taken in adjudicating these cases to ensure that dependents of a deceased employee do not suffer undue hardship because of delay in adjudication. Death benefits are subject to garnishment for overdue child support or alimony payments upon submission of proper documentation from a state agency or a court order (20 CFR 10.423).

2-0700-3 Authority

3. Authority. Death benefits to dependents of employees who die from job-related illness or injury are outlined in 5 U.S.C. 8101 (6-11 and 17), 8102, 8119-8122, and 8133 (which also addresses administrative costs related to terminating the decedent's status as a Federal employee). Section 8134 discusses funeral and burial costs and expenses for transportation of the body, and Section 8135 covers lump-sum payments.

2-0700-4 Responsibilities

4. Responsibilities. The Office of Workers' Compensation Programs (OWCP) and the parties to the claim have the following obligations in death claims:

OWCP. Upon receipt of a new death claim or notice that such a claim is about to be filed, the Claims Examiner (CE) or Supervisory Claims Examiner (SCE) should telephone the surviving spouse or other close family member. The caller should briefly and politely convey knowledge of the death, express sympathy over the event, and state the desire to assist as much as possible in processing the claim. The caller should advise the family member to expect to receive a postcard bearing the case file number and district office's address, as well as a separate letter requesting routine information needed to process the claim. The caller should give a telephone number and assurance that he or she will be available to discuss the claim as needed.

The CE is responsible for advising claimants and employing agencies how to process a death claim. This includes furnishing claim forms and instructions for obtaining evidence. Because evidence in the custody of a Federal establishment is more readily available to OWCP than to a claimant, it is the CE's obligation to secure such evidence. Also, the CE should render a decision on each case as soon as possible to avoid delay in payment of benefits or exercise of appeal rights.

b. Claimant. The claimant is responsible for giving notice of death (5 U.S.C. 8119) and has the burden of proving a relationship between an employee's death and factors of Federal employment. Except where the relationship between the death and the employment is obvious, the claimant must present medical evidence relating the death to the injury. See Bernice W. Curtis, surviving wife of Oscar Lee Curtis (1 ECAB 95), and Rose Martin, claiming as widow of Bruce Martin (24 ECAB 243).

c. Employing Agency. Section 5 U.S.C. 8128 requires the employing agency to report to OWCP any injury resulting in death, and to provide such supplementary reports as OWCP may require. The agency should be asked to assist in compiling and submitting evidence required from the claimant and witnesses except where adjudication occurs long after the decedent has been removed from the agency's rolls, and the agency no longer retains records of the decedent's employment. The claimant or OWCP must obtain statements from witnesses no longer on the agency's rolls.

2-0700-5 Initial Processing

5. Initial Processing.

a. Reports of Death and Claim for Compensation. When an employee dies in the performance of duty, the employing agency must report the death immediately to OWCP by telephone or telefax so that an autopsy may be considered. As soon as possible, the agency must complete and submit Form CA-6, Official Superior's Report of Employee's Death. In accordance with 5 U.S.C. 8119, an eligible beneficiary specified in 5 U.S.C. 8133 or someone acting in his or her behalf must give notice of death on Form CA-5 or CA-5b. A death case will be created upon receipt of any such message or forms.

b. Timeliness. Survivors must give written notice within 30 days of the date of death, but the timely filing of a disability claim will satisfy the time requirements for a death claim based on the same injury as long as the claim is filed during the dependent's lifetime. This provision does not apply to the dependent's heirs or estate (see Ned C. Lofton (John C. Lofton), 33 ECAB 1497).

(1) For an injury occurring on or after September 7, 1974, the time requirements are also satisfied if the immediate supervisor had actual knowledge of the death within 30 days, provided the knowledge was such as to put him or her reasonably on notice of an employment- related death.

(2) If written notice was not given, or the immediate supervisor did not have actual knowledge of the death within 30 days, or a timely disability claim was not filed for the injury on which the death claim is based, compensation benefits may not be allowed unless an original claim for death benefits was filed within three years after the death, or within three years of the date the claimant was aware, or

reasonably should have been aware, that the death was due to an employment-related disease.

c. Notice to Survivors of Right to Claim Compensation. All efforts to obtain a claim from survivors must be fully documented in the file.

(1) Eligible Survivors. The relationship of the survivor to the deceased is determined as of the date the death occurred (dependents who may be entitled to benefits are discussed in paragraphs 7-10). Section 8110 defines the classes of persons who qualify as "dependents" and thereby come within its scope. Those not specified are not included (see William S. Capeller, M.D., 28 ECAB 262).

(2) Spouses and Children. The spouse should be notified in writing of the right to claim compensation (Form CA-1064 may be used for this purpose). If no reply to this letter is received, a second notice will be sent 60 days later. In cases involving minor children, particularly orphans, the CE must send at least two notices to the guardian or custodian of the child. The case may be closed if no claim is received or if the replies to these notices indicate that further follow-up is not needed.

(3) Other Dependents. Generally, only one notice of the right to claim compensation need be sent to a survivor other than a spouse or child. If no claim is received within 60 days, the case may be closed as provided in paragraph 18 below.

(4) Compensation Due at Death. The CE should send Form CA-1085 to the administrator of the estate or to the next of kin to determine if compensation was due at death and, if so, to whom the money should be sent. See paragraph 14c below concerning payment of funeral and burial expenses from compensation due at death.

d. Relationship Between Disability and Death File. If a death is claimed due to an injury already of record, the death case should be doubled into the disability case under the number already assigned to the disability case.

e. Autopsy Reports. Initial reports of death received by telephone or telefax within 48 hours of death should immediately be brought to the attention of the District Medical Adviser (DMA) so that the need for an autopsy can be determined before burial, assuming that the cause of death is not obvious. If an autopsy appears to be necessary, the DMA will telephone or prepare a telefax to the next of kin requesting permission to perform the procedure, which will be carried out at OWCP expense (see FECA PM 3-400).

f. Development. Upon receipt of the case, and after completion of the telephone

call noted in paragraph 4a above, the CE will send Form CA-1063 or a narrative equivalent to the employing agency, and attach Form CA-5 or CA-5b and Form CA-6. If the name and address of the spouse are known, Form CA-1064 may be sent directly. If a claim is received, the case should be developed in accordance with the five basic requirements as described in FECA PM 2-801 through 805. Form CA-1072 or a narrative letter may be used to obtain information needed to establish causal relationship. In addition, the employing agency should be asked about pay rate and health benefits information, and the claimant must also submit the following evidence:

(1) Death certificate.

(2) Name(s) and address(es) of next of kin.

(3) Marriage certificate (civil certificate).

(4) Birth certificate for each child (to show the legal relationship upon which the claim is based).

(5) Divorce, dissolution, or death certificate for prior marriages.

(6) Itemized burial bills, receipted if paid (see paragraph 14).

2-0700-6 Adjudication

6. Adjudication.

a. If the record shows that any of the five basic requirements with regard to the employee's death is not satisfied, or the claimant is ineligible for benefits, the CE will prepare a formal decision (see FECA PM 2-1400). Form CA-1079 is used to transmit the decision. If the case satisfies the five basic requirements and there is at least one eligible beneficiary, the CE will:

(1) Complete Form CA-674, which is a checklist with a section which applies specifically to death cases. The form is a permanent part of the record and should remain at the top of the file.

(2) Obtain the concurrence of the SCE in accepting the case as indicated by certification of the CA-674.

(3) Initial and date Form CA-800 to indicate the acceptance.

(4) Determine whether a dual benefits situation exists with respect to benefits from the Office of Personnel Management or the Veterans Administration (VA)

and take appropriate steps (see FECA PM 2-1000).

(5) Complete Form CA-24, FECA Fatal Benefit Payment worksheet, to authorize payment of applicable benefits if no dual benefits situation or other impediment to payment exists.

(6) Advise the claimant of the acceptance by narrative letter, which should contain information regarding:

(a) Four-weekly and monthly compensation entitlement for each eligible beneficiary (see paragraphs 7 through 10. The amount should be certified before release of the letter.)

(b) "Lump Sum" provision upon remarriage, if applicable (see paragraph 7).

(c) Basis for continued entitlement of children (see paragraphs 8 and 10).

(d) Amount of allowable burial expenses (see paragraph 14).

(e) Entitlement to $200 administrative fee (see paragraph 15).

(f) Requirements for election if dual benefits are at issue (see FECA PM 2-1000).

Entitlement to compensation begins the day after death and is determined according to the schedule from 5 U.S.C. 8113 (see Exhibit 1 Page 1 (Link to Image), Page 2 (Link to Image)). When the beneficiaries are placed on the roll, the CE should prepare Form CA-180, Compensation Order (Death).

b. Where no one is eligible for compensation, or where the eligible beneficiaries must first make an informed election, the burial benefits and administrative closing payment may be made immediately to the appropriate parties, using Form CA-24.

2-0700-7 Compensation to Widow/Widower

7. Compensation to Widow/Widower. To determine if a spouse is entitled, the CE should examine the status of the marriage at the time of the employee's death. If neither the decedent nor the surviving spouse was previously married, a copy of the marriage certificate will establish that the survivor is an eligible beneficiary. If either was married previously, the surviving spouse must also submit copies of the divorce or annulment decree showing dissolution of the previous marriage, or death certificate showing the demise of the former spouse, as the case may

be.

a. Living Circumstances. If the surviving spouse was not living with the deceased at the time of death, the CE should investigate the circumstances surrounding the separation. According to 5 U.S.C 8101(6) and (11), a spouse separated from the decedent must have been "living apart for reasonable cause or because of. . . desertion." The following examples show how the facts may apply in different cases to determine reasonable cause:

(1) Where the parties maintain separate abodes but all other evidence points to the existence of a marital relationship at the time of death, the claimant is entitled to compensation benefits as the surviving spouse.

(2) If the parties lived apart for reasonable cause (e.g., hospitalization due to the fatal illness), or because of desertion by the employee, entitlement exists. If evidence shows that the spouse claiming benefits deserted the employee, the CE must develop the case to determine whether the spouse did in fact desert the employee. This may require personal investigation by an OWCP representative.

(3) If the parties lived apart for other reasons, entitlement may exist if the spouse was dependent on the decedent. The CE should obtain a copy of any court order directing the decedent to contribute to the spouse's support. If none existed, obtain letters from the family explaining the reason(s) for the separation and stating whether the surviving spouse received contribution from and was dependent upon the employee.

(4) If common law marriage is at issue, the CE must determine the status of the marriage according to the law of the state(s) in which the participants lived. The CE should obtain the concurrence of the SCE in determining eligibility.

b. Remarriage. Prior to September 7, 1974, all remarriages resulted in termination of compensation benefits. For remarriages between that date and May 28, 1990, entitlement continues if the beneficiary is age 60 or over (see 5 U.S.C. 8133(b)(1)), but not if he or she is under that age. After May 29, 1990, entitlement continues if the beneficiary is age 55 or over (see Public Law 101-303), but not if he or she is under that age.

(1) To terminate compensation on the ground that a spouse has remarried, OWCP has the burden of establishing that the subsequent marriage took place. In the case of a common law marriage, OWCP must establish that the parties have met the criteria of the state where the parties reside. Cohabitation in and of itself is not sufficient to establish the existence of a bona fide common law marriage unless it is accepted by the state in which the spouse resides (see Marilyn M. Videto (William R. Videto), 23 ECAB 207, and FECA Program Memorandum

156).

(2) Although entitlement to benefits ends with a spouse's remarriage before age 55 (or 60, depending on the date of remarriage), benefits may be reinstated if the marriage is annulled. In the case of a voidable marriage, compensation may resume as of the date the marriage is terminated, whereas in the case of a void marriage, compensation may resume as of the date of the marriage. However, a beneficiary who remarries and is subsequently divorced does not again become entitled to benefits. (See FECA Program Memorandum 4.)

(3) Following a spouse's remarriage, the other beneficiaries are entitled to compensation at the rate they would have received had they been the only beneficiaries.

(4) Under Section 8135(b), a lump sum payment may be made to a spouse who remarries before reaching age 55 (or 60, depending on the date of remarriage). The sum payable is equal to 24 times the amount of monthly compensation paid just prior to the remarriage. If the remarriage later proves to be void or voidable, the entire lump sum award then becomes an overpayment subject to waiver or recovery. Continuing payments should not be withheld while this overpayment issue is being resolved. (See FECA Program Memorandum 150.)

2-0700-8 Compensation to Children

8. Compensation to Children. Section 8101(9) defines a "child" as one who is under 18 years old, or incapable of self-support, or a full-time student under age 23. Included are stepchildren and children who are legally adopted prior to the parent's death according to the laws of the state having jurisdiction (see Marie Jean Kennedy (Fred E. Kennedy), 11 ECAB 247 (1959)).

Illegitimate children and posthumous children of the deceased are also entitled to compensation (a posthumous child is entitled to benefits effective the date of its birth). Excluded are married children and foster children. Compensation payable to, or on behalf of, a child is continued until the child dies, marries, or becomes 18, or, if over 18 and incapable of self-support, becomes capable of self-support.

a. Student Status. Where a child has reached the age of 18 and has indicated no intention to attend school after high school, compensation should cease at the end of the month in which the child graduated from high school. Compensation paid on behalf of an unmarried child which would otherwise be terminated at age 18 may continue, however, if the child is a student pursuing a full-time course of study or training at an accredited institution. Such benefits may be paid for four years of education beyond the high school level, or until the beneficiary reaches age 23, whichever comes first [see 20 C.F.R. 10.417 and 5 U.S.C. 8101(17)].

(1) A "year of education beyond the high school level" is defined as:

(a) The 12-month period beginning the month after the child graduates from high school, if the child has indicated an intention to continue in school during the next regular session, and each successive 12-month period, provided that school attendance continues.

(b) The 12-month period beginning on the date the child actually enters school to continue education, if the child has indicated that he or she will not attend during the next regular session, and each successive 12-month period, provided that attendance continues.

(2) A year of entitlement based on student status means any year during all or part of which compensation is paid based on school attendance. Therefore, if a beneficiary should decide for any reason not to attend school for part of a year during which benefits were paid on account of student status, that beneficiary would be charged with having used an entire year of eligibility out of the allotted four years, even though compensation terminates when the beneficiary leaves school. If a child has already completed one or two more years of college before turning 18, they would be deducted from the four years of entitlement.

(3) If the child does not begin post high school education immediately but later decides to enter school full-time, compensation would begin on the date school attendance began, as stated in (1)(b) above. In this situation, the individual would remain entitled to four years of compensation based on school attendance, provided he or she did not turn 23. In either case, compensation is continued during any interval between school terms if the interval does not exceed four months and if the beneficiary demonstrates a bona fide intent to continue in school the following year. In the absence of specific contrary evidence, the CE may consider the student's decision to begin or continue full time studies a bona fide statement of intent.

(4) Where a student is prevented by reasons beyond his or her control (such as brief but incapacitating illness) from continuing in school, compensation may be continued for a period of reasonable duration. However, any such period would be counted toward the four years of entitlement. The CE will determine what constitutes "reasons beyond the control" of the beneficiary and decide what may be considered a period of reasonable duration during which compensation may be continued. The CE will also place a memorandum in the file outlining the circumstances of the case and the reasons for the decision. (See paragraph (7)(c) below concerning declarations of overpayments in these situations).

(5) The CE obtains proof of student status through the use of Forms CA-1615 and CA-1617. The CA-1615 should be forwarded to the dependent's parent or guardian at least three months before the dependent's 18th birthday. Where compensation is being paid for school attendance, Form CA-1617 should be sent twice each year at least two months prior to the date the current semester (or quarter, etc.) is scheduled to end. The CE should note on the CA-674 the number of years of eligibility remaining for each beneficiary based on student status.

(6) If the beneficiary is still receiving student benefits on turning 23, compensation should terminate at the end of that semester or enrollment period.

(7) Following are examples of common situations:

(a) John Smith's birth date is February 10, 1977. He has received compensation since 1983, and he will graduate from high school in May 1994. John has completed Form CA-1615 to indicate that he will attend college on a full-time basis starting in the fall of 1994. John's first "year of education beyond the high school level" will begin in June 1994, even though he is still entitled to benefits by virtue of being under 18 until February 1995.

(b) Steve Jones' date of birth is January 13, 1976. He received compensation beginning in 1984 and graduated from high school in June 1994. He completed Form CA-1615 to indicate that he would not attend college. He was entitled to receive compensation through June 1994, the month of his high school graduation (he was 18 when he graduated). Should Steve decide at some future date to continue his education, he would begin receiving compensation the month that he actually entered school and would be entitled to the entire four years of eligibility until he turns 23.

(c) Jane Doe's date of birth is April 15, 1974, and she received compensation beginning in 1988. She graduated from high school in May 1992 and indicated on Form CA-1615 that she would continue her education in the fall. Because of this evidence of a bona fide intent to attend school, her compensation was continued over the summer. In September she advised OWCP that she had reconsidered and decided to work instead of attending school.

Compensation was terminated effective October 1, 1992, without declaring an overpayment since 5 U.S.C. 8101(17) states that an individual "is deemed not to have ceased to be a student during an interim between school years if the interim is not more than 4 months and if he shows to the satisfaction of the Secretary that he has a bona fide intention of continuing to pursue a full-time course of study" during the following semester.

Since Jane received compensation after high school based on school attendance, the period for which she was paid represents one full year of eligibility out of her four year allotment. Had she decided at some future date to attend, she would have had three years of eligibility remaining. However, if she had decided to begin attending school in, for example, January 1993, she would still have been within her first year of eligibility, which began in June 1992 and ended in May 1993.

b. Marriage. A dependent child's eligibility for benefits terminates on the date of the child's marriage. A child whose marriage ended prior to the employee's death will not be barred from receiving survivor's benefits if otherwise entitled. A child whose marriage is annulled after the employee's death is eligible for survivor's benefits from the effective date of the annulment or the date of death (see FECA Program Memorandum No. 4) if otherwise entitled, but a child who is divorced or widowed is not eligible for benefits.

c. Children Over 18 Who are Incapable of Self-Support. When claims are made by or for children over 18 who are physically or mentally incapable of self-support, the CE must investigate the extent and expected duration of the illness involved.

(1) Eligibility. To be entitled to benefits, a child over 18 at the time of the employee's death must have been incapable of self-support at the time of the death by reason of a mental or physical disability. Also, a child over 18 who becomes incapable of self-support after the employee's death, but before reaching 18, is eligible. A child over 18 is not entitled to benefits because of inability to obtain employment due to economic conditions, lack of job skills, etc.

(2) Definition. A claimant is incapable of self- support if his or her physical or mental condition is such that he or she is unable to obtain and retain a job, or engage in self-employment that would provide a sustained living wage. This determination must be based on medical evidence. When medical evidence demonstrates incapacity for self-support, this determination will stand unless refuted by the sustained work performance.

(3) Medical Evidence. A medical report covering the child's past and present condition must be submitted and referred to the DMA to determine whether it

establishes incapacity for self-support. A physician's opinion must be based on sufficient findings and rationale to establish unemployability.

d. Method of Payment. In death cases, payment of compensation is made to a child as follows:

(1) Under Age 18. Compensation will be paid to a parent, guardian, or other competent individual responsible for the child's welfare. If a child under age 18 without a parent, guardian or other individual responsible for supervision is found to be competent to receive payments, compensation can be paid directly to the child. Sources of information concerning competency include local juvenile authorities, school officials, police, and relatives. The CE should obtain information from such sources as well as any other pertinent evidence, then make a determination of competency. If necessary, the CE should ask juvenile authorities in the area of the child's residence to appoint a conservator.

(2) Students. Compensation will be paid directly to a child who is a student if he or she is of legal age in the state of residence. If not, and the parent or guardian requests payment of the compensation, the CE must determine whether direct payment of compensation would be in the child's best interest, based on factors in the specific case.

(3) Physically or Mentally Incompetent. On request, compensation will be paid directly to a child of legal age who is incapable of self-support due to physical disability. Compensation on behalf of mentally incompetent individuals must be paid to a parent, guardian, or other person responsible for the individual's welfare.

2-0700-9 Compensation to Parents

9. Compensation to Parents. Parents, stepparents, and parents by adoption may be entitled to survivors' benefits, but foster parents and in-laws are excluded. Proof of parentage is established by a copy of the birth certificate for the employee, or, in the case of adoption, copies of the legal documents. In the case of a stepparent, the file must contain proof of the stepparent's marriage to the natural or adoptive parent of the deceased, along with the birth certificate indicated above.

a Whole or Partial Dependency. Section 8133(a)(4) provides benefits to parent(s) who were wholly or partly dependent on the employee at the time of death. Note that this differs from the provision of Section 8110(a)(4), which provides augmented compensation to a disabled employee on the basis of a parent wholly dependent on and supported by the employee. Form CA-1074 may be used to develop information bearing on this issue.

b. Dependency Criteria. The test of dependency under the FECA is not whether the claimant is capable of self-support without the amount which was previously provided by the deceased. "It is only necessary to show that the person claiming as a dependent. . .looked to and relied upon the contributions. . .in whole or in part, as a means of maintaining or helping to maintain a customary standard of living" (see Viola Davidson, 4 ECAB 263).

c. Percentage of Entitlement. The amount of entitlement for parents is stated at 5 U.S.C. 8133(a)(4) as follows:

(1) If there is no widow, widower, or child:

(a) 25% if one parent was wholly dependent on the employee at the time of death and the other was not dependent at all.

(b) 20% to each if both were wholly dependent.

(c) A proportionate amount in the discretion of the Secretary of Labor if one or both were partly dependent.

(2) If there is a widow, widower, or child, a portion of these percentages may be paid such that the total amount paid to the widow or widower, children and parents will not exceed 75%.

d. Minimum Payable. The minimum amount to which partially dependent parents are entitled was established by the decision in the case of Minnie Ballard, 8 ECAB 716:

> To establish the minimum parental compensation entitlement, ...first determine the percentage that the decedent's contribution [during the 12 months immediately preceding death]. . .bears to the total moneys the parent received from all sources during the same period of time. Multiply the resulting percentage by the 25% [to one parent partially dependent or 20% to each if there are two parents partially dependent] and the result thus obtained is the payable percentage of dependency.

e. Change in Employee's Financial Status. Where the employee's earnings and/or contributions changed significantly over time, the controlling factors are those present at the time of death. In the case of an employee whose Federal earnings represented his or her first full-time employment, the most important factor in determining the amount of compensation payable is the amount the employee was earning and contributing at the time of death, not the amount earned and contributed during the preceding year (see Robert C. Boyd (Roger D. Boyd), 18 ECAB 639).

f. Criteria for Continued Payments. Survivor's compensation is payable from the day after death until the parent dies, marries, or ceases to be dependent. A parent whose entitlement is based on financial dependency should be removed from the rolls when the current income received, less compensation, equals or exceeds the total income from all sources at the time of death. CPI adjustments should be included when making this determination. OWCP has the burden of proving under this formula that the parents are no longer dependent.

2-0700-10 Compensation to Siblings, Grandparents, and Grandchildren

10. Compensation to Siblings, Grandparents, and Grandchildren. As with parents, the relationship on the date of death and the degree of financial dependence determines entitlement to benefits for siblings, grandparents, and grandchildren. The term "sibling" includes stepbrothers and stepsisters, half brothers and half sisters, and brothers and sisters by adoption. The category of grandparents does not include step-grandparents. The term grandchildren includes all biological and adopted grandchildren, whether born into a marriage or not, but does not include step-grandchildren. Unlike posthumous children, posthumous siblings are not entitled to benefits, even if the mother of the deceased employee was dependent on the employee at the time of death and she was pregnant, the reasoning being that the unborn child was dependent on its mother, not the employee, prior to its birth (see J. Quackenbush, 19 ECAB 251).

a. Documentation. The person claiming compensation, or someone acting on this person's behalf, must complete Form CA_5b. Proof of relationship and proof of dependency at the time of death are required. Evidence which establishes physical or mental incapacity is also required if a sibling or grandchild is over age 18 and incapable of self_support.

(1) Proof of relationship is established in the same manner as for a child or parent.

(2) Proof of dependency is established in the same manner as for a parent, but the percentage of entitlement for partly dependent beneficiaries differs:

(a) Section 8133(a)(5)(C) allows 10% to a partly dependent sibling, grandparent, or grandchild rather than the "proportionate amount" allowed to parents by 5 U.S.C. 8133(a)(4).

(b) Therefore, the CE need not calculate the prorated degree of dependency required by the Minnie Ballard decision (8 ECAB 716).

(3) Proof of physical or mental incapacity is established in the same manner as for a child over 18 years of age.

(4) Proof of student status is established in the same manner as for a child of the deceased.

b. Percentage of Payments. The percentages payable are as follows, in accordance with Section 8133(a)(5):

(1) 20% if one survivor was wholly dependent on the employee at the time of

death.

(2) 30% if more than one survivor was wholly dependent, divided among the survivors share and share alike.

(3) 10% if no survivor was wholly dependent but one or more was partly dependent, divided among the survivors share and share alike.

If there is a widow, widower, or child, a portion of these percentages may be paid such that the total amount paid to the widow or widower, children and siblings, grandparents, and/or grandchildren will not exceed 75%.

c. Length of Payment. Compensation is payable until:

(1) The sibling or grandchild dies, marries or becomes 18 years old, or, if over age 18 and incapable of self_support, becomes capable of self_support.

(2) The grandparent dies, marries or ceases to be dependent.

d. Marriage. As with children, a beneficiary in this group who is otherwise entitled may receive survivor's benefits if his or her marriage terminates prior to the employee's death. Annulment of a beneficiary's marriage may result in re-entitlement from the effective date of the annulment if the survivor is otherwise entitled.

2-0700-11 Payments

11. Payments. Pay rate determinations are addressed in FECA PM 2-900. The minimum (GS-2) and maximum (GS-15) basic rates of pay provided by Section 8102 are applicable in death cases, and the amount to which survivors are entitled can never exceed 75% of the decedent's pay rate (before CPI adjustments). To calculate the monthly pay rate, the CE should determine:

a. The Effective Date of the Pay Rate. Compensation for death is based on the pay rate on the date of injury, date disability began, or date of recurrence, or following re-computation under Section 8113.

b. The Monthly Wage. If the employee was working in private industry when death or disability occurred, non- Federal pay may be used in determining the pay rate (see Elizabeth F. Keough, 35 ECAB 347.

c. Entitlement to Health Benefits Coverage.. The survivors will be eligible for continued coverage if the decedent was enrolled at the time of death in a health benefits

plan for which the agency (or OWCP) was making deduction. (Note that when only a spouse survives, the health plan needs to be changed from a family plan to a self-only plan.)

d. The Number of Beneficiaries. When a survivor dies or otherwise becomes ineligible for compensation, the benefits of the remaining survivors are recomputed. This action usually results in an increase for each beneficiary, though payments may not exceed the maximum 75%.

e. The Number of Payees. Payment to a subsidiary recipient as well as a primary beneficiary will always involve multiple payees, since the subsidiary survivor always gets a separate check (see Exhibit 2 (Link to Image)).

f. CPI Entitlement, if any. Such entitlement depends on whether the deceased employee was receiving disability compensation prior to death.

(1) If so, survivors are entitled to CPI adjustments effective more than one year after compensable disability began, even though the date of death may be less than one year prior to the effective date.

(2) If not, survivors are entitled to CPI adjustments beginning one full year after the date of death, even if an earlier pay rate is used.

2-0700-12 Apportionment

12. Apportionment. The FECA provides that a spouse and children have the first right to compensation, which means that other classes of dependents may be excluded if necessary. Thus, the subsidiary dependents (i.e., parents, siblings, grandparents, and grandchildren) may receive compensation only after the entitle- ments of the spouse and/or children have been satisfied fully.

The only exception to this rule occurs where OWCP reapportions the award in the manner provided by Section 8133(d). For example, in the rare event that the survivors include a spouse, two children, and dependent parents, the spouse and the children are entitled to 75%, and the parents are not entitled to benefits. The CE may invoke Section 8133(d), however, to designate a small amount (e.g., 5%) for the parents. Many factors influence this decision. The CE should:

a. Obtain the spouse's opinion.

b. Determine whether the spouse has other income.

c. Consider the actual amount of benefits in proportion to need (e.g., if they are sizable/sufficient for "primary" beneficiaries, then allocating a small amount for parents

would not be harmful).

d. Determine whether the parent(s) live with the spouse. If so, benefits may not need to be divided as the parents will receive them indirectly.

The CE should prepare a memorandum for the file fully explaining the rationale for or against reapportionment, and the SCE must certify it.

2-0700-13 Third-Party Cases

13. Third-Party Cases. The CE is responsible for referring to the designated CE any case in which third-party liability may exist (see FECA PM 2-1100). In accordance with Section 8132, a third-party recovery will result in suspension of death benefits to the recipients of the settlement until the credit is absorbed. During this period, any beneficiaries who did not participate in the third-party recovery will continue to receive compensation at the rate established.

2-0700-14 Burial Expenses

14. Burial Expenses. Section 5 U.S.C. 8134 provides for the payment of burial and funeral expenses by the U.S. not to exceed $800. Like related medical expenses in a disability claim, funeral expenses in a death case may be paid even if the case as a whole is denied on the basis of timeliness as long as causal relationship is established and the requirements for giving notice are met. They may be paid without regard to any life insurance or burial insurance policy which may be in force.

a. Allowable Expenses. Normally the following services are paid: transporting body from place of death, embalming, shaving, dressing, clothes, storage, casket, vault, funeral services, clergy, hearse to cemetery, cars, lowering device, digging grave, grave rental, perpetual care of grave, grave marker, and funeral notice.

(1) Acceptability of other items must be determined on an individual basis according to necessity and reasonableness.

(2) Costs for such items as monuments, obituary notices, and copies of extra death certificates (one for the spouse and one for submission to OWCP are allowed) should be deducted from the itemized bill.

(3) When authorizing payment of the burial allowance, the CE should note on the burial bill which items are allowable. If the reason for allowing a specific item is not apparent, the notation should include a brief explanation of the reasons for allowing it.

b. Payments by Other Agencies. If another Federal agency pays any part of the burial expense for the deceased employee, OWCP's payment shall not exceed the difference between the amount paid by the other agency and $800.

Neither the $225 Social Security lump sum death benefit nor benefits from life insurance or burial policies are deducted from OWCP funeral benefits, however.

The VA will not authorize a burial allowance when the veteran dies from an injury or disability sustained in the performance of Federal employment. Since the VA is no longer the primary benefit payer in such cases, it is not necessary to check with the VA Regional Office (VARO) to determine the amount paid or payable. Rather, the VA will contact OWCP if it appears that the veteran was a Federal employee whose death was work-related. While the VA and OWCP have agreed not to exchange funds where elections are concerned, such a transfer will be made if burial expenses are awarded in error.

c. Method of Payment. OWCP can reimburse, in proportion to the part of the total expense paid, any person who paid part of the burial expenses. In no case will OWCP's payment for burial expense exceed the amount allowed under the FECA, and all claims for burial allowance must be accompanied by an itemized bill prepared by the undertaker who furnished the services. The order of payment is as follows:

(1) If a survivor furnishes proof of payment of burial costs, OWCP pays the $800 to the survivor. If burial costs have not been paid, the $800 is paid to the executor of the estate. If there is no legal representative and the bill is unpaid, the funeral director may claim direct payment. In most, if not all, legal jurisdictions in the U.S., undertakers and others who provide burial services are considered priority creditors, and they therefore have a priority claim against the proceeds of the decedent's estate and any entitlements the decedent's death might create.

(2) If the funeral bill is unpaid or a balance exists, direct payment must be made to the funeral home. For example, if a friend paid funeral expenses of $600 and an unpaid balance of $300 remains, and OWCP allows $550 ($800 less $250 from the VA), OWCP will pay the funeral home $300 with the balance of $250 going to the friend.

Section 5 U.S.C. 8130 prohibits assignment of compensation and exempts it from claims of creditors. Therefore, no claim for compensation due at death by an undertaker or other creditor may be recognized.

d. Transportation and Medical Costs. If the employee died away from home, charges for returning the body and the sealed casket may be paid over and above the $800 allowance. In cases where related medical and transportation expenses were

incurred prior to death, the CE should authorize payment.

2-0700-15 Termination of Employee Status

15. Termination of Employee Status. An additional sum of $200 is payable to the personal representative of the decedent to reimburse the cost of terminating his or her status as a Federal employee. A spouse is considered to be the personal representative unless incompetent. If no spouse survives, the payment will be made to the administrator of the estate.

a. Pay Status. A personal representative is entitled to receive the $200 payment regardless of whether the deceased was in pay status with the employing agency at the time of death. For example, the personal representative of an employee who retired in 1973 and died of work-related causes in 1978 would be entitled to the $200 payment.

b. Employee Status. The $200 payment may be made only in cases of deceased employees as defined by Section 8101(1). Therefore, payment is usually not made to members of groups to which FECA benefits are extended by separate legislation, such as ROTC cadets, Civil Air Patrol volunteers, members of the National Teacher Corps, and non-Federal law enforcement officers. On the other hand, Peace Corps and VISTA volunteers and Job Corps enrollees are considered employees of the U.S. as defined in Section 8101(1) and are therefore entitled to payment of the $200.

2-0700-16 Disappearance Cases

16. Disappearance Cases. Under 5 U.S.C. 5565, when a Federal employee has been missing for at least 12 months and no official report of death or the circumstances of continued absence has been received, the head of the employing agency is authorized to review the case and either continue the missing status, which may result in a continuance of pay status, or make a finding of death, which will terminate pay status. A finding of death must include the date on which death is presumed to have occurred, and a determination made under this section of the law is binding on all other agencies of the U.S. Such a determination can therefore be used as proof of death (in lieu of a death certificate) in a disappearance case. In such cases, especially those occurring outside the U.S., the claimant should be instructed to request such a determination from the employing agency if one has not been made.

a. Pay Status. In some disappearance cases the employee's pay is terminated as of the date of disappearance, while in others it is continued until an official finding of death is made. The claim file must show the date the employee's pay stopped, as compensation cannot be paid for any period prior to that date. If the presumed date of death and the date pay stopped are not the same, the latter date should be used to determine when compensation payments should begin.

b. Findings by Local Courts. In all disappearance cases occurring within the U.S. where a local court makes a finding of death and directs the issuance of a death certificate, OWCP will give full credit to all findings of the court and will not challenge the findings in another court. If no finding of death has been made, the claimant should be instructed to request one from a local court.

c. Unusual Cases. In some very unusual cases of disappearance, a finding of death may not be made. In such a case, the CE must determine whether death likely occurred and, if so, the date it occurred. Such a determination will necessarily require discretion and judgment, and the CE must obtain the best available evidence about the circumstances surrounding the disappearance. The CE should prepare a memorandum which outlines the facts and provides a recommendation for the SCE.

2-0700-17 Periodic Roll Review

17. Periodic Roll Review. The CE should review the case at least once a year to verify continuing entitlement to benefits, ensure that benefits are being paid at the proper level, resolve third party issues, and discontinue benefits when warranted. See paragraph 18 below concerning suspension of benefits for non-receipt of reports of dependents.

a. Rescission. Once OWCP has accepted a fatal case and paid benefits, the CE should not reexamine the basis for acceptance or attempt to rescind it unless the file contains blatant error or clear indication of fraud. A recommendation to vacate the original decision must be routed through the District Director to the Director for Federal Employees' Compensation for review and final decision.

b. Form CA-12, Claim for Continuation of Compensation. This form is sent annually to all recipients of death benefits. If the form has not been returned within 60 days of release, the CE should send a follow-up request for completion. Upon receipt of the form, the CE should check for changes in address, marital status, and financial dependency status. Particularly with elderly recipients of the form, the CE should be alert to changes in the beneficiary's signature; such changes may indicate that someone other than the intended recipient of benefits is completing the affidavit. The CE should also ensure that any address changes are also noted properly in the Automated Compensation Payment System (ACPS) and take any other actions required as noted below.

c. Widows and Widowers. If the spouse has remarried, the CE will need to determine her or his age at the time of remarriage. A widow or widower over age 60 (prior to May 29, 1990) or over age 55 (May 29, 1990 or later) is entitled to continue receiving monthly benefits. If the surviving spouse is younger, the CE must initiate action to terminate benefits and pay the 24-month lump sum.

d. Children, Grandchildren, and Siblings. Form CA-1615 should be released to the guardian three months before the child reaches the age of 18 to determine continuing entitlement to compensation on the basis that the child is a student or is incapable of self-support.

(1) Student Status.

(a) ACPS automatically deletes the records of beneficiaries when they reach age 18 and adjusts the percentages payable to other survivors. The CE should check the CP-285, however, to ensure that benefits are not interrupted if the child's entitlement continues after age 18.

(b) Form CA-1617 should be released twice a year to determine continuing entitlement to compensation based on student status. The CE will need to determine if the student is regularly pursuing a full-time course of study; if the student has completed four years of education beyond the high school level; the end of the semester or enrollment period in which the student turns 23; and any interim periods between school years. Form CA-1617 also includes a question concerning the election of VA or other educational benefits.

(2) Incapable of Self-Support. A person entitled to benefits because of incapacity for self-support, or his or her guardian, should be asked to submit medical evidence to support continued payments of compensation. Such requests should be made at least yearly.

e. Parents and Grandparents. Under 5 U.S.C. 8133(b)(3), survivors' benefits cease when "a parent, or grandparent dies, marries, or ceases to be dependent."

(1) A parent or grandparent should be removed from the rolls when the current income less compensation equals or exceeds the total income from all sources adjusted to compensate for changes in the cost of living at the time of death. This action is taken because the beneficiary would no longer be dependent upon compensation to sustain a living standard equivalent to that enjoyed at the time of the employee's death.

(2) OWCP has the burden of proving that the parent or grandparent is no longer dependent. Approval authority in such cases rests with the SCE and cannot be delegated to the CE.

2-0700-18 Suspension of Benefits

18. Suspension of Benefits. Compensation for beneficiaries in death claims may be

suspended for failure to provide timely reports concerning their status.

a. Determining if Benefits Should be Suspended. If reports requested on Form CA-12 and/or Form CA-1617 are not made in a timely manner, the CE should first determine if extenuating circumstances apply (for example, the beneficiary is hospitalized or has just moved and had no time to notify OWCP).

(1) If no extenuating circumstances exist, the following actions should be taken:

(a) If Form CA-12 has not been returned, all benefits should be suspended even if a current Form CA-1617 is in file for a college-age child unless the child is receiving benefits in his or her own name.

(b) If Form CA-1617 has not been returned, compensation for only the student will be suspended, assuming a current Form CA-12 appears in file.

(2) If extenuating circumstances exist or the form is received but not substantially completed, the CE should advise the beneficiary of the specific information still required and indicate that benefits will be suspended within 30 days if the information is not received within that time.

b. Advising the Beneficiary. Suspension (whether of all benefits or the percentage paid for a particular dependent) should be accomplished by narrative letter which specifies the dependents whose compensation is being suspended; references the letter which was sent and the date; cites the pertinent regulation; and advises the claimant that benefits will be restored retroactively once the necessary information is received as long as it supports continuing payment. Appeal rights should be provided with this letter (a sample is shown in Exhibit 3).

c. Fiscal Action.

(1) Benefits should be suspended effective the beginning date of the next periodic roll cycle. No deductions for health benefits will be made during the period of suspension.

(2) If suspension is effected for a particular dependent, the percentage payable for other beneficiaries remains the same during the period of suspension. For instance, if a widow and student are receiving 45% and 15% respectively, and the student's benefits are suspended due to non-receipt of Form CA-1617, the widow should remain on the roll at 45%.

(3) The CE should take prompt action to restore benefits in cases where the requested information concerning dependents is received after benefits have been

suspended. Compensation should be reinstated retroactive to the date of suspension where the evidence submitted supports the payment of benefits.

2-0700-19 Closure

19. Closure. The CE should take the following steps to close a death case:

a. Cancel any outstanding call-ups.

b. Write the reason for closure on Form CA-800 and Form CA-674.

(1) Where other benefits have been elected, the closing entry should identify the benefit elected, e.g., "elected Civil Service Retirement annuity."

(2) Where no claim is filed because there are no eligible dependents, the closing entry will be "no dependents"; otherwise, the closing entry will be "no claim filed."

2-0700-20 Gratuity

20. Gratuity from Employing Agency

Public Law 104-208 authorized payment of a gratuity not to exceed $10,000 to survivors of employees who died in the line of duty on or after August 2, 1990. These payments are made by employing agencies, not the OWCP. The payments do not constitute dual benefits, and no election is required. However, any burial and administrative expenses paid by the OWCP are deducted from the entitlement. CEs will therefore need to advise employing agencies of the amounts of burial and administrative expenses paid by the OWCP when requested to do so in particular cases.

2-0700 Exhibit 1: Percentages of Entitlement Page 1 (Link to Image)

2-0700 Exhibit 1: Percentages of Entitlement Page 2 (Link to Image)

2-0700 Exhibit 2: Entitlement of Multiple Payees (Link to Image)

2-0700 Exhibit 3: Sample Letter Suspending Benefits When Report of Dependents Is Not

Received

Dear NAME OF BENEFICIARY:

I am writing in reference to the compensation benefits you receive from the Office of Workers' Compensation Programs (OWCP).

Section 10.126 of the OWCP's regulations states that entitlement to compensation for dependents in death claims may be suspended for failure to provide timely reports concerning their status. If the requested information is subsequently received, compensation for dependents is reinstated retroactive to the date of suspension where the evidence submitted supports the payment of compensation.

On DATE, Form (CA-12, CA-1617, ETC.) was sent to you for completion. No reply has been received, and compensation for NAME OF DEPENDENT has been suspended as of DATE. If you complete and return the enclosed copy of Form (CA-12, CA-1617, ETC.) compensation will be restored retroactive to the date it was suspended as long as the information provided shows entitlement to payment.

This is a formal decision, and your appeal rights are attached.

Sincerely,

NAME OF SIGNER
SENIOR CLAIMS EXAMINER

2-0800 DEVELOPMENT OF CLAIMS

Paragraph	Subject	Date	Trans. No.
Table of Contents		01/04	04-01
1	Purpose and Scope	04/93	93-21
2	Definitions	04/93	93-21
3	Responsibilities	04/93	93-21
4	Forms	01/03	03-03
5	Processing Claims	01/04	04-01
6	Evidence	01/04	04-01
7	Obtaining Evidence from Employing Agencies	04/93	93-21
8	Special Situations	01/04	04-01
9	Phrasing Questions	01/04	04-01
10	Investigation	04/93	93-21

11	**Obtaining Information by Telephone**	**01/04**	**04/01**
12	**Conferencing**	**10/95**	**96-01**
13	**Affirmative Defense**	**10/95**	**96-01**
14	**Reopened Short-Form Closure Cases**	**01/04**	**04-01**

Exhibit

1	**Sample Letter to Claimant or Survivor Approving Withrawn Claim**	**01/04**	**04-01**

2-0800-1 Purpose and Scope

1. Purpose and Scope. This chapter describes the fundamentals of claims development. Along with FECA PM Chapters 2-801 through 2-805, it covers the factors which all claims have in common. Claims for occupational disease are discussed in FECA PM 2-806, while additional material about death claims is covered in FECA PM 2-700. The development of special act claims, in which entitlement is based on legislation extending FECA benefits to such groups as Peace Corps and VISTA volunteers, is described in FECA PM 2-1700.

2-0800-2 Definitions

2. Definitions.

a. A Primary Case is a new file on which no developmental, adjudicative, or payment action has been taken except for payment of bills associated with medical care authorized by the employing agency.

b. A Secondary Case is a claim which is under development or which has already been adjudicated.

c. A Traumatic Injury is defined as a wound or other condition of the body caused by external force, including stress or strain. The injury must be identifiable as to time and place of occurrence and member or function of the body affected. It must be caused by a specific event or incident or series of events or incidents during a single day or work shift.

d. An Occupational Disease is defined as a condition which is produced by continued or repeated exposure to elements of the work environment such as noxious substances or damaging noise levels over a period longer than one work day or shift.

e. The Five Basic Requirements which an FECA claim must meet in order to be

compensable are time, civil employee, fact of injury, performance of duty, and causal relationship.

f. A Prima Facie Claim is one which on "first appearance" (the literal meaning of the term) demonstrates entitlement to compensation. Such a claim always requires development if it cannot be accepted immediately.

g. Burden of Proof refers to the claimant's responsibility to establish the five basic requirements of the claim. Once the claimant has made a prima facie case for the five basic requirements, the Office has the responsibility to take the next step, either of notifying the claimant what additional evidence is needed to fully establish the claim, or of developing evidence in order to reach a decision. Once the claim is accepted and benefits are paid, the burden of showing that payments should not continue shifts to the Office.

h. Case Development is the process of defining the issues which must be resolved and soliciting medical and factual evidence in order to adjudicate the case.

i. Controversion of a claim refers to an employing agency's action to dispute, challenge, or deny the validity of a claim. Controversion may be based on the information submitted by the employee or secured on investigation and it is accomplished by completing the indicated portion of Form CA-1 and submitting supporting evidence to OWCP.

2-0800-3 Responsibilities

3. Responsibilities.

a. Claimant. A person claiming compensation must show sufficient cause for OWCP to proceed with processing and adjudicating a claim. OWCP has the obligation to aid in this process by giving detailed instructions for developing the required evidence. OWCP also has a responsibility to develop evidence, particularly when it is the type of information normally obtained from an employing establishment or other government source. In all cases, the claimant must submit the essentials of a prima facie case, which are as follows:

(1) Statutory Time Requirements Have Been Satisfied. Compliance with this requirement is demonstrated when the notice of injury, disease, or death shows that prompt notice and claim were given and filed. The claimant has no particular responsibility unless the claim is not filed within three years after the injury. See FECA PM 2-801.

(2) The Injured or Deceased Party Was a Federal Employee. Compliance

with this requirement is usually a routine matter which is demonstrated by inspection of the notice or claim. The claimant has the burden, however, when the employer is not an agency of the United States or the Federal agency denies the employment status of the injured or deceased. See FECA PM 2-802.

(3) The Occurrence of the Injury. The claimant must show that the accident claimed did in fact occur at the time and place and in the manner alleged. The particular circumstances of the claim, including the nature of injury, the kind of accident claimed, the time when notice was given, and the time when medical care was sought, will influence the kind and amount of proof required of the claimant. See FECA PM 2-803.

(4) The Injury Occurred in the Performance of Duty. The claimant must show not only that an injury occurred but that he or she was performing official duties (or activity appropriately related to employment) at the time of injury. See FECA PM 2-804.

(5) The Disability or Death was Caused by the Injury Claimed. This requirement is satisfied on the basis of medical evidence, which is usually supplied by the attending physician. See FECA PM 2-805.

In occupational disease cases where the claim is not based upon a specific incident, the claimant must also submit sufficient evidence to identify fully the particular work conditions alleged to have caused the disease and show that the employee was exposed to the conditions claimed. It is the claimant's responsibility to prove that work was performed under these specific conditions at the time, in the manner and to the extent alleged. The nature of medical evidence required for the acceptance of specific conditions is discussed in greater detail in FECA PM 2-810.

b. Employing Agency. The FECA requires the employing agency to report to OWCP any injury resulting in death or probable disability and to submit any further information requested by OWCP. Because evidence appearing in the employer's files is not generally available to claimants, the employing agency must assemble and submit such evidence.

In addition to supplying evidence in its own behalf, the agency is expected to aid the claimant in assembling and submitting evidence. In cases where OWCP receives the claim long after the employee has left the agency's rolls, however, the agency is not expected to assist in preparing reports pertaining to the claim, nor is it expected to obtain statements from persons who no longer work for the agency. Such witnesses must be contacted by the claimant or by OWCP.

Additional evidence from other sources may be needed where the agency's confirmation of the claimant's allegations is not sufficient to establish the claim, or where the official

superior disagrees with the claimant's allegations, has no knowledge of the facts concerning the allegations, or is unable to furnish sufficient details.

c. OWCP. In administering the FECA, the OWCP must obtain any evidence which is necessary for the adjudication of the case which is not received when the notice or claim is submitted. The Office is responsible for the following:

(1) Advising the Claimant and Official Superior. The Claims Examiner (CE) must provide information about the procedures involved in establishing a claim, including detailed instructions for developing the required evidence, to all interested parties (the claimant, the employing agency, and the representative, if any).

(2) Requesting Evidence. Upon initial examination of the case, the CE should request all evidence necessary to adjudicate the case.

(3) Identifying Potential Third Party Cases. The CE should be alert for situations where a party other than another Federal employee or agency may be responsible for the injury (see FECA PM 2-1100). It is best to advise the claimant promptly of any potential third party action so that attempts at recovery may begin before the applicable State statute of limitations expires.

(4) Making Prompt Decisions. It is OWCP's obligation to render a decision on each case as promptly as possible. It is particularly essential that action be expedited in those disability cases where the injured employee is losing pay. All compensation payments must be made as promptly as possible in accordance with the timely payment procedures.

(5) Advising All Parties. The CE is responsible for notifying the claimant of unresolved issues which, if not satisfied, will lead to denial of the claim; notifying the agency of the disposition made of controverting evidence submitted by the agency; and notifying both claimant and agency of OWCP's decision in all denied cases and all cases where the claimant has not returned to work when the decision is made.

2-0800-4 Forms

4. Forms. A primary case must contain one of the notice forms listed below, and may include one or more of the claim forms. The form must identify the claimant, the employing agency, and the date of injury.

a. Forms Used.

(1) In disability cases, the appropriate forms are:

(a) Form CA-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation.

(b) Form CA-2, Federal Employee's Notice of Occupational Disease and Claim for Compensation.

(c) Form CA-7, Claim for Compensation on Account of Traumatic Injury or Occupational Disease.

(2) In death cases, the appropriate forms are:

(a) Form CA-5, Claim for Compensation by Widow, Widower, and/or Children.

(b) Form CA-5b, Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren.

(c) Form CA-6, Official Superior's Report of Employee's Death.

b. Completion of Forms. A case which is created and entered into the data base may nonetheless lack appropriate forms. If either Form CA-1, CA-2 or CA-2a are incorrectly submitted, the CE must obtain the appropriate notice of injury or disease. Submission of an incorrect form is a technical error. It is improper to deny a case on the basis that the claimant failed to submit the correct form. The CE must obtain the appropriate notice of injury or disease if it does not already appear in file.

(1) It is sometimes impossible to locate an official who has the authority, records, or knowledge of the facts to complete the reverse side of a notice of injury or claim form. This situation may arise due to a delay in reporting the injury and/or deactivation of the employing establishment. In such cases the CE should contact the Federal Records Center to obtain any information available (see paragraph 8 below).

(2) When the notice of injury or claim for compensation is received directly from the claimant, the CE should send a copy to the employing agency with a request for completion of the reverse side of the form.

If forms received from the employing agency lack essential information, which does not appear elsewhere in the file, a copy of the form must be returned for completion. The original form should always remain in the claim file.

2-0800-5 Processing Claims

5. Processing Claims. It is the policy of OWCP to minimize financial hardship to claimants by processing claims in the following order: death claims; cases where pay has been terminated, or will be terminated shortly; cases in which continuation of pay (COP) has been controverted; and uncontroverted COP cases. After ensuring that the forms are complete, the CE must evaluate them and any other material submitted to establish whether the case meets the five basic requirements of the claim. The CE will then take one of the following actions:

a. Approve the Case. When the evidence is sufficient to determine that the five basic requirements have been met, the CE should:

(1) Enter the accepted condition, case and adjudication status codes into the CMF.

(2) In traumatic injury cases, determine if COP is payable (see FECA PM 2-807). In occupational disease cases and in those traumatic injury cases where the claimant is not entitled to COP but has lost wages, determine if compensation is payable (see FECA PM 2-900) in accordance with timely payment procedures.

(3) If the claimant has not returned to work, or if a schedule award is likely due to a significant injury to a schedule member, a letter of acceptance with findings of fact on the basic requirements will be released. The letter must include the date of injury, name of the employer, accepted work-related condition(s), information regarding entitlement to COP, and instructions for filing a wage-loss claim. If the employing agency controverted the claim, the controversion must be addressed. A copy of the letter must be sent to the employing agency. Form letter CA-1008 may be used as the decision letter. CA-1009 must be released as an attachment to the decision letter.

b. Develop the Case. Development is usually undertaken by mail, although communication by telefax may be employed when an expeditious reply is required. The telephone should be used where the request involves answers to specific and simple questions, such as pay rate, date when pay stopped, or date when employee returned to work. Evidence obtained by telephone must be carefully documented in writing (on CA-110) and written confirmation should be requested from the source. In developing a claim, the CE should:

(1) Identify and request all information that will be required both to adjudicate the claim and set up payments if the case is accepted. This approach will avoid piecemeal development and delays in adjudication and payment. For instance, in a case where additional evidence is needed to establish both fact of

injury and the correct pay rate, the CE should request information pertaining to both issues at the same time even though the pay rate information is not needed immediately.

(2) Attempt to secure evidence in the custody of a Federal agency, as it is more readily available to OWCP than to the claimant. A classic example of this is exposure data of a historical nature.

(3) Avoid requesting evidence which already appears in the file or for which no need is anticipated. Such requests place an unwarranted burden on the party asked to submit the information, and unnecessary material creates a bulky file which then requires additional time to review.

(4) To the extent possible the same Claims Examiner should handle all claims involving the same part of the body for a given claimant.

c. Deny the Case. In some instances, the evidence may indicate that no additional information could possibly overcome one or more defects in the claim (for instance, a claim with a clear statement concerning incidents alleged to have caused a disability where none of the incidents occurred within performance of duty). Such a case may be denied without further development (see FECA PM 2-1400).

d. Processing a Request to Withdraw a Claim. A claimant or survivor may submit a written request to withdraw his or her claim prior to adjudication of the claim. This includes claims for a traumatic injury, occupational disease, and survivor benefits. It also applies to short-form closures cases that have not been formally adjudicated. Although a claimant or survivor may withdraw a claim, the notice itself cannot be withdrawn. [See FECA Regulations, 20 C.F.R. 10.100(b)(3), 10.101(a) and 10.105(a)]. Upon receipt of a written request from the claimant or survivor, the CE must take the following actions:

(1) In any compensation case where a written notice of intent to withdraw a claim is received prior to the adjudication of the claim, the CE must advise the claimant or survivor in writing that the claim is now viewed as withdrawn. If a request is received to reopen a withdrawn claim, a new case number should be assigned. The CE should use information from the previously withdrawn claim to develop any issues (e.g., performance of duty) on the new case.

(2) The CE should use the sample letter shown in Exhibit 1 as written notification to the claimant or survivor.

(3) The case must be coded as withdrawn and the imaged copy retained by the Office. The CE should code the claim as follows:

Adjudication Status: SU
Case Status: CL
Rep/Acc flag: N

(4) In traumatic injury cases, determine if COP is payable (see FECA PM 2-807). Any COP paid will be charged to either sick or annual leave or become an overpayment with the employing agency. The claimant, not the employing agency, should make the choice of electing either sick or annual leave.

(5) Employing agencies are not permitted to compel any employee to withdraw a claim. However, if OWCP is notified of an allegation that an employing agency has compelled a claimant or survivor to withdraw a claim, the CE must immediately advise district office management in writing.

(6) Upon notification of a credible allegation that the employing agency may have improperly compelled the claimant or survivor to withdraw a claim, the district office manager should immediately contact the employing agency by telephone or written correspondence to discuss the matter and to prevent future occurrences. The telephone conversation must be documented on Form CA-110 and imaged in the case file. (See FECA Regulations, 20 C.F.R. 10.117(b)).

(7) A claim may be reinstated if a district office manager has concerns that a claimant or survivor may have been compelled by the employing agency to withdraw his or her claim.

2-0800-6 Evidence

6. Evidence. Decisions on claims are based on the written record, which may include forms, reports, letters, and other evidence of various types such as photographs, drawings, and X-rays. Evidence may not be incorporated by reference, nor may evidence from another case file be used. Most of the evidence required in a compensation claim is obtained from the following sources:

a. Claimant. In disability cases, the claimant is the injured employee, while in death cases the claimant is the dependent seeking benefits. The claimant must always submit enough evidence to establish a prima facie case and other evidence which the Office may require.

b. Employing Agency. The employing agency is required to complete the reports and statements needed from it and then submit the evidence to OWCP. Unless the employee has long since left the agency's rolls, it should also assist the claimant in completing the notice of injury, claim form, and other evidence.

c. Witnesses. Statements from witnesses are not required in the same way as affidavits from the claimant and employing agency; a claim may be approved in the absence of witness statements. They are very useful, however, when the employing agency is unable to confirm or refute the claimant's allegations. Such statements may be obtained by the claimant, the agency, or OWCP, depending on the circumstances of the case. The agency should be asked to obtain these statements from witnesses who are its employees.

d. Medical Sources. These sources include reports of doctors and hospitals providing examination or treatment to the employee either before or after the injury. The CE should request medical evidence which is in the possession of Federal medical officers or hospitals, or which is maintained by a doctor who attended the claimant through authorizatoin by OWCP. The claimant is responsible for obtaining the medical reports in all other situations.

Requests for reports or records from a Veterans Administration (VA) hospital or clinic should be sent to the vacility which provided the service (the addresses of all VA facilities appear in the U.S. Government Organization Manual). A completed Form CA-57, Authorization for Release of Information, must accompany the request, which should also contain the employee's VA claim number, date of birth, and military service number or Social Security Number.

e. Other Sources. In most cases, the required evidence will be available from one of the sources noted above. In certain cases, however, the CE will need to request evidence from other sources. For meteorological information, the CE may contact the Department of Commerce, Environmental Data Service, National Climatic Center, Federal Building, 151 Patton Avenue, Asheville, NC 28801-5001. This agency will supply information by telephone or in writing by request.

2-0800-7 Obtaining Evidence from Employing Agencies

7. Obtaining Evidence from Employing Agencies. OWCP will attempt to obtain evidence in possession of another Federal agency. Following is a description of the procedures which should be used with respect to requests for information from employing agencies.

a. Factual Evidence. If the agency has factual evidence which is necessary to make a decision in the claim, the CE should make a written request with a copy to the claimant, indicating a time period within which the agency should reply. The agency should be advised that if it fails to provide the requested information, a decision will be made on the basis of available evidence and that the claimant's statements, if sufficiently clear and detailed, will be accepted on matters concerning which he or she is knowledgeable.

b. Medical Evidence. If it appears that the agency has medical records in its possession pertaining to the injury or to any relevant pre-existing condition, the CE should ask the agency to submit copies of such records if they are not sent with the original submission.

2-0800-8 Special Situations

8. Special Situations.

a. Group Injuries. Where two or more employees are injured in the same incident, such as an explosion or auto accident, or by the same substance, such as contaminated drinking water, the entire group of cases must be adjudicated as a unit in order to ensure uniformity of action and to minimize the amount of material to be assembled by the agency. Each case file must bear a record by name and case number of the other cases involved. Once the cases are adjudicated, they may be separated for ease in handling, provided that each case is annotated to show the disposition of the others.

b. Personnel Records for Separated Employees. Official Personnel Files (OPFs) and Employee Medical Folders (EMFs) for separated Federal employees are usually sent to the Federal Records Center (FRC) in St. Louis, MO within 30 days after separation. Therefore, in many cases where the injury is reported after the employee's separation, the CE will need to contact the FRC to obtain information necessary to adjudicate the case. The CE may handle such requests in one of two ways:

(1) Ask the employing agency to recall the OPF/EMF and supply the information required.

(2) Ask the FRC to loan the OPF/EMF to the Office. The CE may then

review the file and duplicate pertinent material.

c. Deactivated Establishments. When the employing establishment has been deactivated, the CE may obtain evidence which would otherwise be required of the employing agency in one of two ways:

(1) Obtain the pertinent evidence through the claimant or directly from the party possessing the information.

(2) Ask the FRC to loan the OPF/EMF to the Office. The CE may then review the file and duplicate pertinent material.

d. Transferred Employees. When a Federal employee transfers from one agency to another, the OPF and EMF are sent to the new agency. If the Office requires information from the OPF or EMF after the employee has transferred from the agency where the injury occurred, the original employing agency will be unable to supply it. The CE should request the information from the current employing agency.

2-0800-9 Phrasing Questions

9. Phrasing Questions. The way a question is asked can affect the amount and quality of information which will be received.

a. Types of Questions. Broadly speaking, questions can be asked in three ways:

(1) Open Questions. These queries are phrased so that the respondent has little information about what information is desired and how it is to be presented.

Example: How were you harassed on March 12, 1989?

(2) Direct Questions. These queries are phrased so as to offer little chance for interpretation. They require either yes-no answers or very short responses.

Example: Describe what occurred at the counseling session of March 12, 1989. Who was present? What was said? What happened during the session and immediately after the session?

(3) Leading Questions. These queries are phrased to suggest what the answer should be.

Example: Your supervisor indicates that you were not scheduled to work on March 12, 1989 and therefore counseling did not occur on this date. Is this correct?

b. Combined Questions. Open questions are best used when little information about a given matter is available. They require the person to present a variety of data from which the CE can choose what to pursue. The drawback to this type of question is that while a great deal of information may be received, it may not adequately address the issue if the question is not specific enough. Therefore, it is best to follow an open question with a direct question since it requires more specificity.

Example: How were you harassed on April 10, 1989? Who was present? What was said? By whom? To whom? What specific event occurred which led you to feel harassed?

Leading questions should be used only as a last resort and never in the context of a referral to an impartial medical specialist. If the respondent is unwilling or unable to respond to open or direct questions, a leading question may be the only tool remaining to collect the necessary data..

2-0800-10 Investigation

10. Investigation. As far as possible, the CE is expected to adjudicate claims on the basis of evidence obtained by correspondence. However, in cases where fraud or other criminal wrongdoing is suspected, the case must be referred for investigation to the Office of the Inspector General. Procedures for referring cases for investigation are outlined in FECA PM 2-402. The primary purpose of investigation is to obtain required evidence by personal contact with claimants, immediate superiors, co-workers, doctors, and others.

a. When to Consider Investigation. The CE should consider requesting an investigation into possible fraud where:

(1) Essential information about the employee's prior industrial and/or medical history is unavailable from the employing agency or other sources.

(2) The employing establishment cannot adequately confirm or refute the employee's allegations.

(3) Repeated requests for earnings or dependent information have not been fully answered.

(4) Information has been received from witnesses, the employing agency or relatives which bears on the level of compensation.

(5) The period of the claimant's disability is inconsistent with the type of injury sustained and a new condition emerges.

(6) An unusual pattern of repeated claims filed by the claimant emerges.

b. Prima Facie Case. The CE should not request an investigation until the claimant has stated the specific basis of the claim and established a prima facie case. Otherwise, the investigator is effectively assuming the claimant's burden of proof. Moreover, the lack of specific information concerning the claimant's allegations makes the investigator's work considerably more difficult.

2-0800-11 Obtaining Information by Telephone

11. Obtaining Information by Telephone. Use of the telephone is encouraged to obtain information where possible.

a. Factual Information. Where it appears that the claimant has difficulty in written communication, the CE should contact the claimant by telephone. In other instances, especially where the CE lacks just one or two pieces of information to take an action, it may be expedient to use the telephone. However, where there are disputes in the factual evidence the case should be considered for conferencing.

b. Medical Information. The telephone may be used to schedule examinations, request reports, and address other administrative matters. However, long-standing ECAB precedent provides that oral statements of doctors to OWCP personnel do not constitute competent medical evidence (see John M. Fuller, 9 ECAB 320). In addition, OWCP examiners may not communicate orally with a referee medical specialist on a disputed issue. Such communication must be made in writing. See FECA PM 3-500.5.b.2..

c. Documentation. The CE should complete a comprehensive and informative Form CA-110 for the file while memory of the call is still fresh.

d. Confirmation. The CE should confirm all evidence obtained over the telephone in writing. It may be sufficient to provide the party with a copy of the completed phone message, ask him or her to review the message, and advise that absent a response within 10 days, the stated information will be presumed fully accurate. Generally, further claims action should not be delayed for a response.

2-0800-12 Conferencing

12. Conferencing. In situations where written requests for information have been unsuccessful and fraud is not suspected, the CE may use conferencing as the method to obtain the necessary data for adjudication. Procedures for conferencing are fully described in FECA PM 2-500. The CE should consider conferencing in situations where:

a. Conflicting evidence exists on an issue important to the adjudication of the case, and letters have not resolved the issue.

b. The reporting procedures of the employing agency are inadequate.

c. The employing agency has controverted the claim on the issue of fact of injury or performance of duty.

2-0800-13 Affirmative Defense

13. Affirmative Defense. The law states that an injury caused by the claimant's intoxication, willful misconduct, or intent to injure self or another is not compensable. These factors are described and their development discussed in FECA PM 2-804, Performance of Duty. Any finding that one of these factors applies to a claim constitutes an affirmative defense which must be considered at the same time the five basic requirements are examined, as the ECAB has stated that an affirmative defense cannot be raised for the first time on appeal (see Hope Kahler, 39 ECAB 588). Therefore, whenever the file contains an indication that an affirmative defense may apply, that issue must be developed prior to the initial adjudication.

2-0800-14 Short-Form Closure Cases

14. Reopened Short-Form Closure Cases. The CE will need to adjudicate any reopened cases which were originally closed by the system because they were uncontroverted traumatic injury claims, the medical bills did not exceed $1500, or no wage loss claim was filed. Such reopened cases will usually contain some medical evidence, and unless they involve a late controversion by the agency, they should be adjudicated immediately. Extent and duration of injury-related disability do not have to be fully developed before adjudication.

a. Automatic Reopening. Cases closed short form will be automatically reopened if the medical bills exceed $1500, a wage loss claim is received or the CONTROVERTED INDICATOR in the CMF record is changed to "Y". If the agency submits a late controversion, the supervisor should change the CONTROVERTED INDICATOR from "N" to "Y".

b. Manual Reopening. Cases closed short form may also be reopened manually. The case should be reopened when, for example, a request for surgery is received or a recurrence claim is submitted. "

EXHIBITS

Exhibit 1 Sample Letter to Claimant or Survivor Approving Withdrawn Claim

SAMPLE LETTER TO BE SENT TO CLAIMANT OR SURVIVOR
WHEN APPROVING A WITHDRAWN CLAIM

Dear :

I have received your written request to withdraw your claim under the Federal Employees' Compensation Act (FECA). As your case file has not been adjudicated, this request is granted. Pursuant to 20 C.F.R. 10.100(3), a claimant may withdraw his or her claim (but not the notice of injury) by so requesting in writing to OWCP at any time before OWCP determines eligibility for benefits. Accordingly, the Office of Workers' Compensation Programs will take no further action in consideration of your claim.

Please note that any Continuation of Pay (COP) paid by your employer due to the filing of this claim may be converted to sick or annual leave at your choice. Should you choose not to do so, your employer may view any COP payment made as an overpayment.

Should you have any questions, please contact me at the above address or by telephone at (000) 000-0000.

Sincerely,

Claims Examiner

2-0801 TIME

Paragraph	Subject	Date	Trans. No.
1	Purpose and Scope	03/93	93-18
2	"Time" is the First Requirement Considered	03/93	93-18
3	Statutory Filing Requirements	03/93	93-18
4	Determining Date Claim is Filed	03/93	93-18
5	Traumatic Injury Claims	03/93	93-18
6	Occupational Disease and Latent Injury Claims	03/93	93-18
7	Death Claims	03/93	93-18
8	Special Circumstances	03/93	93-18
9	Further Development	03/93	93-18

2-0801-1 Purpose and Scope

1. Purpose and Scope. This subchapter presents policies and procedures for determining if a report of injury or claim for benefits under the Federal Employees' Compensation Act (FECA) is timely filed under the provisions of the Act. (Consult the FECA PM Index under "Time" for reference to Program Memorandums on several complex time issues.)

2-0801-2 "Time" is the First Requirement Considered

2. "Time" is the First Requirement Considered. All cases must first satisfy the statutory time requirements of the FECA. The Claims Examiner (CE) must therefore determine whether timely notice of injury and claim for compensation have been given and filed in all primary cases. To determine whether there has been compliance with the time requirements in any case, it must be decided what requirements govern that case.

2-0801-3 Statutory Filing Requirements

3. Statutory Filing Requirements. This paragraph discusses the provisions of the FECA which apply to timeliness of filing. The date of injury governs which time limitation provisions apply in a case. The date of injury is the date that a traumatic injury occurs, the date of death, or

the date of last injurious exposure in the case of occupational disease.

a. Injuries and Deaths on or After September 7, 1974.

(1) Written notice of injury or death must be filed within 30 days after the occurrence of the injury or death, under 5 U.S.C. 8119.

The Office of Workers' Compensation Programs (OWCP) should accept as a notice of injury or death any written document received by the employing agency or by the OWCP which is signed by the claimant or someone acting on the claimant's behalf and which contains the name of the employee, the date and location of the injury or death, and the cause and nature of the injury, or the employment factors believed to be the cause.

(2) An original claim for compensation for disability or death must be filed within three years after the occurrence of the injury or death under 5 U.S.C. 8122. If claim is not filed within three years, compensation may still be allowed if:

(a) Written notice of injury or death was given within 30 days as specified in 5 U.S.C. 8119; or

(b) The immediate superior had actual knowledge (including verbal notification) of the injury or death within 30 days after occurrence. The knowledge or notification must be such as to put the immediate superior reasonably on notice of an on-the-job injury or death.

(3) Knowledge by the immediate superior, another official at the employing agency, or any agency physician or dispensary that an employee has sustained an injury, alleges that an injury has been sustained, or alleges that some factor of the employment has resulted in a physical condition constitutes actual knowledge. Such knowledge does not have to be firsthand or acquired as an eyewitness to the accident.

(a) For confirmation in doubtful cases a statement should be requested from the person named as having actual knowledge, showing what specific knowledge the person has of the injury or disease, how and from whom this knowledge was acquired, and when it was acquired. Where treatment was received from the physician or dispensary of the employing agency, a copy of the medical record should be requested.

(b) Such knowledge or notification must be such as to put the employing agency reasonably on notice of an on-the-job injury or death. It is not sufficient that the immediate superior, official or dispensary worker at the agency was aware that the employee complained of back

pain, suffered a myocardial infarction, etc. To constitute actual knowledge, it must be found that the immediate superior, other official, or dispensary worker was aware that the employee related the back pain, MI, etc. to an injury sustained while in the performance of duty or to some factor of the employment.

(c) If an agency, in connection with a recognized environmental hazard, has an employee testing program and a test shows the employee to have positive findings this should be accepted as constituting actual knowledge. For example, an agency where employees may be exposed to hazardous noise levels may give annual hearing tests for exposed employees. A hearing loss identified on such a test would constitute actual knowledge on the part of the agency of a possible work injury.

(4) OWCP may excuse the failure to comply with the three-year time requirement under 5 U.S.C. 8122 on the ground that notice of injury or death could not be given because of exceptional circumstances. One "exceptional circumstance" recognized is a case of a claimant who could not file a claim because that person was a prisoner of war during the entire three-year period.

b. Injuries and Deaths Occurring Between December 7, 1940 and September 6, 1974.

(1) Written notice of injury should be given within 48 hours under 5 U.S.C. 8119. This requirement is automatically waived if the employee filed notice within one year after the injury or if the immediate superior had actual knowledge of the injury within 48 hours after occurrence.

(2) An original claim for compensation for disability or death must be filed within one year after the injury or death under 5 U.S.C. 8122.

(3) Waiver of the requirements for giving notice and filing a claim within one year could be granted under 5 U.S.C. 8122 if a claim was filed within five years after the injury or death, and

(a) The failure to comply was due to circumstances beyond the control of the individual claiming benefits; or

(b) The individual claiming benefits could show sufficient cause or reason in explanation of the failure to file within one year, and material prejudice to the interest of the United States did not result from such failure. Material prejudice to the interest of the United States may result in rare situations because the OWCP is unable to investigate the facts because of the passage of time, the employing agency has been

deactivated, there are no available records, and the claimant is unable to supply evidence to corroborate allegations made. In these cases, the burden is on OWCP to show that material prejudice has resulted.

The second reason for waiver can often be applied. Some examples include lack of knowledge of causal relationship between injury and disability (James T. Nunn, 1 ECAB 165) and immediate disability for work did not follow injury (Theodore E. Holmbug, 2 ECAB 195).

(4) Medical treatment for the results of an injury can be provided if timely written notice of injury was filed in accordance with 5 U.S.C. 8119, or if the immediate superior had actual knowledge of the injury within 48 hours. This is so even if a claim for compensation was not timely filed so as to permit an award for monetary compensation. For a full discussion of this situation, see Edward T. Lowery (8 ECAB 745).

c. Injuries and Deaths Prior to December 7, 1940. The FECA required that written notice of injury and claim for compensation for disability or death be given or filed within one year after the injury or death. There is no waiver provision with respect to such cases or any provision for delayed filing for latent disease or any other such circumstances.

2-0801-4 Determining Date Claim is Filed

4. Determining Date Claim is Filed. This paragraph addresses how the date of filing is determined. This date is the date of receipt of a claim by the OWCP or by the employing agency, rather than the date the claim was completed.

a. Forms CA-1, CA-2, CA-5, CA-5b and CA-7 constitute claims for the purpose of considering the time requirements. The CE must determine whether the claim was received by OWCP or the employing agency within the time specified in paragraph 3. In most cases, this may be established by:

(1) The entries on Form CA-1 or CA-2;

(2) The date of receipt noted by the employing agency or OWCP;

(3) The date the employing agency transmitted it to OWCP;

(4) The date the official superior completed the claim form; or

(5) A statement from the official superior confirming the date the claim was received by the employing agency.

b. If a prescribed claim form has not been timely filed, the CE should consider any written documents from the person claiming benefits, or someone acting on this person's behalf, from which the substance of a claim can be reasonably deduced.

(1) If the injured employee is still working, the official superior should be asked to examine the official personnel file or other records, and provide OWCP with any communication from or on behalf of the claimant which may contain words of claim.

(2) Where the injured employee is not still employed by the Federal Government, and if there is any indication of earlier communication about a claim, the CE should request the official personnel file from the Federal Records Center. If any document in this file contains words of claim the CE should place a copy in the OWCP file along with memorandum identifying the document and its source.

(3) Decisions concerning the use of a document other than a prescribed form as a claim, should be made at an adjudicative level above that of the CE.

(4) If a claim is not received by OWCP or the employing agency within the statutory time frame after the date of injury, the CE must determine when time begins to run. Time begins to run as stated in the following paragraphs depending upon the type of injury or the status and location of the person claiming benefits.

2-0801-5 Traumatic Injury Claims

5. Traumatic Injury Claims. This paragraph discusses how determinations of timeliness are made in traumatic injury cases. Time begins to run from the date of injury where the injury can be identified as to time, place, and circumstances of occurrence. The CE must be reasonably certain that the date of injury has been correctly stated. This question should receive particularly careful consideration if the reporting has been delayed to the extent that the injury may not have been reported within the appropriate time frame. Additional evidence should be obtained when the CE questions whether the date has been properly reported. Sources used to verify the date of injury include:

a. Statements from the claimant, official superior, or witnesses explaining why they believe the date of injury has been correctly stated. A statement from the official superior may address the leave and attendance records showing whether the employee (and the witnesses where so indicated) was in fact present for duty on the alleged date of the accident or during the period claimed;

b. Copies of the medical records covering the medical examinations immediately

following the injury with particular emphasis on the date of the accident shown in the history; and

c. Copies of any documents prepared immediately following or soon after the accident relating to the injury.

2-0801-6 Occupational Disease and Latent Injury Claims

6. Occupational Disease and Latent Injury Claims. This paragraph discusses how determinations of timeliness are made in occupational disease cases. In these cases, time begins to run when the injured employee becomes aware, or reasonably should have been aware, of a possible relationship between the disease or condition and the employment. Where the exposure to possible injurious employment-related conditions continues after this knowledge, the time for filing begins to run on the date of the employee's last exposure to the implicated conditions.

a. Form CA-2 requests the date the claimant first realized the presence of an occupational disease and related it to the employment, and how the employee came to this realization. Form CA-2 also requires the official superior to comment upon the claimant's statements. Where necessary, the CE should obtain additional information to clarify this issue.

b. If the claimant did not file within the statutory time limitations after exposure to the employment factors ceased, the medical reports should be examined to determine whether the claimant was aware, or reasonably should have been aware, of the illness and its possible relationship to employment. For example, the history obtained at the time of the first and subsequent examinations, the date when a definite diagnosis was made, or the advice given by the doctor to the claimant, may assist the CE in determining the issue of possible awareness.

c. If the employing agency gave regular physical examinations which might have detected signs of illness (for example, regular X-rays or hearing tests), the agency should be asked whether the results of such tests were positive for illness and whether the employee was notified of the results. [If the claimant was still exposed to employment hazard on or after September 7, 1974 and the agency's testing program disclosed the presence of an illness or impairment, this would constitute actual knowledge on the part of the agency, and timeliness would be satisfied even if the employee was not informed (see paragraph 3 a (2)(b) above.]

2-0801-7 Death Claims

7. Death Claims. This paragraph discusses how determinations of timeliness are made in death cases.

a. The statutory time requirements for filing such claims begin to run from the date of death, which normally will be determined by the official death certificate.

(1) In cases of death due to disease, time does not begin to run until the beneficiary is aware of, or by the exercise of reasonable diligence should have been aware of, the causal relationship of the death to the factors of employment [see 20 C.F.R. 10.105(c)]. Development of the question of when time begins to run in this situation should follow that outlined in subparagraph 6 above.

(2) In cases of deaths on and after September 7, 1974, the timely filing of a disability claim will satisfy the time requirements for a death claim based on the same injury.

b. For individuals who are missing under circumstances not affording immediate proof of death or those coming within the scope of the Missing Persons Act (Pub. Law 77-490), the OWCP must make its own independent finding on date of death, since the findings and date of presumptive death made under the Missing Persons Act are not binding upon OWCP. To make this finding, the following should appear in the record:

(1) Disappearance During a Period of Hostilities. The employing agency should advise the date of disappearance; whether the employee disappeared while actively participating in combat or under comparable conditions; whether the employee is accounted for as a prisoner of war or as a parolee or internee; whether there has been any official or other information concerning the employee's existence after the disappearance; and whether after termination of hostilities or declaration of peace, any information has been received which would rebut the inference of death arising from the facts. The claimant should advise whether the family has received any information as to the employee's whereabouts subsequent to the disappearance or after the restoration of normal conditions.

(2) All Other Disappearances. The employing agency should advise the date when the employee was last seen; a full description of the particular circumstances leading up to and resulting in the disappearance; and whether there has been any official or other information concerning the employee after the disappearance. The claimant should advise whether the family has received any information as to the employee's whereabouts subsequent to the disappearance.

c. A finding of death shall be made, and the date of death determined, as soon as practicable after the claim is filed, when the situation leaves little or no doubt that death occurred at the time of disappearance. Where the facts lead to a reasonable presumption that the employee may have escaped death, the determination should be deferred until enough time has elapsed to overcome the presumption of survival. In cases coming

within the scope of the Missing Persons Act, the determination will not be made while the employee is being carried in a missing status.

2-0801-8 Special Circumstances

8. Special Circumstances. The purpose of this paragraph is to address determinations of timeliness in unusual situations.

a. For a Minor. The time limitations do not begin to run until this person reaches the age of 21 or has had a legal representative appointed.

b. For an Incompetent Individual. The time limitations do not begin to run while this person is incompetent and has no duly appointed legal representative. A determination of incompetence must be based on probative medical evidence and must be consistent with other actions by the claimant during the period in question (Paul S. Devlin, 39 ECAB 715).

c. For an injury or death occurring outside the United States between December 7, 1941 and August 10, 1946. The time for giving notice and filing claim began to run on October 14, 1949.

d. Posthumous Claim. Such a claim may be made by the estate or a survivor of a deceased employee for medical benefits only. A posthumous disability claim cannot be accepted. If OWCP receives a claim within the statutory requirement outlined in paragraph 3 (three years on and after September 7, 1974 and one year prior to September 7, 1974), the claim is timely filed and no further development of this issue is necessary.

2-0801-9 Further Development

9. Further Development. Where timely written notice of injury was given or the immediate superior had timely actual knowledge of the injury, it should be accepted that the time requirements are met for further consideration of eligibility for compensation or medical benefits as appropriate. Findings must then be made on the issues of civil employee, fact of injury, performance of duty and causal relationship.

2-0802 CIVIL EMPLOYEE

Paragraph	Subject	Date	Trans. No.

Table of Contents		06/98	98-05
1	Purpose and Scope	06/95	95-25
2	Additional References	06/95	95-25
3	Proof that the Employer is an Instrumentatlity of the U.S.	06/95	95-25
4	Proof that the Injured/Deceased Individual is an "Employee"	06/95	95-25
5	Question of Applicant vs. Employee	06/95	95-25
6	Question of Independent Contractor vs. Employee	06/95	95-25
7	Postal Service Mail Messengers	06/95	95-25
8	Contract Job Cleaners Used by the Postal Service	06/95	95-25
9	Workers Serving Without Compensation	06/95	95-25
10	Volunteer Workers with the Department of Veterans Affairs	06/95	95-25
11	Attendants Authorized to Travel with DVA Patients	06/95	95-25
12	Affiliate Student Nurses of the DVA	06/95	95-25
13	Volunteer Workers with the Forest Service	06/95	95-25
14	Volunteer Weather Observers of the National Oceanic and Atmospheric Administration	06/95	95-25
15	Employees of the U.S. Property and Fiscal Officers (National Guard)	06/95	95-25
16	Employees Transferred to International Organizations	06/95	95-25
17	Loaned Employees	06/95	95-25
18	Cadets at State Maritime Academies	06/95	95-25
19	PHS Employees Detailed to a State or Local Agency	06/95	95-25
20	Grand and Petit Jurors	06/95	95-25
21	Alaska Railroad Employees	06/95	95-25
22	Participants in Community Work Experience Programs (CWEP)	06/95	95-25
23	Job Training Partnership Act	06/95	95-25
24	U.S. Park Police and Secret Service Employees	06/95	95-25
25	Volunteer Workers with the National Park Service	06/95	95-25
26	Employees of Wholly-Owned Instrumentalities of the U. S.	06/95	95-25
27	Student Volunteers, International Trade Administration	06/95	95-25
28	National Guard Civilian Youth Opportunities Pilot Program	06/95	95-25
29	NASA Exchange Employees	06/95	95-25
30	AmericCorps Members	06/95	95-25
31	Department of Defense Volunteers	06/95	95-25
32	Federal Emergency Management Agency (FEMA) Volunteers	09/96	96-28
33	Contract Observers on Vessels	06/98	98-05

2-0802-1 Purpose and Scope

1. Purpose and Scope. When it is determined that the notice of injury or claim for compensation was timely given or filed, the Claims Examiner (CE) must consider whether the injured or deceased individual was a civil employee of the United States within the meaning of 5 U.S.C. 8101(1). This chapter contains policies and procedures for making this determination.

2-0802-2 "Civil Employee" is Second Requirement Considered

2. Additional References. Further information may be obtained from the following sources:

a. FECA Program Memoranda (ProM), which discuss numerous groups of employees and provide rationale for many decisions.

b. PM Chapter 2-1700, which addresses Peace Corps and VISTA Volunteers, Neighborhood Youth Corps and Job Corps enrollees, law enforcement officers not employed by the United States, and members of the D.C. Metropolitan Police Reserve Corps.

c. PM Part 4, which discusses non-Federal law enforcement officers, claimants under the War Hazards Compensation Act and the War Claims Act, Civil Air Patrol volunteers, Reserve Officers' Training Corps (ROTC) Cadets, various Federal relief workers, foreign nationals, and Panama Canal Commission employees.

d. The FECA PM Index, which lists many groups of workers under the heading of "Employee." Also consult the Index to the decisions of the Employees' Compensation Appeals Board (ECAB).

2-0802-3 Proof that the Employer is an Instrumentality of the U.S.

3. Proof that the Employer is an Instrumentality of the U.S. The CE must first determine whether the reporting agency is a "branch of the Government of the United States" as that term is used in 5 U.S.C. 8101(1) of the FECA. Completion by the official superior of the report of injury is prima facie proof of the status of the reporting office. The CE should examine the claim forms to identify the particular agency reporting the injury.

The CE may decide this question affirmatively when the evidence clearly shows the reporting agency is a component of the legislative, judicial, or executive branch of the Government of the United States. For this purpose, the executive branch includes the Executive Office of the President, the executive departments, the independent agencies and instrumentalities of the United States. The CE should refer to the United States Government Organization Manual if the reporting agency is unfamiliar. The CE should consult with a Senior CE or supervisor if not

satisfied that the requirements have been met.

If further information is needed, the reporting office should be asked to clarify its status as a branch or instrumentality of the United States by citing the statutory authority for its existence and providing a copy of the pertinent statute. The agency should also be asked to state the source of its operating funds. The issue should then be referred, with the supporting documents, to the Director for Federal Employees' Compensation. Or, the agency may request a determination directly from the National Office.

2-0802-4 Proof that the Injured/Deceased Individual is an "Employee"

4. Proof that the Injured/Deceased Individual is an "Employee". The CE must next decide whether the injured or deceased individual had status as an officer or employee of the reporting office at the time of the injury. Here again, the supervisor's completion of a report of injury or death is prima facie proof of the worker's status as an "employee."

The CE may decide this question affirmatively when the evidence clearly shows that the service performed for the reporting office by the individual was of a kind usually performed by an employee, as distinguished from an independent contractor, and that a contract of employment was entered into prior to the injury.

Questions may arise concerning the status of volunteers or enrollees in social assistance programs. The employing agency should be asked to cite the statutory basis for accepting the services of volunteers or enrollees and to provide a copy of this legislation. The issue should then be referred, with the supporting documents, to the Director for Federal Employees' Compensation. Or, the agency may request a determination directly from the National Office.

2-0802-5 Question of Applicant vs. Employee

5. Question of Applicant vs. Employee. This question must be considered where it is unclear that a contract of hire was established before the injury or if the claimant worked at the agency prior to the injury.

a. The most usual situations involve cases where:

(1) The claimant is a casual employee;

(2) The injury occurs about the time the employment contract began or was about to begin; or

(3) The injury occurs in connection with a pre-employment examination, vaccination or immunization, or an event of a similar nature where the individual

may not have as yet acquired the status of an "employee."

b. Where the claimant's status is unclear, the CE should obtain the information noted below. Any material discrepancy in the statements must be clarified by requesting supplemental statements from principals, or by obtaining similar evidence from other sources. The CE should ask the worker and reporting agency:

(1) The precise time when the worker accepted an offer of employment from the reporting agency;

(2) Whether such agreement was verbal or written (a copy should be requested if there was a written agreement; otherwise, particulars of the agreement should be furnished);

(3) Whether the worker was required to take an oath of office and, if so, whether the oath was taken prior to the injury;

(4) What work, if any, the worker had performed for the reporting office prior to the injury; and

(5) The precise time when the worker began rendering this service and when pay began accruing.

2-0802-6 Question of Independent Contractor vs. Employee

6. Question of Independent Contractor vs. Employee.

a. Contract Employees. Not every person rendering service for the Federal government is necessarily an "employee."

Many such individuals are independent contractors or employees of independent contractors and have no status under the FECA. For this reason the CE must be particularly careful to determine whether the worker is an independent contractor or an "employee." Where this issue becomes a factor, the CE should request statements from the worker and the reporting agency, to show:

(1) Whether the worker performs services or offers services to the public generally as a contractor or is permitted to do so by the reporting agency and, if so, a full explanation;

(2) Whether the worker is required to furnish any tools or equipment and, if so, a full explanation;

(3) The period of time the work relationship is to exist;

(4) Whether the reporting agency has the right to discharge the worker at any time and, if so, when and under what circumstances;

(5) Whether the reporting agency has any right to control or direct how the work is to be performed and, if so, a full explanation;

(6) The manner in which payment for the worker's services is determined; and

(7) Whether the activity in which the worker was engaged was a regular and continuing activity of the reporting agency and, if not, a full explanation.

b. Proof of Status. Any material discrepancy in these statements must be clarified by requesting supplemental statements from the principals, or by obtaining similar evidence from other sources. A copy of the contract or agreement should be obtained if there was a written instrument to support the agreed-upon work relationship. Proofs of employee status are similar to those for regular employees of the United States.

2-0802-7 Postal Service Mail Messengers

7. Postal Service Mail Messengers. Determinations of whether mail messengers who perform service for the U.S. Postal Service are considered civil employees are made on a case-by-case basis. These cases should be referred to a Senior CE.

Before referral, the CE should ask the reporting agency for copies of any written agreement or work contract executed by the mail messenger or the Postal Service when the injured individual began working or at any later date, and of any oath executed by the worker. Absent a written contract, the postmaster and the mail messenger should be asked to submit statements showing in full detail the terms of the oral agreement and the precise manner in which it was reached.

The reporting agency should also be asked to submit a statement showing:

a. The manner in which the worker qualified and was selected to act as mail messenger;

b. The distance the mail was carried;

c. The kind of equipment used and by whom it was furnished;

d. Whether the mail messenger was required to personally perform the service or whether assistants or substitutes were permitted and, if so, under what conditions and circumstances;

e. Whether the mail messenger had any other employment or performed or offered like or similar services to the public as an independent business service and, if so, this should be explained fully;

f. The manner and circumstances under which the relationship could be terminated;

g. The manner in which the pay was determined;

h. Who determined how, when, and in what manner the mail would be carried; and

i. What right, if any, the postmaster had to direct or supervise the work performed by the mail messenger and to what extent the postmaster exercised this right.

2-0802-8 Contract Job Cleaners Used by the Postal Service

8. Contract Job Cleaners Used by the Postal Service. In lieu of using employees with civil service appointments, the U.S. Postal Service frequently contracts for the services of individuals to perform janitorial work. The contracts consist of signed agreements, which may result from negotiation or invitation-bid. Determinations of whether contract job cleaners are civil employees under the FECA are made on a case-by-case basis and will depend on the particular facts of each case.

Cases of contract job cleaners are to be referred to a Senior CE for adjudication. The Senior CE should request:

a. A copy of the Postal Service agreement form under which the worker was serving when injured;

b. A statement from the postmaster showing the extent to which there was a right to control the manner of the worker's performance and the amount and extent of the control exercised over the worker; and

c. A statement from the contract job cleaner showing whether the injured person worked for any employer other than the Postal Service during the year before the injury and, if so, the employers' names and addresses and the inclusive dates worked, the kinds of work performed, the rates of pay, and the total amounts earned from each employer.

2-0802-9 Workers Serving Without Compensation

9. Workers Serving Without Compensation. Except for cases of certain volunteers with the Department of Veterans Affairs (see paragraphs 10-12 below) and certain volunteers with the

U.S. Department of Agriculture, Forest Service (see paragraph 13 below), determinations of civil employee status for volunteers must be made by a Senior CE or higher adjudicative authority.

a. Statutory Authority. In any case where status as a civil employee is claimed by reason of 5 U.S.C. 8101(1)(B), the CE must obtain a statement from the reporting agency citing the statutory authority by which the services of the injured or deceased individual were used. (See paragraph 4 concerning referral of such issues to the National office.)

b. Kind of Service Rendered. The CE must also ensure that the evidence shows whether the injured or deceased individual was "rendering a personal service of a kind similar to those of civilian officers or employees of the United States."
If such evidence is not received with the initial submission, the CE should ask the reporting agency to submit a statement which fully describes the services rendered by the injured or deceased individual and shows whether the agency has persons on its payroll who render similar services and, if so, the job titles for those positions.

2-0802-10 Volunteer Workers with the Department of Veterans Affairs

10. Volunteer Workers with the Department of Veterans Affairs. OWCP has determined that the Department of Veterans Affairs (DVA) has statutory authority to use the services of persons who serve without compensation in its Volunteer Service Program. Therefore, the CE need not ask the DVA to cite its statutory authority for using the services of these individuals.

However, the CE must be certain that the injured or deceased individual was "rendering a personal service of a kind similar to those of civilian officers or employees of the United States" as required by 5 U.S.C. 8101(1)(B). (See instructions in preceding paragraph.)

The CE may affirmatively determine the status of these individuals when the service performed by the injured or deceased individual is clearly like the services in well-established positions in the Federal service, e.g., nurse's aide, recreation supervisor, etc. Otherwise, the question should be submitted for determination by a Senior CE or higher adjudicative authority.

2-0802-11 Attendants Authorized to Travel with DVA Patients

11. Attendants Authorized to Travel with DVA Patients. OWCP has ruled that a person has status as an "employee" while traveling under an authorization from the DVA as an attendant for one of its beneficiaries. The authority for the DVA to use the services of these individuals appears in Pub. Law 76-432 (38 U.S.C. 76), as amended. In any case of this nature, the CE should ask the DVA to submit:

a. A copy of the authorization issued to the attendant by the Department of Veterans Affairs; and

b. A statement showing whether the services of the injured or deceased individual were used pursuant to the provisions of Pub. Law 76-432 (38 U.S.C. 76), as amended. The CE may affirmatively determine the status of these individuals when the attendant was serving under a valid authorization and it is shown it was issued pursuant to this legislation.

2-0802-12 Affiliate Student Nurses of the DVA

12. Affiliate Student Nurses of the DVA. OWCP has determined that an affiliate student nurse of the DVA has status as an "employee" when appointed for training pursuant to section 14A, Pub. Law 79-293. In any case of this nature the CE should ask the DVA for a statement showing whether the services of the injured or deceased individual were used pursuant to the provisions of this section. The CE may determine the status of these individuals affirmatively when it is shown they were serving under the authority of this legislation.

2-0802-13 Volunteer Workers with the Forest Service

13. Volunteer Workers with the Forest Service. A volunteer with the U.S. Department of Agriculture, Forest Service, whose services are accepted or used under the authority of Pub. Law 92-300 (Volunteers in the National Forests Act of 1972) has status as an employee by virtue of section 3(c) of that Act.
Therefore, in cases of volunteers with the Forest Service, the CE should ask the employing agency for a statement showing whether the services of the injured or deceased individual were used pursuant to the provisions of that law. The CE may determine the status of the individual affirmatively when it is shown that the services were accepted or used under the authority of this legislation.

2-0802-14 Volunteer Weather Observers of the National Oceanic and Atmospheric Administration

14. Volunteer Weather Observers of the National Oceanic and Atmospheric Administration. The National Oceanic and Atmospheric Administration (NOAA) has many small weather stations where, by agreement, individuals make observations on a voluntary basis without pay. They are known as "volunteer weather observers." The operation of the station may be by agreement with:

a. Individuals who make observations on their own time. These individuals have status as employees while actually engaged in taking the observations or while performing activities incidental to making the observations. The CE may determine the

status of these individuals affirmatively when the evidence clearly shows the agreement to operate the station was with the individual.

b. A company or institution, where its employees take the observations as part of their regular duties. These individuals do not have status as employees.

c. Individuals who are employees of a company or institution and who are permitted to take observations on company time. The status of these individuals is questionable and such cases should be referred to a Senior CE for final determination after the facts have been developed fully.
The CE should ask the NOAA to submit a copy of the agreement made with the individual, company, or institution for the operation of the weather station. If this agreement is not sufficiently detailed or otherwise fails to clarify the status of the injured or deceased individual, additional information should be requested of the NOAA, the injured individual or claimant, or the company or institution which may also be involved. In many of cases involving individuals (subparagraphs 14a or 14c), the more difficult issue is whether the injury occurred in the performance of duty, and particular attention should be given to the guidance in FECA PM 2-804.

2-0802-15 Employees of the U.S. Property and Fiscal Officers (N. Guard)

15. Employees of the U.S. Property and Fiscal Officers (National Guard). All cases in this category must contain a statement from the U.S. Property and Fiscal Officer (or from some other responsible and knowledgeable official of the National Guard) certifying that the injured or deceased individual was a civil employee of the U.S. paid from Federal funds, and at the time of injury was performing duties in a civilian status. These agencies have been instructed to submit this certification with the original reports on Form CA-1 or CA-2. It should be requested from the reporting agency if it is missing.

a. This certificate is required because these civilian caretakers and technicians serve in a dual capacity:

(1) As members of the State National Guard in a military capacity, and

(2) As employees of the U.S. Property and Fiscal Officer in a civilian capacity. This certification is prima facie proof that at the time of the injury, the injured or deceased individual had status as an employee.

b. The CE may accept this certificate and affirmatively determine the employee's status on this basis, unless the particular facts and circumstances of the case or other evidence creates doubt whether the certification is correct. The CE should consult with the Senior CE or supervisor if it is felt that certification is not valid.

2-0802-16 Employees Transferred to International Organizations

16. Employees Transferred to International Organizations. A Federal employee who transfers to an international organization retains the coverage, rights and benefits of the FECA if, prior to the transfer, the employee was serving under a Federal appointment not limited to one year or less, and the head of the Federal agency consented to the transfer (see Pub. Law 85-795).

In any case of injury or death to a Federal employee after transfer to an international organization, the CE should ask that the forms, reports, or certificates required of an official superior be completed and signed by an appropriate official of the Federal agency which originally employed the claimant.

Alternatively, forms, reports, claims, etc., will be acceptable when completed by an official of the international organization if they are either countersigned by an official of the Federal agency, or accompanied by a certificate from the Federal agency confirming the employee's employment status and duty status at the time of the accident.

Additionally, an appropriate official of the Federal agency should be asked to submit a statement showing the following:

(1) Whether, prior to the transfer to the international organization, the employee was serving with the Federal agency under a Federal appointment not limited to one year or less; and

(2) Whether the employee transferred to the international organization with the consent of the head of the Federal agency as provided by Pub. Law 85-795. In this situation the Federal agency should always be asked to act as the reporting office.

2-0802-17 Loaned Employees

17. Loaned Employees. Careful consideration must be given to the employment status of Federal employees who are injured while performing service for a private employer. The CE must determine whether the injured or deceased individual was merely loaned to the private employer and retained status as a Federal employee, or whether a transfer of employment occurred, thereby terminating the prior status as a Federal employee. The CE should obtain a statement from the reporting agency which shows:

a. The citation of any statute which authorizes the injured or deceased individual to perform service for a private employer;

b. The name of the person who had immediate control and direction of the work activities of the injured or deceased individual at the time of the injury;

c. What right or general responsibility, if any, the reporting agency had at the time of the injury to direct or control the work activities of the injured or deceased individual;

d. From whom the injured or deceased individual received salary at the time of the injury. If the private employer paid the salary, did the reporting agency reimburse that employer from Federal funds appropriated for the payment of personal services, and if so, how;

e. Whether after completion of the assignment the injured or deceased individual was expected to resume the performance of service for the reporting agency and, if so, when and under what circumstances;

f. What interest, if any, the reporting agency had in the work being performed by the private employer; and

g. What benefit, if any, the reporting agency derived from the service performed for the private employer by the injured or deceased individual.

2-0802-18 Cadets at State Maritime Academies

18. Cadets at State Maritime Academies. OWCP has determined that cadets at state maritime academies in Maine, Massachusetts, New York, Texas and California are eligible to receive the benefits of the FECA by reason of their status as enrolled members of the United States Maritime Service. The reports and certificates which OWCP requires of an official superior may be completed by an appropriate official of the state academy, who will in turn forward them to the Director, Office of Maritime Labor and Training, U.S. Department of Transportation, Maritime Administration, 400 Seventh Street, S.W., Washington, D.C. 20590.

The Washington office of the Maritime Administration will make the necessary inquiries and otherwise determine the accuracy of the reports and then forward them to the proper OWCP district office. The original submission of the basic compensation reports must include a certification from the Supervisor for State Maritime Academies showing whether at the time of the injury the individual was enrolled as a cadet in the U.S. Maritime Service.

2-0802-19 PHS Employees Detailed to a State or Local Agency

19. PHS Employees Detailed to a State or Local Agency. U.S. Public Health Service employees who are assigned to state or local agencies either maintain their Federal status in all respects, including entitlement to compensation, or are carried by PHS on leave without pay status and are paid by the state. In either case, they are entitled by law to benefits of the FECA.

In all cases of PHS employees injured while assigned to state or local agencies, inquiries should be made to determine if they are receiving or have received benefits under a state compensation law. If so, the Public Health Service Act of 1943 requires that an election should be requested and must be made within one year. If the claimant elects FECA coverage, the state should be reimbursed from any compensation due, and the balance should be paid to the claimant.

2-0802-20 Grand and Petit Jurors

20. Grand and Petit Jurors. Pub. Law 97-463, effective January 12, 1983, provides that persons serving as grand or petit Federal jurors are entitled to benefits under the Act, for injuries occurring on or after that date.

a. Coverage of jurors is limited to injury in, or arising from, situations where the juror is:

(1) In attendance at court pursuant to a summons.

(2) In deliberation.

(3) At a location, such as the scene of a crime, for the purpose of taking a view.

(4) Sequestered by order of a judge.
A juror is not covered while traveling to and from home.

b. The pay rate for compensation purposes for grand or petit Federal jurors will be that of a GS-2, step 1, unless the juror is a Federal employee. In that case the pay rate is based on the juror's actual Federal employment and is determined in accordance with 5 U.S.C. 8114. Entitlement to compensation for disability does not begin until the day after termination of service as a juror.

c. The continuation of pay provisions of 5 U.S.C. 8118 would only apply if the juror is a Federal employee who would be entitled to COP by virtue of the definition given at 5 U.S.C. 8101(1)F.

d. Jurors who are not otherwise Federal employees are entitled to all rights and benefits under the FECA, aside from COP.

e. The clerk of the court, or a designee, will serve as the official superior in these cases.

2-0802-21 Alaska Railroad Employees

21. Alaska Railroad Employees. The Federal Railroad Administration and the State of Alaska have transferred the Alaska Railroad to State control. As part of the transfer agreement, it was determined that all compensation cases involving injuries or occupational diseases occurring on or after January 6, 1985 were the responsibility of the State of Alaska through the Alaska Railroad Corporation. On that date, employees of the Alaska Railroad ceased to be employees of the Federal government for purposes of the Act.

a. Injuries sustained before January 6, 1985 are covered under the FECA, and the Federal Railroad Administration of the Department of Transportation is the responsible Federal agency. Inquiries about cases arising because of injury or exposure which occurred on or after January 6, 1985 should be referred to:

Mr. Marvin Yetter
Comptroller
Alaska Railroad Corporation
Pouch 7-2111
Anchorage, Alaska 99510

b. In an occupational disease case where exposure to employment factors claimed as injurious occurs on or after January 6, 1985, the CE should return the claim to the claimant and advise that the FECA does not apply. The claimant should be instructed to contact the Alaska Railroad Corporation at the address noted above. Where exposure ended prior to January 6, 1985, the FECA continues to apply, and such cases will be handled in the usual manner.

c. If it is not clear when exposure ceased, or whether a "recurrence" is a "new injury," it may be necessary to create a case and develop the issue. In any event, any request from a claimants for a formal decision on the coverage of the FECA should be honored.

2-0802-22 Participants in Community Work Experience Programs (CWEP)

22. Participants in Community Work Experience Programs (CWEP). On July 18, 1984, the Congress passed Pub. Law 98-369, which determined that participants in community work experience programs at Federal agencies are not to be considered Federal employees. Further, it held that:

> The State agency shall provide appropriate workers' compensation and tort claims protection to each participant performing work for a Federal office or agency...on the same basis as such compensation and protection are provided to other participants...in the State.

While CWEP participants hosted by Federal agencies would qualify as Federal employees for the purpose of the FECA, as long as a Federal supervisor controlled the work activities, the intent of Congress in passing the above-cited legislation is clear. Therefore, it has been determined that for the purpose of the FECA, a participant working at a Federal installation under the supervision of a Federal employee prior to July 18, 1984 is entitled to coverage under the Act.

a. Where an injury is sustained before July 18, 1984, the CE should determine if it occurred while the participant was hosted at a Federal facility and whether the work activities were controlled by a Federal employee. If so, the participant is to be considered covered under the FECA.

b. Where an injury is sustained on July 18, 1984 or later, the case should be denied on the basis that the claimant is not considered an employee of the Federal government for purposes of the FECA.

2-0802-23 The Job Training Partnership Act (JTPA)

23. The Job Training Partnership Act (JTPA). The JPTA superseded the Comprehensive Employment and Training Act (CETA), and training programs covered under the JTPA have superseded CETA training programs, which have been discontinued. (The JTPA continues to fund the Job Corps, whose enrollees are covered under 5 U.S.C. 8143.)

Some Federal agencies host participants in JTPA training programs (participants are sponsored by State agencies, local organizations which have contracted to operate programs, etc.) Similar to CETA enrollees, program participants hosted at a Federal installation who are under the technical direction and supervision of a Federal employee are employees for compensation purposes under 5 U.S.C.8101(1).

a. Where a participant in a JTPA training program is hosted at a Federal installation, the participant will be considered to be an employee for the purposes of the FECA, where the work performed is under the technical direction and supervision of a Federal employee.

b. The hosted participants who meet the criteria in subparagraph 23a above are considered to be civil employees under the provisions of 5 U.S.C. 8101(1)(B) and are not entitled to continuation of pay (COP) under 5 U.S.C. 8118. They are not direct employees of the Government.

2-0802-24 U.S. Park Police and Secret Service Employees

24. U.S. Park Police and Secret Service Employees. The Federal Employees' Retirement System Act of 1986 removed U.S. Park Police officers and Secret Service officers hired after December 31, 1983 from entitlement to certain medical and disability benefits granted in Title 4 of the District of Columbia Code. These individuals are now covered under the FECA.

a. Park Police and Secret Service officers and agents hired after December 31, 1983 are covered by the FECA for injuries at work which occurred on or after January 1, 1987. In occupational disease cases, injurious exposure on or after January 1, 1987 would entitle the officer to FECA coverage for periods of disability subsequent to that date.

b. For these officers, any recurrence of disability due to an injury or illness occurring prior to January 1, 1987 is covered under Title 4 of the District of Columbia Code. If such a claim is filed with FECA, it should be denied, and the employing agency should be notified of the recurrence of a prior injury.
However, an event at work on or after January 1, 1987, which aggravated a previously established condition would bring the officer under FECA coverage for subsequent disability, since a new injury would be involved. Medical records of previous treatment may be requested from the claimant and the employing agency.

2-0802-25 Volunteer Workers with the National Park Service

25. Volunteer Workers with the National Park Service. Pub. Law 91-357 (Volunteers in the Parks Act of 1969) authorizes the U.S. Department of the Interior, National Park Service to use the services of volunteers in the national parks, and such individuals are considered employees by virtue of section 3(c) of that Act. Therefore, in any case involving a volunteer with the Park Service, the CE should ask the reporting agency to state whether the services of the injured or deceased individual were accepted or used according to the provisions of Pub. Law 91-357. If so, the individual may be considered a civil employee.

2-0802-26 Employees of Wholly-Owned Instrumentalities of the U.S.

26. Employees of Wholly-Owned Instrumentalities of the U.S. Section 8101(1)(A) of the FECA provides coverage for employees of "an instrumentality wholly owned by the United States". Such entities may include corporations established for the specific purpose of supporting a government agency, as with research corporations funded to support projects directed by the Department of Veterans Affairs, and which are authorized by Pub. Law 100-322. Workers in such organizations may be considered civil employees.

2-0802-27 Student Volunteers, International Trade Administration

27. Student Volunteers, International Trade Administration. These volunteers for the U. S.

Department of Commerce may be U.S. citizens or foreign nationals. Their services are specifically authorized under 5 U.S.C. 3111, which states that they are considered Federal employees under 5 U.S.C. 8101 et seq. They work under a Volunteer Service Agreement (VSA) and are supervised by the Foreign Commercial Service Officer at the assigned mission. According to the VSA, their duties include assignments such as conducting market research, preparing reports, drafting replies to correspondence, and promoting and recruiting exhibitors for trade events. These volunteers may be considered civil employees.

2-0802-28 National Guard Civilian Youth Opportunities Pilot Program

28. National Guard Civilian Youth Opportunities Pilot Program. Participants in this program, which was established by the Defense Authorization Act of 1993 and which is also known as the Youth Challenge Program, undergo military-based training which includes supervised work experience in community service and conservation projects. The enrollees may be considered civil employees for purposes of coverage under the FECA, since the Defense Authorization Act specifically authorizes their services and states that they will be considered Federal employees under 5 U.S.C. 8101 et seq.

The law defines performance of duty for these enrollees much as FECA PM Chapter 2-1700.6c describes it for Job Corps enrollees.

The guidance in that chapter should be used in making performance of duty determinations for enrollees in the Youth Opportunities Pilot Program.

2-0802-29 NASA Exchange Employees

29. NASA Exchange Employees. Employees of exchanges operated by the National Aeronautics and Space Administration (NASA) work in cafeterias and other facilities designed for the welfare of NASA employees. These exchanges are similar to those operated by the armed forces, whose employees are covered under the Longshore and Harbor Workers' Compensation Act (LHWCA) rather than the FECA. Because the LHWCA covers only employees of the armed forces, it has been determined that NASA exchange employees are to be considered civil employees under the FECA.

2-0802-30 AmeriCorps Members

30. AmeriCorps Members. The Commission on National and Community Service administers the American Conservation and Youth Corps, which makes grants to states or other applicants (non-profit groups) to fund youth service corps. The participants are not generally considered Federal employees, even though some may work directly for Federal agencies. However, section 42 U.S.C. 12655n (b)(2) states in part that:

a participant or crew leader serving in a program that receives assistance under this subtitle...shall be considered an employee of the United States...as defined in section 8101 of title 5, United States Code, and the provision of that subchapter shall apply, except--

(A) the term "performance of duty", as used in such subchapter, shall not include an act of a participant or crew leader while absent from the assigned post of duty of such participant or crew leader, except while participating in an activity authorized by or under the direction and supervision of a program agency (including an activity while on pass or during travel to or from such post of duty); and

(B) compensation for disability shall not begin to accrue until the day following the date that the employment of the injured participant or crew leader is terminated.

The CE should inquire whether the crew leader or participant was serving with a Federal agency, a non-profit agency which received a grant directly from the Commission on National and Community Service, or with a state program. Only in the first two instances may the AmeriCorps member be considered a Federal employee for purposes of coverage under the FECA.

The pay rate for these workers is set at the GS-5, step 1 level. They are not entitled to receive continuation of pay (COP).

2-0802-31 Department of Defense Volunteers

31. Department of Defense Volunteers. The National Defense Act of 1995 (Pub. Law 103-337) authorized a six-month pilot program expanding the Department of Defense's authority to accept the services of volunteers at designated installations. The pilot will end on August 31, 1995, but it is anticipated that the program will continue after that date.

a. Services. These volunteers will perform a variety of services in medical, dental, nursing, and other health-care settings; museums and natural resources programs; and family support programs, child development and youth activities, libraries, educational and religious settings, housing referral, spouse employment assistance, and morale, welfare and recreation programs.

b. Coverage. The law specifically provides coverage under the FECA for these volunteers, except that those volunteers working for non-appropriated fund instrumentalities are covered for workers compensation purposes by the Longshore and Harbor Workers' Compensation Act.

c. Pay Rate. The law also specifies that the monthly pay rate for these volunteers is to be determined by multiplying the average monthly number of hours that the person provided the services by the minimum wage determined under the Fair Labor Standards Act.

2-0802-32 Federal Emergency Management Agency (FEMA) Volunteers

32. Federal Emergency Management Agency (FEMA) Volunteers.
The Robert T. Stafford Disaster Relief and Emergency Act, P.L. 93-288, as amended, 42 U.S.C. 5121, et. seq., authorizes the FEMA to form Urban Search and Rescue (US&R) Response system member squads from state and local police, firefighter and emergency medical personnel. The squads train at FEMA's direction and according to FEMA's requirements, so they are ready when activated in case of a disaster. FEMA transports them to the disaster and directs their actions for the duration of the crisis. A FEMA employee will complete the supervisor's part of the notice of injury, illness or death.

2-0802-33 Contract Observers on Vessels

33. Contract Observers on Vessels. Public Law 104-297, enacted on October 11, 1996, provides that observers on vessels who are under contract to carry out responsibilities under the Magnuson-Stevens Fishery Conservation and Management Act or the Marine Mammal Protection Act of 1972 shall be considered Federal employees for the purpose of compensation under the FECA.

Contract observers are employed in private industry to carry out the requirements of these Acts, which are under the jurisdiction of the Department of Commerce. Since these individuals are not Federal employees, the Department of Commerce will not be directly involved in the claims process. All claims from contract observers and their survivors will be forwarded to the National Operations Office (District 25) without jacketing.

2-0803 FACT OF INJURY

Paragraph	Subject	Date	Trans. No.
1	Purpose and Scope	06/95	95-23
2	Components of Fact of Injury	06/95	95-23
3	Sources of Evidence	06/95	95-23
4	Development of Factual Evidence	06/95	95-23

2-0803-1 Purpose and Scope

1. Purpose and Scope. This chapter contains guidelines for determining fact of injury. After the elements of "time" and "civil employee" have been considered, the Claims Examiner (CE) must decide whether the employee sustained a personal injury.

The term "injury" includes both traumatic incidents and occupational illnesses. This chapter addresses traumatic injury, i.e., a condition attributable to a definite occurrence which can be assigned to a time and place during one work day or shift. PM 2-806 addresses occupational illness, i.e., a condition which arises over more than one work day or shift. For a claim based on both traumatic injury and occupational illness, the CE should be guided by the instructions applicable to both.

2-0803-2 Components of Fact of Injury

2. Components of Fact of Injury.

a. This element of the claim consists of two components, which must be considered together:

(1) Whether the claimant actually experienced the accident, untoward event, or employment factor which is alleged to have occurred. This is a factual determination.

(2) Whether a medical condition has been diagnosed in connection with this event. To make this determination, medical evidence is required.

b. The need to consider both of these factors is described in the decision of the Employees' Compensation Appeals Board in Elaine Pendleton, 40 ECAB 1143, 1147 (1989):

> Establishing whether an injury, traumatic or occupational, was sustained in the performance of duty as alleged, i.e. "fact of injury," and establishing whether there is a causal relationship between the injury and any disability and/or specific condition for which compensation is claimed, i.e. "causal relationship," are distinct elements of a compensation claim. While the issue of "causal relationship" cannot be established until "fact of injury" is established, acceptance of fact of injury is not contingent upon an employee proving a causal relationship between the injury and any disability and/or specific condition for which

compensation is claimed. An employee may establish that an injury occurred in the performance of duty as alleged but fail to establish that his or her disability and/or specific condition for which compensation is claimed are causally related to the injury.

2-0803-3 Sources of Evidence

3. Sources of Evidence. To determine whether the injury occurred, the CE should consider the following evidence:

a. A statement from the claimant, or someone acting on the claimant's behalf, indicating the nature of the injury and showing when, where, and how it occurred. Such a statement is mandatory.

b. A statement from the supervisor confirming that the alleged injury occurred. A positive statement from the supervisor (or compensation specialist) is required, except where the injury occurred under circumstances such that employing agency personnel could not or probably would not have personal knowledge of its occurrence.

c. Statements from one or more witnesses confirming or refuting the claimant's allegations concerning the occurrence of the injury. The absence of statements from witnesses does not defeat a compensation claim if the claimant's statements and course of action are consistent with the surrounding facts and circumstances and otherwise appear to be true. However, witness statements should be requested if the occurrence of the incident is in doubt.

d. A medical report from the treating physician which provides a diagnosis linked to the injury. The report does not need to address causal relationship between the incident claimed and the medical condition diagnosed. The report also does not need to address any disability which may have resulted from the injury. But a medical condition, however minor or seemingly incongruous, must be stated. Findings of pain or discomfort alone do not satisfy the medical aspect of the fact of injury determination.

2-0803-4 Development of Factual Evidence

4. Development of Factual Evidence.

a. The CE should study the evidence to assess whether it is consistent and detailed enough to establish that the injury occurred at the time and place and in the manner alleged by the claimant. If not, the CE should request clarification and/or additional evidence from one or more of the parties noted in paragraph 3 above.

b. Witness statements should be requested through the supervisor if the CE decides that they are needed. Where no witnesses are named on Form CA-1, the CE should ask the supervisor to arrange for submission of statements from coworkers or others who may have observed the injury. If no witness statements are submitted in response to these inquiries, the CE may wish to ask the claimant and supervisor why they cannot be furnished.

c. Problematic situations include those where one or more of the following conditions pertain: the injury was not promptly reported, medical treatment was not obtained right after the injury, the supervisor did not witness the injury, and/or no witnesses to the injury have been identified. In such instances the CE should obtain, as appropriate:

(1) A statement from the supervisor as to how the information submitted about the injury was obtained, and when it was acquired.

(2) A statement from the claimant addressing one or more of the following issues:

(a) Whether the claimant had a similar condition prior to the alleged injury. If so, full details should be provided, accompanied by medical reports describing the treatment rendered.

(b) Whether the claimant ever had a similar injury. If so, full details should be provided, accompanied by medical reports describing the treatment rendered.

(c) Whether the claimant knew of the requirement under the FECA to provide prompt notice of injury and why the claimant did not do so.

(d) Why the claimant delayed seeking medical care.

Form CA-1011 or a narrative letter may be used to obtain this information. However, medical reports in the possession of the employing agency should be requested directly from the supervisor.

2-0803-5 Development of Medical Evidence

5. Development of Medical Evidence. A medical report must appear in file before fact of injury can be affirmatively determined. If it does not appear, the CE should request it. As noted in paragraph 3d above, the report must contain a diagnosis in connection with the claimed incident.

a. If such a diagnosis is present, the CE may continue developing the claim with respect to whether the injury occurred within performance of duty, and whether the condition stated by the physician is causally related to the injury or illness claimed. Causal relationship is a separate issue from fact of injury, even though medical evidence is needed to establish both aspects of the claim. A case with a diagnosis present should never be denied on the basis that fact of injury is not established.

b. If such a diagnosis is not present, the claim should be denied on the basis that fact of injury is not established. It is not necessary to develop the claim further, and causal relationship should not be stated as a basis for the denial.

c. An example of the distinction to be made is as follows: The claimant alleged that he sustained a herniated disc while bending over to tie his shoe at work, and the supervisor confirmed that the incident occurred as described. The medical report from the attending physician contained a history of the injury and a diagnosis. This evidence is sufficient to establish fact of injury.

If no diagnosis was present, the case could be denied without further development on the basis that fact of injury had not been established.

2-0804 PERFORMANCE OF DUTY

Paragraph	Subject	Date	Trans. No.
Table of Contents		07/97	97-19
1	Purpose and Scope	08/92	92-32
2	Adjudication	08/92	92-32
3	Terminology and Sources of Evidence	09/95	95-34
4	Industrial Premises	08/92	92-32
5	Off-Premises	08/92	92-32
6	To and From Work	08/92	92-32
7	Diversions from Duty	08/92	92-32
8	Recreation	08/92	92-32
9	Idiopathic Falls	08/92	92-32
10	Assault Cases	08/92	92-32
11	Horseplay	08/92	92-32
		03/94	94-16
12	Coworker Harassment or Teasing	03/94	94-16
		01/97	97-07
13	Prohibited Activities	03/94	94-16
14	Statutory Exclusions	03/94	94-16

		09/95	95-34
15	Suicide	03/94	94-16
		09/95	95-34
16	Representational Functions	03/94	94-16
		07/97	97-19
17	Work-Connected Events Which Are Not Factors of Employment	03/94	94-16
		01/97	97-07
		07/97	97-19
18	Employing Agency Physical Fitness Programs	03/94	94-16
19	Deleterious Effects of Medical Services Furnished by the Employing Establishment	03/94	94-16

2-0804-1 Purpose and Scope

1. Purpose and Scope. This chapter contains guidelines for determining the question of "performance of duty". Additional references may be obtained from the FECA Procedure Manual Index. Also consult the Index to the decisions of the Employees' Compensation Appeals Board (ECAB). After the questions of "time," "employee," and "fact of injury" have been determined affirmatively, the Claims Examiner (CE) should decide whether the employee was in the performance of duty when the injury occurred.

2-0804-2 Adjudication

2. Adjudication. The performance of duty question may be decided affirmatively by the CE if there is no conflict in the evidence and if the facts establish that the employee was in a duty status. Adverse determinations and determinations requiring evaluation of conflicting evidence and/or involving borderline situations must be made at an adjudicative level above that of the CE. If it appears that any of the statutory exclusions to compensation set forth in 5 U.S.C. 8102(a)(1), (2) and (3) may be applicable, evidence to make a determination must be obtained in accordance with paragraphs 13 and 14 of this chapter.

2-0804-3 Terminology & Sources of Evidence

3. Terminology and Sources of Evidence. Certain statutes administered by the Office, relating mainly to military or quasi-military establishments, stipulate that injury or death must have occurred in the "line of duty" for compensation to be paid. This phrase does not appear in most workers' compensation statutes. The Office's policy is to follow, to the extent possible, the principles and interpretations applied by the particular service which employed the disabled or deceased individual. Such "line of duty" determinations, however, are subject to review for

conformance with the "performance of duty" concept.
The question of performance of duty is determined by the same evidence outlined in FECA PM 2-800.6 and by the answers to questions on Forms CA-1, CA-2 and CA-6.

2-0804-4 Industrial Premises

4. Industrial Premises. An employee who has a fixed place of employment, and is injured on the premises of the employer, has the protection of the FECA unless one of the statutory exclusions applies or the employee was doing something unconnected with the employment.

a. Injuries arising on the premises may be approved by the CE if it is shown the injury occurred on the premises and:

(1) The employee was performing assigned duties, or

(2) The employee was engaged in an activity reasonably incident to the employment such as:

(a) Personal acts for the employee's comfort, convenience and relaxation,

(b) Eating meals and snacks on the premises and

(c) Taking authorized coffee breaks, or

(3) The injury occurred while the employee was on the premises within a reasonable time before or after the end of the normal work shift.

b. Was Employee on Premises When Injured? If the employee has a fixed place of work, the CE must ascertain whether the employee was on the premises when the injury occurred. The answers to the appropriate sections of Forms CA-1, CA-2 and CA-6 contain information on this point. If clarification is needed, it should be secured from the official superior in the form of a statement which describes the boundaries of the premises and shows whether the employee was within those boundaries when the injury occurred. Where indicated, the clarification should include a diagram showing the boundaries of the industrial premises and the location of the injury site in relation to the premises.

c. What Was The Employee Doing When Injured?

(1) If the injury occurred on the premises, the CE must ascertain whether or not the employee was acting within the scope of employment. The appropriate portions of Form CA-1 and CA-6 request this information from the official

superior. An affirmative response by the official superior is sufficient to establish that the employee was in the performance of duty unless there are facts or other evidence which indicate the answer may be incorrect.

(2) If the employee was not doing regular work, the record must show exactly what the employee was doing when injured and the location of the area where the injury occurred in relation to the regular workplace. In disability cases both the official superior and the claimant should submit a statement showing precisely what the employee was doing when injured. If the initial reports and statements do not contain precise information in this regard, the official superior should be asked to submit a supplemental clarifying statement. When the official superior has no knowledge of the facts and circumstances of the injury, statements should be obtained from coworkers or other witnesses who may have such knowledge. A conference should be held when conflicting statements are presented.

d. Before Starting Time and After Quitting Time.

(1) There is no need to inquire about an injury which occurs before starting time or after quitting time unless the interval between the injury and the work hours seems excessive. The official superior should be requested to:

(a) Submit a statement explaining why the employee was on the premises at the time of the injury, or

(b) Obtain statements from coworkers who may know why the employee was on the premises at the time of the injury, if the official superior does not have this information.

(2) In disability cases an explanatory statement should also be obtained from the injured employee.

e. Bunkhouse Rule.

(1) An employee has the protection of the FECA if injured during the reasonable use of premises which he or she is required or expected to occupy, and which are provided by the employer. In this category of cases, the official superior should be requested to submit a statement showing:

(a) Whether the employee was required or expected to occupy the quarters where the injury occurred and, if so, this should be explained fully;

(b) Whether the employer provided the quarters for the employee and,

if so, this should be explained fully; and

(c) In what activity the employee was engaged at the time of the injury.

(2) The statement from the official superior should be sufficient to make a proper determination in most cases. Where needed, additional information should be obtained from the official superior, injured employee, co-workers, and witnesses.

f. Parking Facilities. The industrial premises include the parking facilities owned, controlled, or managed by the employer. An employee is in the performance of duty when injured while on such parking facilities unless engaged in an activity sufficient for removal from the scope of employment. In such cases the official superior should be requested to state whether the parking facilities are owned, controlled, or managed by the employer, and whether the injury did in fact occur in the parking area. The CE may approve the case when the official superior's response is affirmative and consistent with the other evidence.

g. Proximity Rule.

(1) An employee who has a fixed place of employment generally is not in the performance of duty when the injury occurs off the employer's premises. There are certain recognized exceptions to this general rule. One of these is the so-called proximity rule. It concerns those cases where the industrial premises are constructively extended to encompass a hazardous condition proximate to the premises, such as a public highway or railroad crossing, and considered to be a hazard of the employment as distinguished from a hazard which is not peculiar to the employer's premises. In this type of case the official superior should be requested to submit:

(a) A diagram showing the boundaries of the industrial premises and the location of the injury site in relation to the premises; and

(b) A statement which

(i) Describes any particular hazard which may have caused or contributed to the occurrence of the injury, and shows what relationship, if any, such hazard had to the employment, and

(ii) Also shows what control, jurisdiction, or care, if any, the employer assumed or had the right to assume over the place where the injury occurred.

(2) Determinations of this question must be made at an adjudicative level above that of the CE.

h. Visit to Premises.

(1) An employee's presence on the premises does not of itself afford the protection of the FECA. At the time of an injury, the employee must be on the premises for a work-related purpose; otherwise, the employee is not covered by the premises rule. Therefore, the CE must be alert for injuries which occur when the employee is on the premises for a personal reason as distinguished from a purpose incidental to the work. This usually concerns visits to the premises on days when the employee is not scheduled to work.

(2) In these situations the CE should ask the official superior for a statement which explains the reasons for the employee's presence on the premises at the time of the injury. In disability cases, the injured employee should be requested to submit such a statement. Similar statements should be obtained from co-workers or witnesses if the evidence is in conflict or otherwise requires clarification.

2-0804-5 Off-Premises Injuries

5. Off-Premises Injuries. The protection of the FECA is not limited to injuries which occur on the industrial premises. There are many workers who are required to perform some or all of their duties away from the employer's premises. Here we are concerned with coverage for injuries which occur to these off-premises workers.

a. There are four broad classes of off-premises workers:

(1) Messengers, letter carriers, and chauffeurs who, by the nature of their work, perform service away from the employer's premises;

(2) Traveling auditors and inspectors, whose work requires them to be in a travel status;

(3) Workers having a fixed place of employment who are sent on errands or special missions by the employer; and

(4) Workers who perform services at home for their employer.

b. In these cases, the CE must determine whether at the time of the injury the employee:

(1) Was performing assigned duties,

(2) Was engaged in an activity which was a reasonable incident of the assignment, or

(3) Had deviated from the assignment and was engaged in a personal activity which was not related to the work. The general principles for deciding these cases differ because the protection of the premises rule does not exist for off-premises injuries. Furthermore, there is a difference in the application of these principles among the several kinds of off-premises injuries.

c. Workers Such as Messengers, Letter Carriers, and Chauffeurs.

(1) By the nature of their work, employees in this category are on the premises of the employer for only part of each working day and it follows that many of their injuries are sustained away from the industrial premises. Of course, claims for these employees when injured on the premises will be examined and adjudicated in accordance with the principles for all on-premises injuries. The off-premises injuries will require somewhat different consideration.

(2) For the off-premises injuries of these employees, it is neither necessary nor practicable to develop the evidence in all cases as fully as is required for the injuries sustained by other kinds of off-premises workers. No additional evidence is needed if the CE can reasonably conclude from the evidence on the notice of injury combined with other material in the file that the employee was performing assigned duties when the injury occurred.

(3) If it appears questionable that the employee was in the course of employment when injured, the official superior should be asked to submit:

(a) A statement with full explanation showing specifically whether the employee was in the performance of duty when the injury occurred, and whether at the time of injury the employee had deviated from the proper route for personal reasons; and

(b) A diagram showing the location of the accident in relation to the route of travel the employee was to follow to perform the assigned duty.

(4) In most cases, the evidence should be sufficient to adjudicate the claim. If not, supplemental statements should be obtained from the official superior, co-workers, or other possible witnesses, and in disability cases, from the injured employee.

d. Workers in a Travel Status.

(1) For injuries sustained in a travel status the record must contain evidence showing:

(a) When and where the employee last performed official duty;

(b) The distance between the place of injury and the place where official duty was last performed;

(c) Between what points the employee was traveling when injured;

(d) The purpose of the trip;

(e) When and where the employee was next expected to perform official duty;

(f) Whether the injury occurred on the direct or most usually traveled route between the place of last official duty and the place where the employee was expected to next perform official duty and, if not, the nature and extent of the deviation should be given with a full explanation of the reason for such deviation;

(g) Whether at the time of the injury the employee was riding in or driving a Government-owned vehicle; and

(h) Whether the employee's travel expenses were reimbursable.

(2) In injury cases, this information should be supplied by the injured employee, with the official superior confirming or refuting the employee's allegations (see Form CA-1014). In death cases, the information will be supplied by the official superior (see Form CA-1014). In appropriate cases, the CE should request:

(a) A copy of the employee's travel authorization, and

(b) A map or diagram showing the location of the place where official duty was last performed, the place where the employee was next expected to perform official duty, the shortest or most usually traveled route between these points, and the place where the accident occurred.

e. Workers on an Errand or Special Mission. For workers having a fixed place of employment, who are injured while on an errand or special mission, the CE will obtain the same information as for workers in travel status.

f. Workers Who Perform Service at Home.

(1) Ordinarily, the protection of the FECA does not extend to the employee's home, but there is an exception when the injury is sustained while the employee is performing official duties. In situations of this sort, the critical problem is to ascertain whether at the time of injury the employee was in fact doing something for the employer. The official superior should be requested to submit a statement showing:

(a) What directives were given to or what arrangements had been made with the employee for performing work at home or outside usual working hours;

(b) The particular work the employee was performing when injured; and

(c) Whether the official superior is of the opinion the employee was performing official duties at the time of the injury, with appropriate explanation for such opinion.

(2) In disability cases, the injured employee should be required to submit a statement showing:

(a) What directives were received from, or what arrangements had been made with, the employer for performing work at home or outside usual working hours;

(b) The particular work the employee was performing when injured; and

(c) The reasons for the belief that the employee was in the performance of duty at the time the injury occurred.

(3) If the statements are not sufficiently detailed or are otherwise insufficient to permit a proper determination, additional statements should be obtained from others in a position to know the circumstances.

2-0804-6 To and From Work

6. To and From Work. Employees do not generally have the protection of the FECA when injured while en route between work and home.

a. Exceptions. There are five well-established exceptions to this general rule. These

exceptions are:

(1) Where the employment requires the employee to travel;

(2) Where the employer contracts for and furnishes transportation to and from work;

(3) Where the employee is subject to emergency duty, as in the case of firefighters;

(4) Where the employee uses the highway or public transportation to do something incidental to employment with the knowledge and approval of the employer; and

(5) Where the employee is required to travel during a curfew established by local, municipal, county or state authorities because of civil disturbances or for other reasons.

b. Where the Employment Requires the Employee to Travel. This situation will not occur in the case of an employee having a fixed place of employment unless on an errand or special mission. It usually involves an employee who performs all or most of the work away from the industrial premises, such as a chauffeur, truck driver, or messenger. In cases of this type the official superior should be requested to submit a supplemental statement fully describing the employee's assigned duties and showing how and in what manner the work required the employee to travel, whether on the highway or by public transportation. In injury cases a similar statement should be obtained from the injured employee.

c. Where the Employer Contracts for and Furnishes Transportation to and from Work. Where this expectation is claimed, the official superior should be requested to submit a supplemental statement showing, with appropriate explanation, whether the employee's transportation was furnished or otherwise provided by contract by contract by the employer. In injury cases a similar statement should be obtained from the injured employee. Also see Program Memorandum 104 dated October 24, 1969.

The Safe, Accountable, Flexible, Efficient Transportation Equity Act of 2005 (Public Law 109-59) amends Title 31, Section 1344 of the U.S. Code to allow Federal agencies in the National Capitol Region to pay for the costs of shuttle buses or other means of transportation between the place of employment and mass transit facilities. The bill statues that for "purpose of any determination under chapter 81 of title 5 ... an individual shall not be considered to be ' in the performance of duty' or 'acting within the scope of his or her employment' by virtue of the fact that such individual is receiving transportation services" under this legislation.

IF it is determined that a shuttle bus or other means of transportation to and from mass transit is authorized under this statue, then the injury is not considered to have occurred within the performance of duty. When requesting information from the agency about the employer-provided conveyance, the agency should be asked whether the service in question was provided pursuant to the above statutory authority.

d. Where the Employee is Subject to Emergency Duty.

(1) When it is alleged that the employee was subject to emergency duty, the official superior should be requested to submit:

(a) A copy of the injured employee's official position description, or other document showing that as the occasion arose, the duties did in fact require the performance of emergency duty; and

(b) A specific statement showing that at the time of the injury the employee was in fact traveling to or from work because of emergency duty.

(2) In disability cases, a statement from the injured employee should be requested showing whether at the time of the injury the employee was in fact going to or from work because of emergency duty.

e. Where the Employee Uses the Highway or Public Transportation to Perform a Service for the Employer.

(1) Where this exception is claimed, the official superior should be requested to submit a statement showing:

(a) The precise duty the employee had performed or was expected to perform for the employer during the trip in question; and

(b) Whether this was being done upon directions of the employer and, if not, whether the employer had prior knowledge of and had previously approved the employee's activity.

(2) In disability cases the injured employee should be requested to submit a similar statement.

f. Travel During a Curfew.

(1) When it has been determined that the employee was required to travel during a curfew established by local, municipal, county or state authorities

because of civil disturbances or for other reasons, the official superior should be requested to submit:

(a) The reason the employee was requested to report for duty;

(b) Whether other employees were given administrative leave because of the curfew; and

(c) Whether the injury resulted from a specific hazard caused by the imposition of the curfew, such as an attack by rioting citizens.

(2) In disability cases the injured employee should be requested to submit a similar statement.

(3) When all the facts are developed, the case should be referred to the National Office.

2-0804-7 Diversions from Duty

7. Diversions from Duty.

a. Emergencies.

(1) Some injuries occur when the employee steps outside the sphere of assigned duties to assist in an emergency, such as to extinguish a fire, assist a person who is injured or in imminent danger, etc. In these cases, it is particularly essential to determine the extent to which the employee diverted from assigned duties to perform the emergency act, and whether the employee was acting in the scope of employment just before the diversion. It is the CE's responsibility to obtain a statement from the official superior, showing:

(a) The precise location of the scene of the accident in relation to the industrial premises, and the place where the employee regularly performed assigned duties;

(b) Whether the employee was performing assigned duties immediately preceding the emergency and, if not, this should be fully explained;

(c) A full description of the particular emergency act performed by the employee; and

(d) The extent of the employee's diversion from duty in terms of time

and distance.

(2) In disability cases a statement should be obtained from the injured employee setting forth the same information required of the official superior. Statements from co-workers or other witnesses to the injury should also be obtained, when needed to clarify situations where the evidence submitted by the official superior and the injured employee is unclear or in conflict. The parties should set forth the same information required of the official superior and should show how they acquired the information.

b. Personal Acts.

(1) Injuries sometimes occur while the employee is allegedly engaged in a personal act for the employee's comfort, health, convenience, or relaxation. In these cases, it is particularly essential to determine whether the act was one which is regarded as a normal incident of the work experience, or was one which is foreign or extraneous to the work experience, and the extent to which the employee diverted from duty to perform the act. The evidence appearing on Form CA-1 or CA-2 may, in many cases, contain sufficient information to permit a proper determination. This will be particularly so where the diversion is inconsequential or not excessive and the act is one which is well established to be a normal incident of the work experience. Where clarification is needed, the official superior should be asked to submit a statement showing:

(a) The precise location of the scene of the accident in relation to the industrial premises, and the place where the employee regularly performed assigned duties;

(b) Whether the employee was performing assigned duties immediately preceding the personal act and, if not, this should be fully explained;

(c) A description of the personal act in which the employee was engaged;

(d) Whether for this purpose the employee was using the nearest available facilities or those intended for such use; and

(e) The extent of the employee's diversion from duty in terms of time and distance.

(2) In disability cases, a similar statement should be obtained from the injured employee. Statements from co-workers and/or other witnesses to the injury should also be obtained when needed to clarify the extent of the employee's

diversion and the nature of the personal act.

2-0804-8 Recreation

8. Recreation.

a. An employee is considered to be in the performance of duty while engaged in formal recreation and either the employee is paid for participating or the recreational activity is required and prescribed as a part of the employee's training or assigned duties. The CE may approve injuries occurring under these circumstances if the file contains a statement from the official superior showing that:

(1) At the time of the injury, the deceased or injured employee was engaged in a recreational activity organized and directed by the employing establishment and the employee was being paid for participating, or

(2) The activity was required and prescribed as a part of the employee's training or assigned duties.

It is the CE's responsibility to obtain this statement from the official superior.

b. Where injuries are sustained while the employee is engaged in a recreational activity under other circumstances, the determination must be made at an adjudicative level above that of the CE. In these cases, it is necessary to ascertain what benefit, if any, the employer derived from the employee's participation in the activity, the extent to which the employer sponsored or directed the activity, and whether the employee's participation was mandatory or optional. See ECAB decisions in the cases of Donald C. Huebler, 28 ECAB 17, and Stephen H. Greenleigh, 23 ECAB 53. The CE should require the official superior to submit a statement showing:

(1) Whether the employee was required to participate in the activity and, if so, the reason or authority for such requirement should be given or otherwise explained. If the participation was not mandatory, the official superior should explain fully whether participation was optional or what degree of persuasion was used to influence the employee's participation;

(2) What specific benefit the employer derived from the employee's participation in the activity (increasing employee morale is not considered a direct benefit);

(3) Whether other employees were required, persuaded, or permitted to participate in the activity and, if so, this should be explained;

(4) Whether the employee's participation in the activity violated any rules or

regulations of the employer and, if so, these should be explained, including discussion of the manner in which the rule or regulation was enforced;

(5) Whether the injury occurred on the employer's premises and during the employee's regular working hours and, if not, this should be explained; and

(6) What leadership, equipment, or facilities the employer provided for the activity.

c. In disability cases, the injured employee should be required to submit a statement showing:

(1) Whether the employer required or persuaded the employee to participate in the activity and, if so, this should be explained;

(2) Whether other employees were required or persuaded to participate in the activity; and

(3) Whether the injury occurred during regular working hours or on the employer's premises and, if not, this should be explained.

d. The need for additional statements from co-workers, witnesses, or other sources will be determined by the circumstances of the case, the discrepancies in the evidence, or other matters requiring clarification.

2-0804-9 Idiopathic Falls

9. Idiopathic Falls.

a. The CE should give particular attention to those cases where the injury is due to a fall which may have been caused by a personal and non-occupational pathology, such as a myocardial infarction, fainting spell, or epileptic seizure. Injuries caused by such conditions are excluded from coverage under the FECA unless there is intervention or contribution by some hazard or special condition of the employment, including normal furnishings of an office or other workplace.

b. In such cases it is the CE's responsibility to obtain appropriate evidence from the injured employee, the immediate superior, the witnesses, and the attending physician, showing whether the fall was due to an idiopathic condition or an unknown cause. If the incident was due to an idiopathic condition, the record must also clearly show whether the fall was to the immediate supporting surface (floor) or whether some special condition, hazard, or instrumentality of the work contributed to or intervened as a cause of the injury. If some factor of the employment intervened or contributed to the injury

resulting from the fall, the employee has coverage under the FECA for the results of the injury but not for the idiopathic condition which caused the fall.

c. A distinction must be made between idiopathic falls and those falls which are merely unexplained. If a fall is not shown to be caused by an idiopathic condition, it is simply unexplained and is therefore compensable if it occurred in the performance of duty. An idiopathic fall is one where a personal, non-occupational pathology causes an employee to collapse. An unexplained fall is one where the cause is unknown even to the employee.
The ECAB made the distinction between idiopathic and unexplained falls in the following two cases:

(1) Martha G. List, 26 ECAB 200. Employee Joseph G. List's fall at work on December 21, 1972 resulted in his death. There was no evidence that any obstacle or other irregular condition of the workplace caused the fall. The employee had a history of hypertension and episodes of falling but he had not fallen from the end of 1967 until December 21, 1972. An Office medical adviser filed a brief opinion stating that it was "reasonable to assume that the hypertension probably was out of control and that a 'small stroke' occurred on 21 Dec. 72 and was the reason for the fall."

The Board reversed the Office's decision that the employee's injury was caused by an idiopathic fall and neither arose out of nor was causally related to the employment. In support of its finding that the employee's fall was unexplained and his resulting death was compensable, the Board stated:

> The question of causal relationship in a case of a fall like that in the present case is a medical one. The only medical evidence in the case record indicating that the employee's fall was idiopathic is the statement of the Office medical adviser. His opinion is speculative and lacking in rationale; it is therefore insufficient to establish that the employee's fall was idiopathic and to prove that it was due to a preexisting physical condition. The 5-year interval between his 1967 fall and the fatal 1972 incident militates against such a conclusion.

(2) Gertrude E. Evans, 26 ECAB 195. Employee Wesley W. Evans' fall at work on May 7, 1973 resulted in his death. There was no indication that anything in the workplace caused him to fall. The employee had a three to five year history of dizziness and fainting spells as well as a series of falls and hospitalizations in the period immediately preceding the May 1973 episode. He had been hospitalized a month before the May 1973 episode, complaining of dizziness and passing out. Although the attending physician could not diagnose the employee's condition, his reports and those of other physicians made it clear that they

regarded the May 1973 episode and the previous ones as having as a common cause an abnormal physical condition.

The Board affirmed the Office's finding that the employee's fall was idiopathic in nature but remanded the case for a determination as to whether or not the employee struck an intervening object when he fell on May 7, 1973.

Whether a fall at work is idiopathic or unexplained will usually be determined on the basis of the medical evidence. If the medical evidence shows that the employee's fall was caused by a non-occupational, preexisting physical condition, it is idiopathic and not compensable. Absent such evidence, the fall is unexplained and compensable.

CEs should carefully read the List and Evans decisions, as they illustrate the difference between idiopathic and unexplained falls.

2-0804-10 Assault Cases

10. Assault Cases. Where the injury or death is caused by the assault of another person, it is necessary to establish to the extent possible whether the assault was accidental, arose out of an activity directly related to the work or work environment, or arose out of a personal matter having no connection with the employment. In the case of a personal matter, the evidence must show whether it was materially and substantially aggravated by the work association. An assault occurring off the agency's premises and outside of work hours may be compensable if it arose for reasons related to the employment.

a. It is the responsibility of the CE to obtain copies of any police reports which may have been made. Statements should also be obtained from the official superior and co-workers or other witnesses showing:

(1) Whether there was any animosity between the injured or deceased employee and the assailant by reason of a personal association away from work and, if so, this should be explained fully; and

(2) A full description of the events and circumstances which immediately preceded, led up to, and resulted in the assault.

b. A similar statement should be obtained from the assailant, if possible, and in disability cases, from the injured employee.

2-0804-11 Horseplay

11. Horseplay.

a. An employee injured during horseplay is considered to be in the performance of duty if the horseplay was of a character that could reasonably be expected where a group of workers is thrown into personal association for extended periods of time. In such cases, it is important to determine whether the particular activity was one that was a reasonable incident of the employment or was an isolated, unanticipated event which could not reasonably have been expected to result from the workers' close association.

The CE must also consider whether the horseplay may have constituted a prohibited activity; resulted from the employee's intoxication, willful misconduct, or intention to bring about self-injury or injury to another; or occurred while the employee was so removed from assigned duties in point of time or space as to be removed from the course of employment.

b. If there is sufficient evidence to properly find the injury was sustained in the performance of duty, the CE may approve the case. Otherwise, the CE should ask the official superior to submit a statement which includes:

(1) A full description of the particular horseplay in which the employee was engaged when injured, including the precipitating cause and the number of employees involved;

(2) Whether horseplay of this character had been prohibited previously and, if so, full details of the prohibition should be given, showing when and how the employees were notified and what efforts had been made to enforce prohibition;

(3) The precise location where the injury occurred in relation to (a) the industrial premises, and (b) the place the employee regularly performed assigned duties;

(4) Whether the employee was performing assigned duties immediately preceding the horseplay and, if not, this should be explained fully; and

(5) Whether this was a single, isolated act of horseplay or whether this had occurred or prior occasions and, if so, the frequency of such prior occurrences.

c. In disability cases a similar statement should be obtained from the injured employee. Other workers engaged in the horseplay should be asked to submit statements responsive to the same questions. The need for statements from other coworkers or witnesses should be considered if the evidence conflicts or otherwise requires clarification.

2-0804-12 Coworker Harassment or Teasing

12. Coworker Harassment or Teasing.

a. Harassment or teasing of employees by coworkers is a compensable factor of employment. Employees who are harassed teased or called derogatory names by coworkers are considered to be in the performance of duty provided that the reasons for the harassment or teasing are not imported into the employment from the employee's domestic or private life.

The Office had previously taken the position that coworker harassment was a factor of employment only if the employing establishment failed to intervene to moderate or resolve the situation, based on the Board's decision in Joe N. Richards, Docket No. 91-836, issued December 17, 1991. In its remand order the Board stated "if the evidence establishes appellant's supervisor failed to intervene when appellant was harassed by coworkers or, as alleged by appellant, actually instigated such harassment, appellant's emotional reaction to the harassment would arise within the performance of duty." Thus, under the Office's interpretation of Richards, management intervention effectively removed the harassment victim from the performance of duty even if the harassment continued following such intervention.

Board decisions in Gregory J. Meisenberg, Docket No. 92-1098, issued February 24, 1993 (remanded) and David W. Shirey, 42 ECAB 783, issued July 5, 1991 (affirmed because of appellant's inability to prove alleged incidents of harassment actually occurred), were less clear regarding coverage. In both cases the Board stated:

> To the extent that disputes and incidents alleged as constituting harassment by coworkers are established as occurring and arising from appellants performance of his regular duties, these could constitute employment factors. (emphasis supplied)

However, in Abe E. Scott, 45 ECAB 164, the Board specifically stated that under a particular fact pattern, coworker harassment is a factor of employment.

b. Another factor to consider in determining the compensability of injuries allegedly due to coworker harassment is the "friction and strain doctrine" (see Larson, The Law of Workmen's Compensation, §11.16[a]) which is followed by the Board. Under this doctrine the fact that employees with their individual characteristics (emotions, temper, etc.) are brought together in the workplace creates situations leading to conflicts which may result in physical or emotional injuries. Because these conflicts have their origin in the employment they arise out of and in the course of employment even though they have no relevance to the employee's tasks. In other words, a conflict between employees involving a nonwork topic may be found to have occurred in the performance of duty

because the employment brought the employees together and created the conditions which resulted in the conflict.

However, the "friction and strain doctrine" does not apply to privately motivated quarrels or disputes imported from outside the employment. (see Larson, §11.20).

Although the Board did not use the phrase "imported into the employment" in the case of Sharon R. Bowman, 45 ECAB 187, its decision is based on the same principle. In affirming the Office's decision that appellant had not sustained an emotional condition in the performance of duty the Board found that the gossip of coworkers regarding her ex-husband did not relate to her job duties or requirements and was therefore not compensable.

The Board had previously found in the case of Gracie A. Richardson, 42 ECAB 850, issued August 8, 1991 (footnoted in Bowman) that "Appellants fear of gossip is a personal frustration which is clearly not related to her job duties or requirements and is thus not compensable."

c. If the evidence shows that the alleged incidents of harassment actually occurred, and that they arose out of the employment and did not involve personal matters imported from outside the employment, the CE may find that the employee was in the performance of duty. However, in most cases the initial reports will not provide enough information for the CE to make this determination. Therefore, the CE should develop the evidence by obtaining the following:

(1) A statement from the employee (if a statement has not been submitted or a submitted statement is inadequate) describing in detail the alleged incidents of harassment, the frequency of their occurrence and their effect on the employee;

(2) Statements from coworkers allegedly involved in the harassment describing in detail their version of events;

(3) A statement from the employee's supervisor stating whether he or she was aware of the situation as described by the employee and coworkers, and describing any supervisory action taken; and

(4) Statements from any other persons who may have knowledge of the alleged harassment stating what they know and how they obtained such knowledge.

After all of the pertinent factual information has been obtained, the CE must determine whether the alleged incidents of harassment actually occurred and, if so, whether they arose out of the employment or were provoked by something occurring in the employee's private or domestic life; that is, imported into the employment.

If it is established that the harassment arose out of the employment, the question of whether the employee's claimed physical or mental disability is causally related to the harassment must be determined in accordance with the procedures outlined in Chapter 2-805.

2-0804-13 Prohibited Activities

13. Prohibited Activities.

a. There may be no right to compensation where the injury occurs while the employee is knowingly engaged in an act which has been prohibited by the employer. The test in such a case is whether the injury was caused by the willful misconduct of the employee as outlined in 5 U.S.C. 8102(a)(1) and as covered in paragraph 13 of this chapter. In these cases it is essential to determine whether the employee was fully aware of the prohibition, whether the prohibition was enforced, the extent to which the employee had diverted from assigned duties, and whether the particular act was within the general scope of the assigned duties. It is the responsibility of the CE to obtain a statement from the official superior which:

(1) Identifies the full range of the employee's assigned duties;

(2) Fully describes the prohibited act in which the employee is accused of engaging;

(3) States how, when, and how often the employee or coworkers were informed of the prohibition (copies of the notice should be obtained if it is asserted that written notification of the prohibition had been given); and

(4) Describes the manner in which the prohibition had been enforced and what disciplinary action, if any, had been taken against the employee or co-workers for prior violations.

b. In disability cases the injured employee should be asked to submit a statement which:

(1) Identifies the full range of assigned duties;

(2) Shows whether the claimant was aware that an act prohibited by the employer was being performed and, if so, states how, when, and how often the employee was informed of the rule;

(3) Describes the particular act in which the employee was engaged at the

time of the injury and whether, in the employee's opinion, this was within the general scope of the duties;

(4) States whether the employee had previously violated this prohibition and, if so, this should be explained fully, including an opinion as to whether the employee's supervisors were aware of such violations; and

(5) Includes any explanation which the employee believes would justify the violation of the prohibition.

c. Statements should also be obtained from co-workers or other witnesses which:

(1) Describe what they know about the injury, the manner in which it was sustained, and the particular activity in which the employee was engaged at that time, and also how they acquired this knowledge;

(2) State whether they were aware of the prohibition which was allegedly violated and, if so, they should state how, when, the number of times, and the manner in which they were informed of the prohibition; and

(3) Describe the manner in which the prohibition had been enforced and what disciplinary action had been taken against the injured employee for prior violations.

2-0804-14 Statutory Exclusions

14. Statutory Exclusions.

a. Willful Misconduct, Intoxication, or Intention to Bring About Injury or Death to Self or Another. Where the questions of "fact of injury" and "performance of duty" are decided affirmatively, consideration must also be given to the question of whether the injury or death was caused by the willful misconduct of the employee, by the employee's intention to bring about the injury or death of self or of another, or if intoxication of the injured employee was the proximate cause of the injury or death (see 5 U.S.C. 8102). The CE has authority to decide these questions when these factors were not the cause of the injury. Otherwise, the CE has no authority to decide these questions adversely to the claim and must not in any way notify or imply to the claimant or the representative that the claim has been or will be denied because of one of these factors.

(1) The claimant enjoys an affirmative defense against these factors. The OWCP must overcome such defense. Adverse decisions must always be made at an adjudicative level above that of the CE.

(2) The official superior's answers to the appropriate items on the Form CA-1, and the particular circumstances of the accident, are the factors which require the CE's attention when considering these questions. In most cases these questions may be determined negatively with ease. In those few cases where it appears that an adverse determination may be indicated or where there is confusion in the facts, it will be the CE's responsibility to obtain all available evidence which may be relevant to the question. Thereafter, the CE should present the case to the next adjudicative level with a written explanation of the factors involved and a reasoned recommendation for approval or disapproval of the claim.

b. Willful Misconduct.

(1) The question of willful misconduct arises where at the time of the injury the employee was violating a safety rule, disobeying other orders of the employer, or violating a law. Safety rules have been promulgated for the protection of the worker--not the employer--and, for this reason, simple negligent disregard of such rules is not enough to deprive a worker or the worker's dependents of any compensation rights. All employees are subject to the orders and directives of their employers in respect to what they may do, how they may do certain things, the place or places where they may work or go, or when they may or shall do certain things. Disobedience of such orders may destroy the right to compensation only if the disobedience is deliberate and intentional as distinguished from careless and heedless. A distinction is also made in respect to orders which relate to the manner in which assigned tasks are to be done, as distinguished from other activities which are merely incidental to the employment. It is necessary, therefore, that the evidence be unusually well developed before any steps are taken to disallow a claim because of willful misconduct.

(2) Violating a Safety Rule.

(a) In these cases the official superior should be required to submit a statement which: identifies the particular safety regulation which was allegedly violated; states how, when, and how often the employee and co-workers were informed of the rule (copies of the notice should be obtained if written notice of the rule was given); and describes the manner in which the rule had been enforced and what disciplinary action was taken against the employee and coworkers for this or prior violations.

(b) In disability cases, a statement from the injured employee should be required which: shows whether the employee was aware of the safety rule which was allegedly violated and, if so, contains information as to

how, when, the number of times, and the manner in which the employee was informed of the rule; the reason, if any, for violating the rule; the particular act in which the employee was engaged at the time of the injury and whether, in the employee's opinion, this was a part of assigned duties; whether the employee had previously violated this rule and, if so, a full explanation therefor, including an opinion whether the supervisors were aware of such violations; and any explanation the employee believes would justify the violation of the rule.

(c) Statements should also be obtained from any co-workers or witnesses which show: what they know about the injury, the manner in which it was sustained, the particular activity in which the employee was engaged at that time, and how they acquired this knowledge; whether they were aware of the existence of the safety rule which was allegedly violated and, if so, how, when, the number of times, and the manner in which they were informed of the rule; and the manner in which the rule had been enforced and what disciplinary action, if any, had been taken against them or the injured employee for prior violations.

(3) Disobeying Other Orders of the Employer.

(a) In these cases the official superior should be required to submit a statement which: identifies the particular order which was allegedly disobeyed; gives the reasons the employer found it desirable and necessary to issue this order; states how, when, the number of times, and the manner in which the employee and co-workers were informed of the order (copies of any written orders should be obtained); and describes how the order had been enforced and what disciplinary action was taken against the employee and co-workers for prior instances of disobedience.

(b) In disability cases, the injured employee should be required to submit a statement showing: the particular person from whom these orders had been received and what supervisory responsibility that person had; how, when, and how often these orders were received; the particular act in which the employee was engaged at the time of the injury, and whether this was a part of the employee's assigned duty; whether the employee had previously disobeyed these or similar orders and, if so, this should be fully explained, including whether the supervisors were aware of such disobedience; and any explanation which the employee believes would justify such disobedience.

(c) Statements should also be obtained from any co-workers or

witnesses which show: what they know about the injury; the manner in which it was sustained; the particular activity in which the employee was engaged at that time, and how they acquired this knowledge; whether they were aware of the existence of the particular order which was allegedly violated and, if so, how, when, and how often they were informed of such order; and the manner in which the order had been enforced and what disciplinary action had been taken against them or the injured employee for prior instances of disobedience.

(4) Violation of a Law.

(a) In these cases the official superior should be required to submit a statement citing the particular law which was allegedly violated, stating what legal action was taken by the authorities to prosecute the employee for this violation, and showing the results of such action.

(b) In disability cases, a statement from the injured employee should be requested, describing the particular act in which the employee was engaged at the time of the injury, with an opinion whether this was a part of the employee's assigned duties and any explanation justifying the violation of the law.

c. Intoxication.

(1) Where intoxication may be the proximate cause of the injury, the record must contain all available evidence showing: (a) the extent to which the employee was intoxicated at the time of the injury, and (b) the particular manner in which the intoxication caused the injury. It is not enough merely to show that the employee was intoxicated. It is also the OWCP's burden to show that the intoxication caused the injury. An intoxicant may be alcohol or any other drug.

(2) The official superior should be required to submit a statement which: describes the employee's activities during the several hours immediately preceding the injury, with particular emphasis on the personal conduct, apparent sobriety, and the extent to which the employee appeared to be inebriated or otherwise not in control of all faculties; states whether the employer is aware of the nature and amount of intoxicant consumed by the employee and, if so, supplies full details; states whether the employer believes the employee's intoxication was the proximate cause of the injury with appropriate explanation for such belief; and shows whether immediately prior to or after the injury any tests were made by the police or others to determine the employee's sobriety (the results of any such tests should be requested).

(3) A statement should be obtained from the physician and the hospital where

the employee was examined following the injury which describes as fully as possible the extent to which the employee was intoxicated and the manner in which the intoxication was affecting the employee's activities. The results of any tests made by the physician or hospital to determine the extent of intoxication should be obtained.

(4) In disability cases, the injured employee should be requested to submit a statement which: includes a full account of activities during the several hours immediately preceding the injury; states whether any intoxicants were used or consumed during that time and, if so, the precise nature and amount consumed; and states whether or not the employee feels intoxication was the proximate cause of the injury, with appropriate explanation for the belief.

(5) Statements from coworkers or other witnesses should also be obtained which: describe the employee's activities during the several hours immediately preceding the injury with particular emphasis on personal conduct, apparent sobriety, and the extent to which the employee appeared to be inebriated or otherwise not in control of all faculties; states whether they are aware of the nature and amount of intoxicants consumed by the employee and, if so, full details; and states whether they believe the employee's intoxication was the proximate cause of the injury with appropriate explanation for their belief.

d. Employee's Intention to Bring About Injury or Death to Self or Another.

(1) Where it appears the injury or death was caused by the employee's intention to bring about the injury or death of self or another, it is the responsibility of the CE to obtain a statement from any physician or hospital where the employee was examined following the injury, which states whether it appeared the employee was in full possession of all faculties and, if not, a full description of the situation.

(2) The official superior should also be requested to submit a statement which describes the employee's activities during the several hours immediately preceding the injury and states whether it is believed that the injury or death was caused by the employee's intention to bring about injury or death of self or another, with a fully detailed explanation for the belief.

(3) In disability cases, the injured employee should submit a statement which includes a full account of activities during the several hours immediately preceding the injury, and gives a full description of the manner in which the injury occurred, with a definite statement, including explanation, whether the injury was caused by intention to bring about the injury or death of self or another.

(4) Statements from co-workers or other witnesses should also be requested which describe the employee's activities during the several hours immediately preceding the injury, and state whether they believe the injury or death was caused by the employee's intention to bring about the injury or death of self or another, with a fully detailed explanation for their belief. (See paragraph 14 of this chapter for information on suicide cases.)

2-0804-15 Suicide

15. Suicide. As outlined in paragraph 13 above, section 5 U.S.C. 8102(a)(2) would appear to preclude payment of compensation in all suicide cases. In some such cases, however, compensation can be paid if the job-related injury (or disease) and its consequences directly resulted in the employee's domination by a disturbance of the mind and loss of normal judgment which, in an unbroken chain, result in suicide.

a. Tests. Various tests are applied in different jurisdictions for determining compensability in suicide cases. The different tests are known as: Sponatski's Rule, New York Rule and Chain-of-Causation Test. (For a discussion of these different tests refer to Arthur Larson, The Law of Workmen's Compensation [New York, Matthew Bender, 1979], Volume 1A, Chapter VI, Section 36.) It is OWCP's policy to apply the Chain-of-Causation Test in suicide cases filed under the FECA. All jurisdictions, of course, require that a worker's suicide be caused by some mental derangement arising out of and in the course of the employment to be compensable under workers' compensation law.

b. Chain-of-Causation Test.

(1) For a suicide to be compensable under this test, it is not necessary to establish that the employee's act of suicide occurred immediately or within a short time after the injury, that the suicide was unpremeditated, violent, occurred in a delirium of frenzy, or that the employee was genuinely insane, psychotic, or suffered from physical damage to the brain. Further, whether the employee knew of the purpose and physical consequences of the act of suicide is irrelevant to the question of causation and, therefore, "knowledge-of-the-physical- consequences" is not a factor sufficient to break the chain-of-causation from the injury to the suicide. In discussing the "chain-of-causation" test, Arthur Larson states:

> If the sole motivation controlling the will of the employee when he knowingly decides to kill himself is the pain and despair caused by the injury, and if the will itself is deranged and disordered by the consequences of the injury, then it seems wrong to say that this exercise of will is "independent," or that it breaks the chain of causation. Rather, it seems to be in the direct line of causation. [Arthur Larson, The Law of

Workmen's Compensation (New York, Matthew Bender, 1979), Volume 1A, Chapter VI, Section 36.30.]

(2) If the injury and its consequences resulted directly in a mental disturbance, or physical condition which produced a compulsion to commit suicide, and disabled the employee from exercising sound discretion or judgment so as to control that compulsion, then the test is satisfied and the suicide is compensable.

c. Development.

(1) It is the CE's responsibility to develop the necessary information to determine whether the "chain-of-causation" test is met if it is asserted, or there is evidence to suggest, that a mental disturbance or physical condition is present and such condition was causally related to the injury or conditions of employment. Statements as to the employee's mental or physical condition prior to the suicide should be requested from the employee's family, supervisor, co-workers, and other associates who might have pertinent knowledge or information concerning the circumstances surrounding and leading to the suicide. Since almost all, if not all, suicides are investigated by local authorities, a copy of the investigation report should be obtained. Copies of any notes or other communication left by the employee should also be obtained.

(2) A rationalized opinion concerning the relationship between the suicide and the employment-related injury should be obtained from the employee's attending physician or second opinion specialist. The physician should be advised of the test to be met for the death to be compensable (that the suicide was a direct result of the employment injury) and should be asked to describe the employee's mental and physical condition prior to the suicide. If a conflict of medical opinion develops in the case, it should be resolved by referral to a psychiatrist or clinical psychologist.

(3) For the suicide to be compensable, the chain of causation from the injury to the suicide must be unbroken. Therefore, if the evidence indicates or suggests the existence of other factors in the employee's life which may break the chain-of-causation (such as personal or family problems, non-employment-related injuries, etc.), the CE must develop such factors to determine what effect, if any, they had in causing the employee to commit suicide, and whether they constitute independent intervening factors sufficient to break the direct chain of causation from the injury to the suicide.

(4) All development efforts in a suicide case must be documented clearly in the case file, and all reasoning behind the recommended decision (be it approval or denial) must be made a part of the record in the form of a Memorandum to the Director.

(5) A decision either accepting or denying a suicide case must be made by the District Director or higher authority.

2-0804-16 Representational Functions

16. Representational Functions.

a. In the Civil Service Reform Act of 1978, at 5 U.S.C. 7101, it is held that:

experience in both private and public employment indicated that the statutory protection of the right of employees to organize, bargain collectively, and participate in decisions which affect them--

(A) safeguards the public interest
(B) contributes to the effective conduct of public business, and
(C) facilitates and encourages amicable settlements of disputes between employees and their employers involving conditions of employment.

Thus, the Congress held that certain representational functions performed by employee representatives of exclusive bargaining units benefit both the employee and the agency.

b. OPM defines "representational functions" to mean those authorized activities undertaken by employees on behalf of other employees pursuant to such employees' right to representation under statute, regulation, executive order, or terms of a collective bargaining agreement. It includes activities undertaken by specific, individual designation (such as designation of a representative in a grievance action or an EEO complaint), as well as those activities authorized by a general collective designation such as the designation of a labor organization recognized as exclusive representative under Chapter 71 of Title 5.

c. Official Time. Official time is defined as time granted to an employee by the agency to perform representational functions, when the employee would otherwise have been in duty status, without charge to leave or loss of pay. Official time is considered hours of work and is distinguished from administrative leave. OPM has stated that this may include scheduled overtime or a period of irregular unscheduled overtime, if an event arises which requires representational capacity.

Official time granted to union representatives under section 7131 of 5 U.S.C. Chapter 71 is authorized for an employee acting as an exclusive representative in the negotiation of a collective bargaining agreement, including attendance at impasse proceedings. In addition, certain executive orders and Government-wide regulations require the use of

official time for such functions in connection with health and safety matters, agency administrative grievance procedures, prevailing wage-rate appeals and EEO complaints.

Agency regulations and practice, and collective bargaining agreements, may also provide official time for other representational functions.

The Postal Service National Agreement specifies conditions under which a union representative can provide representational service "on the clock."

d. OWCP Policy. Employees performing representational functions which entitle them to official time are in the performance of duty and entitled to all benefits of the Act if injured in the performance of those functions. Activities relating to the internal business of a labor organization, such as soliciting new members or collecting dues, are not included.

e. Case Development. When an employee claims to have been injured while performing representational functions, an inquiry should be made to the official superior to determine whether the employee had been granted "official time" or, in emergency cases, would have been granted official time if there had been time to request it. If so, the claimant should be considered to have been in the performance of duty. This includes Postal Service employees who are "on the clock" while performing representational activities under the National Agreement.

If the agency states that the employee was not performing an activity for which official time is allowed, the Office should issue a letter warning the claimant that the case will be denied unless additional information is provided, and allowing thirty days for a response. If there is no timely response from the claimant, a formal decision should be issued on the ground that the claimant is not in the performance of duty.

If the claimant provides evidence contradicting the agency's position, the official superior should be asked to reply to this evidence, providing documentation in the form of appropriate regulations, executive order or union agreement covering the specific situation. The Office will accept the ruling of the agency as to whether a representative was entitled to official time, unless this ruling is later overturned by a duly authorized appellate body.

2-0804-17 Work-Connected Events Which Are Not Factors of Employment

17. Work-Connected Events Which Are Not Factors of Employment.

a. The Cutler Rule. As the ECAB stated in the case of Lillian Cutler, 28 ECAB 125:

Workers' compensation law does not apply to each and every illness that is

> somehow related to an employee's employment... Where the disability results from his emotional reaction to his regular or specially assigned work duties or to a requirement imposed by the employment, the disability comes within the coverage of the Act.

This concept has come to be known as the Cutler rule.

When an employee experiences emotional stress in carrying out assigned employment duties, or has fear and anxiety regarding his or her ability to carry out these duties, a resulting disability is considered to have "arisen out of and in the course of employment." Similarly covered is a disability arising from a special assignment or requirement imposed by the employing establishment. The assignment need not have been unusually strenuous, as long as the medical evidence shows that it caused the claimed condition. The Board continues:

> On the other hand, the disability is not covered where it results from such frustration from not being permitted to work in a particular environment or to hold a particular position.

In Cutler, where the employee became emotionally upset over not receiving an anticipated promotion, the Board held that:

> the resulting disability does not have such a relationship to the employee's assigned duties as to be regarded as arising from the employment. The emotional reaction in such circumstances can be truly described as self-generated and as not arising out of and in the course of employment.

"Self-generated" in this context apparently refers to the employee's voluntary application for a higher position, when to seek promotion was not a requirement of the position she already held.

b. Reassignment. The Board has applied the Cutler standard in other cases largely by example, always seeming to distinguish between the performance (or the results) of actual work duties, and dissatisfaction with the structure of the work or position. Thus, under the standard set forth in Cutler, it is clear that reassignment is not a factor of employment: Dario G. Gonzales, 33 ECAB 119; Clair Stokes, Docket No. 82-508, issued May 24, 1982; John A. Snowberger, Docket No. 85-2076, issued January 31, 1986; Robert C. McKenzie, Docket No. 85-532, issued May 10, 1985; Teresa M. Lacona, Docket No. 88-1262, issued May 8, 1989.

However, the case of Brenda Getz, 39 ECAB 245, presents a different situation. Here the employee alleged that she had an emotional reaction to a detail assignment to another city because of the working conditions involved. The Board concluded that the detail

assignment constituted specially assigned work duty within the meaning of Cutler and therefore any disability arising out of an emotional reaction to the assignment would be covered.

c. Performance Ratings. The Board remanded the case of Lizzie J. McCray, 36 ECAB 419 listing the dispute over the employee's performance rating as a factor of employment and citing Derderian. But in Arthur F. Hougens, 42 ECAB 455, the Board found that the employee's reaction to his rating on his performance evaluation was not covered under the Act. The Board stated:

> In view of the fact that appellant's rating was "satisfactory" and was changed to a higher rating on his appeal, his reaction to it can accurately be described as "self-generated." Appellant has presented no evidence to substantiate his contention that a rating of satisfactory was a "bad rating" and "as low as you can go" at his employing establishment.

Although the Board did not state the distinction between Hougens and Derderian and McCray, the Board finding that Hougens' reaction was self-generated apparently is based on the fact that his performance was evaluated as satisfactory and his mere perception of the rating as a "bad" one was not sufficient for his reaction to be covered under the Act.

This interpretation is reinforced by the Board's decision in Thomas D. McEuen, 41 ECAB 387 and 42 ECAB 566. In McEuen the Board stated:

> In this case, the medical evidence establishes more than appellant's feeling of job insecurity: It establishes that appellant's episode of severe depression and impaired functioning was directly precipitated by what appellant regarded as an unsatisfactory performance appraisal. The Board finds that appellant's emotional reaction bears a direct relationship to his regular or specially assigned duties and constitutes an injury in the performance of duty within the meaning of the Act.

The Office petitioned for reconsideration on the ground that the Board's January 10, 1990 decision contained legal and factual errors. The petition stated in part:

> In the decision on January 10, 1990, the Board concluded that appellant's depression constituted an emotional condition sustained while in the performance of duty because it was "directly precipitated by what appellant regarded as an unsatisfactory performance appraisal." In so doing, the Board departed from longstanding precedent holding that feelings of job insecurity do not constitute an illness sustained while in the performance of duty. Raymond S. Cordova, 32 ECAB 1005 (1981); Lillian Cutler, 28 ECAB 125 (1976). Rather, the Board concluded that "feelings of job insecurity" may be compensable, depending upon the "source" of those feelings.

In an April 3, 1991 decision granting petition for reconsideration and reaffirming its January 10, 1990 decision, the Board noted:

> an unsatisfactory performance rating, without more, is insufficient to provide coverage. Although the rating is generally related to the employment, it is an administrative function of the employer, not a duty of the employee. As was held in Cutler, an emotional reaction under such circumstances would be self-generated. Exceptions will occur, however, in those cases where the evidence discloses error or abuse on the part of the employing establishment. That is what has occurred in this case. An error was committed by the employing establishment that resulted in appellant's emotional reaction. Such a reaction cannot be labeled "self-generated."

In the instant case, appellant felt the employer was out to get his job. He based this "perception" on the fact that, instead of receiving a performance rating when due, the employer deferred it in several particulars for 90 days. He alleged, and the employer conceded, that the proposed performance rating was incorrectly based on standards not derived from his job description and, with these standards removed, his performance was satisfactory. As the Office correctly points out, appellant was never given an 'unsatisfactory' rating. The rating was simply deferred for 90 days. The decision here therefore turns, not on whether the performance rating was unsatisfactory per se, but on the fact the employer took erroneous action that resulted in the employee's emotional condition. Such reaction cannot be deemed self-generated.

The Board has thus made it clear that an unsatisfactory performance ratings, performance assessments and informal discussions of performance, standing alone, are insufficient to provide coverage under the Act. An employee's reaction to an unsatisfactory performance rating, performance assessment or informal discussion of performance, absent any evidence of error or abuse by the employing establishment, is self-generated and therefore not compensable.

d. Fear of Removal. The Board has also distinguished between an employee's reaction to criticism arising from performance of day-to-day duties, or fear of inability to perform, and the fear of losing a job or a particular position, even when a performance evaluation is the sole or principal reason for an employee's actual or possible removal or job change.

In Allen C. Godfrey, 37 ECAB 334, the employee alleged extreme depression due partly to his reaction to a letter received from the employing establishment proposing to remove him from his position for failure to meet certain performance requirements of his job. His performance deficiencies were documented in official performance evaluations. A subsequent letter from an agency official stated he would not sustain the proposal to remove the employee but would assign him to a lower-graded position.

The Board referred to two of its previous decisions where an employee's reaction to a discussion with his supervisor concerning the performance of his work duties, and another employee's emotional reaction to attempting to meet quality and quantity standards for his job, both constituted injury in the performance of duty. In this case, the Board found the facts to lead to the contrary conclusion that, while the employee's disabling reaction had some connection to his employment, it was not a reaction to his day-to-day duties or fear or anxiety concerning his ability to perform his employment duties but to what he perceived as a "sudden loss of his career." The employee's disabling emotional reaction was due to a fear of losing his job and a fear of losing a particular position, which does not constitute a factor of employment.

e. Harassment. Since Stanley Smith, 29 ECAB 652, the Board has consistently held that an employee is not required to show that a supervisor's actions constituted harassment or were improper as long as the employee could show that the disability arose directly from experience of the supervisor's actions and reaction to them, and that the actions themselves were appropriately related to the employee's assigned duties and position. In Lewis Leo Harms, 33 ECAB 897 (902), the Board stated:

> Where an employee asserts that emotionally stressful employment situations or conditions, including actions by the employing establishment described by the employee as constituting harassment or discrimination, caused a disabling condition on his part, the issue, generally speaking is not whether in fact there was harassment or discrimination but instead is whether such disabling reaction was precipitated or aggravated by conditions of employment. The Board's function is not to make a finding on the merits of an employee's charges against the employing establishment; its only function is to determine whether or not the medical evidence supports causal relationship between the employment factors alleged and the physical conditions.

Thus, the Board makes no determination of whether harassment occurred and does not require the Office to make factual determinations of whether an employee was the victim of harassment or discrimination. The Board does, however, rely on the findings of agencies or bodies which have the authority, and whose function it is, to decide the validity of an employee's allegations.

In the case of Norman A. Harris, 42 ECAB 923, the employee alleged that he sustained an emotional condition causally related to his federal employment. The employee was terminated by his employing establishment for falsifying his time records. He appealed the termination to the Merit Systems Protection Board (MSPB) and was restored to his position. The MSPB found:

> There was no showing that the appellant intentionally misrepresented his hours or deceived the agency by claiming hours that he did not work.... The charges in this

> case are predicated upon the appellant reporting late on various dates during the period in question. However, I note that the agency presented no evidence from Paramount officials who could verify [whether or not appellant was] at work.

The MSPB reversed the removal action. Based on the MSPB decision the Board found that the employing establishment had terminated the employee without the proper evidence and that this error was sufficient to bring any emotional reaction by the employee to the termination action within the coverage of the Act. The Office was directed to determine whether the employee had established that he sustained an emotional condition causally related to the termination action.

f. Erroneous Administrative Actions. In Robert E. Green, 37 ECAB 145, the employee alleged an emotional condition stemming from charges that he had falsified lodging costs on his travel vouchers and a finding that he had to reimburse the Government $24,423.14. He was removed from his position for falsifying official records for monetary gain and for other unrelated charges. The MSPB found no evidence of willful intent to defraud the agency by submitting false travel vouchers and no evidence that the lodging expenses submitted were false, but sustained the employee's removal on the other charges. Citing 5 U.S.C. 5702, which provides a per diem allowance for Federal government employees traveling on official business away from a designated post of duty, the Board found that the employee's emotional reaction to the denial of the reimbursement of his travel expenses constituted an injury sustained in the performance of duty. The circumstances relating to the travel vouchers were part of the employment and related to the duties the employee was employed to perform. Since the employee had been exonerated of charges that he falsified official records, there was no wrongful misconduct charge which would prevent coverage of his alleged emotional condition under the Act.

In Mary Alice Cannon, claiming as widow of Aubrey B. Cannon, 33 ECAB 1235, the employee received an erroneous personnel action reducing his salary. He suffered cardiac arrest and subsequent total disability leading to his death. Prior to his death the erroneous personnel action was corrected and the employee received a check for the amount by which his salary had been reduced. The claim was denied because the employee's cardiac arrest was not "closely associated with his job duties." The Board found that the employee's cardiac arrest and subsequent disability leading to his demise was an injury sustained in the performance of duty.

The Board noted that Cannon was unlike Cutler because the employee was not aspiring to change his working conditions or status. He was immediately concerned about a direct, unanticipated and erroneous action by the employing establishment affecting the conditions of his employment. His emotional reaction could not be considered self-generated because the action by the employing establishment affected the conditions of his employment; neither could it be considered self-generated because the action by

the employing establishment was directed to a particular employee on an official basis, and later found to be erroneous. Therefore, his cardiac arrest and subsequent death constituted an injury within the meaning of the Act.

Where the evidence shows error or abuse by the employing establishment, an employee's reaction cannot be considered self-generated and will come within the coverage of the Act. However, a reversal or modification of a disciplinary or other action taken against an employee does not necessarily establish that the employing agency's actions were in error or abusive. In Nicholas D. Buckley, Docket No. 91-673, issued October 24, 1991 the Board stated:

> appellant has submitted medical evidence which attributed the aggravation of his preexisting emotional condition to his termination from the letter carrier position he held at the employing establishment following 60 days of his probationary period. The evidence does not establish, however, that appellant's disability arose within the performance of duty. The record establishes that appellant's separation from the postal service resulted from two letters of warning he received, for failure to obey a direct order and for missing a collection box, and a preventable motor-vehicle accident. Following his separation, appellant filed grievances which resulted in one letter of warning being removed from appellant's record, in order that he could apply for a mailhandler position, and the second letter of warning being reduced to an official discussion, a form of discipline at the employing agency. In taking these administrative actions, appellant has not introduced any evidence which would demonstrate that the employing establishment erred or acted abusively in these matters. There is no evidence of record in this case that the employing establishment did not act reasonably in the administration of these personnel matters. The fact that one disciplinary letter of warning was removed and the second letter of warning was reduced to a discussion does not establish that the disciplinary actions brought against appellant were in error.

g. Personnel Actions. Personnel actions may be canceled or modified through various procedures such as arbitration, grievance, etc., or disputes may be settled without prejudice to the position of any party. Cancellation or modification of personnel actions and settlements of disputes do not, of themselves, establish that the actions were erroneous or unreasonable and therefore constitute factors of the employment. Affirming the Office's decision in William Cook, Docket No. 90-1343, issued November 30, 1990, the Board stated:

> appellant attributes his emotional condition to certain events and circumstances that occurred while he was a postal employee. These events and circumstances, although contemporaneous or coincident with appellant's employment, do not constitute factors of employment giving rise to coverage under the Federal

> Employees' Compensation Act. Appellant primarily complains that he has been the subject of long-standing harassment and discrimination from superiors and fellow employees, and he notes that he has filed complaints with the NLRB and EEOC, and numerous grievances. Yet, the record discloses no finding by the NLRB or EEOC to support appellant's assertions, and it appears that his grievances have yielded nothing more favorable than settlements without prejudice to the position of any party. The evidence does not establish that appellant was in fact the subject of harassment or discrimination.

Requirements imposed by the employment are not limited to assigned duties as such. Other circumstances relating to assigned duties may become part of the employee's employment and be sufficient to bring an injury or illness within the coverage of the Act.

In Pasquale Frisina, 34 ECAB 1230, the employee claimed that his emotional condition resulted from his receipt of an employing establishment letter criticizing his wife for the method of reporting his illness (telephone request to supervisor for sick leave). The employing establishment had procedures for reporting sick leave and returning to work. The employee's method for reporting sick leave had been questioned in the past. Citing 5 CFR 630.101, which charges agency heads with the responsibility for administering sick leave accounts for employees and provides how employees shall apply for sick leave, the Board found that the procedure for reporting sick leave was a requirement imposed by the employment. According to the Board the circumstances leading to the employee's alleged emotional reaction (wife's request on his behalf for sick leave; receipt of employing establishment letter) were part of the employment and related to the duties the employee was employed to perform and to the requirements imposed by the employment.

The Board reached a different conclusion in Joseph C. DeDonato, 39 ECAB 1260. Appellant contended that his emotional disability was caused by several factors including the employing establishment's refusal to grant his application for sick leave. The Board found that all of the factors cited by appellant, including the denial of sick leave, were factors involving personnel matters which did not have such a relationship to his assigned duties so as to be regarded as arising out of and in the course of the employment. The Board distinguished its holding in Frisina by noting that "Frisina addresses the issue of a duty imposed upon the employee by required reporting instead of the issue in the instant case which addresses the administrative denial of leave, and which is purely a personnel matter."

Since both cases involve procedures which employees must follow in order to obtain sick leave, it was unclear why the Board considered the procedural requirements a "duty imposed upon the employee" in Frisina but "purely a personnel matter" in DeDonato (the Board noted in DeDonato that, in response to his written request for sick leave, the employee received an immediate response from the employing establishment instructing him to "comply with employing establishment regulations within five days since his

current absence had exceeded three days"). The Office took the position that Frisina stood alone among cases of this type and that all circumstances related to the administration of leave were strictly personnel matters and not factors of the employment.

The Board clarified its position in Anthony A. Zarcone, 44 ECAB 751, finding that employment establishment requirements for the use of sick leave were not compensable factors of employment. In affirming the Office's decision that appellant had not met his burden of proof to establish that he sustained an injury in the performance of duty, the Board discussed its previous decisions in Cutler and Raymond H. Schulz, Jr., 23 ECAB 25. The Board stated:

> In the case of Pasquale Frisina, the Board stated that the procedure for reporting sick leave was a requirement imposed by the employment. It found, without explanation, that the circumstances presented were a part of the employment and related to the duties that the claimant was employed to perform and to the requirements imposed by the employment. This holding was not explained in light of the Board's prior decisions in Edgar Lloyd Pake, (33 ECAB 872) which found that the disapproval of a request for sick leave was not a compensable factor arising from the employment. Because there was no explanation of how the requirement related to the duties the claimant was hired to perform, Frisina implies that any "requirement" of employment constitutes a compensable factor of employment. Such a holding is too broad, as the above discussion of Lillian Cutler and Raymond H. Schulz, Jr., demonstrates. Accordingly, the Board expressly overrules Pasquale Frisina to the extent that it is inconsistent with Cutler, Pake and the holding herein. The Board notes that Pasquale Frisina was implicitly overruled in subsequent cases, notably Joseph C. DeDonato and Ralph O. Webster, (38 ECAB 521) which held that emotional conditions resulting from actions taken by the employing establishment in personnel matters such as use of leave are not sustained in the performance of duty.

The Board has thus made clear that requirements for use of sick leave are personnel matters, administrative in nature, and have no relationship to the duties the employee was hired to perform

h. Other Factors. The Board reiterates in its decisions the principles set forth in Cutler distinguishing between injuries or illnesses which have some connection with the employee's employment but do not result from the regular or special duties or a requirement imposed by the employment, and those that do. An employing establishment may take action against or relating to an employee because of something the employee did while on the job, or in connection with the employment, or because of his or her activities as a private citizen, which may result in a claim by the employee or dependents. In such cases the CE must determine whether the employee's actions were related to the

assigned duties and the requirements of the employment.

In <u>Walter Asberry, Jr</u>. 36 ECAB 686 (1985), the employee claimed that his emotional disability was the result or being terminated from his employment because of discrimination. The evidence showed that the employee's dismissal was properly based on his willful misconduct and the charges of discrimination were unsupported. The Board found that the employee's emotional upset was self-generated and did not arise out of or in the course of his Federal employment.

In <u>Helen Marrotte</u>, claiming as widow of Walter E. Marrotte, 36 ECAB 670 (1985), the employee accepted stolen military clothing from a co-worker who claimed to have found it in a locker. The employee was found to have had no part in the theft, but he received a written reprimand for having in his possession military clothing not received through regular supply channels. He filed a grievance but died of cardiac arrest before hearing were concluded. The Board found that, regardless of whether the employee knew that the clothing had been stolen, his acceptance of it through other than official channels was unrelated to his regular day-to-day duties, his specifically assigned duties or to a requirement imposed by his employment, and therefore the proceedings instituted against him were not factors of his employment.

In <u>Pauline Phillips</u> 36 ECAB 377 (1984), the employee, a postmaster, signed a petition regarding a community problem, which lead to a complaint filed against her by a local businessman. She received notice from the Postal Service that the complaint would be investigated. She alleged that worry over this caused her to develop an anxiety reaction and congestive heart failure. No investigation was initiated and Postal Service officials assured the employee that no adverse action would be taken against her. In finding that the employee was not entitled to coverage under the Act, the Board noted that her emotional reaction allegedly resulted from a situation which did not involve her ability to perform her day-to-day duties, or a special assignment, or because of a requirement imposed by the employing establishment. The situation arose because she exercised her rights as a private citizen.

The Board noted a similarity to the case of <u>Manuel W. Vetti</u>, 33 ECAB 750 (1982), a postmaster who developed a disabling emotional condition due to his reaction in an investigation involving a sale to the employing establishment of a parcel of land in which he had an interest. The Board found that the fact that the investigation would not have been initiated if Vetti were not a postmaster was "not a sufficient link to employment to consider his emotional reaction to it to have arisen out of the employment."

Ashberry's disability was not compensable because it had its origin in his willful misconduct. Marrotte's failure to conform to official procedures removed him from the coverage of the Act. Phillips' claim stemmed from her actions as a private citizen and the fact that she was the postmaster was insufficient to consider her disability as having

arisen out of her employment.

i. Distinguishing Among Factors and Non-Factors of Employment. In George Derderian, 33 ECAB 1910, issued September 16, 1982, the employee alleged numerous causes of his emotional condition, all of which had some connection with his employment but not all of which could be deemed conditions of his employment. In its remand order the Board stated that situations which could be deemed conditions of employment as enunciated in Cutler were the employee's emotional reaction to the circumstances of his performance rating; confrontations with his supervisor involving criticism and other verbal altercations concerning his performance; the employee's assignment to a special project and its subsequent cancellation; legal action taken against the employee by a subordinate for his failure to promote the subordinate; and the employing establishment's failure to arrange for the employee's defense in the ensuing lawsuit causing him to retain private counsel. Factors which were not compensable under Cutler were distress over reduction-in-force and the appeals process which followed; distress over a newly created position and the national advertisement of that position; and distress over the assignment of one of the employee's subordinates as his acting supervisor.

The Board's finding that Derderian's emotional reaction to the circumstances of his performance rating resulted from his employment preceded the Board's clarification of its McEuen decision that an unsatisfactory performance rating, without more, is insufficient to provide coverage. Therefore, Derderian does not apply to claims which involve an emotional reaction to performance evaluations or assessments or to discussions of performance. McEuen is considered to be the definitive opinion with regard to the compensability of performance evaluations, assessments or discussions and is the basis for Office policy that these are not deemed conditions of employment.

j. Developing Factors of Employment. An employee who claims to have had an emotional reaction to conditions of employment must identify those conditions. The CE must carefully develop and analyze the identified employment incidents to determine whether or not they in fact occurred and if they occurred whether they constitute factors of the employment. When an incident or incidents are the alleged cause of disability, the CE must obtain from the claimant, agency personnel and others, such as witnesses to the incident, a statement relating in detail exactly what was said and done. If any of the statements are vague or lacking detail, the responsible person should be requested to submit a supplemental statement clarifying the meaning or correcting the omission.

When all available evidence has been obtained, the CE must prepare an objective and neutral account of the facts (Statement of Accepted Facts, or SOAF). Where the evidence is in conflict, the CE must decide which is the best supported and most likely version. The CE must distinguish in the SOAF between those activities and circumstances which are factors of employment and those which are not (see PM Chapter

2-809.13c). The evaluating physician will be required to give a rationalized opinion specifying which activities and circumstances, as set forth in the statement of accepted facts, caused or contributed to the condition found on examination.

The determining factor in the types of cases discussed in this section is whether the alleged disability resulted from an incident or incidents which are sufficiently connected to the employment to be considered factors of the employment. To make this determination, the CE must fully develop the circumstances of the alleged injury as well as the employee's duties and working conditions. This will include not only those duties specifically defined (official position description) but also implied (not specifically defined but expected by the employing establishment), if any. Where a claim is filed because of an incident which appears to have no direct relationship to an employee's regular or specially assigned duties, the CE must decide whether a requirement imposed by the employment was involved that, under the circumstances, would be considered part of the employment.

Claims filed for injury or illness allegedly due to employing establishment actions against or relating to an employee solely because of willful misconduct, failure to conform to or violation of official agency procedures, or an employee's actions as a private citizen, do not have the coverage of the Act because the injury or illness does not result from the employee's regular or special duties or a requirement imposed by the employment. These situations are not the result of work performance, but of a type of behavior which removes the employee from the performance of duty. Claims filed for emotional reactions to personnel actions such as performance evaluations and administration of leave also do not have the coverage of the Act. Where the evidence, after proper development, shows the existence of any of the described situations, and requirements for time, civil employee and fact of injury have been met, the claim will be denied for failure to meet the performance of duty requirement.

CEs must become familiar with significant Board decisions in this area and apply the established precedents to new cases. In addition to the cases cited above, CEs should note Carol Medlinger, 29 ECAB 168, and Kenneth Vreeland, 12 ECAB 281.

k. Rescission. In some claims, factors which were originally accepted as work-related would no longer be considered so in light of the ECAB decisions quoted above. Therefore, it may sometimes be necessary to rescind a claim where the acceptance was based on factors which are no longer considered to fall within performance of duty. Decisions to rescind acceptance of a claim will be made only by journey-level CEs and above.

The Board has upheld the Office's authority to reopen a claim at any time on its own motion under section 8128(a) of the Act and, where supported by the evidence, set aside or modify a prior decision and issue a new decision. (Eli Jacobs, 32 ECAB 1147). To

justify rescission of acceptance, the Office must establish that its prior acceptance was erroneous based on a new or different evidence or through new legal argument and/or rationale as was done in the case of Curtis Hall, Docket No. 92-683, issued January 11, 1994.

In that case, appellant claimed an employment-related disabling emotional condition which he attributed to a confrontation with a coworker who objected to his bible reading during work breaks. He also alleged a previous incident when a toxic substance had been placed in his chair causing contact dermatitis, diabetes mellitus and hypertension. The Office accepted appellant's claim for a depressive reaction based solely upon medical opinion evidence without determining whether his allegations were supported by the factual evidence of record.

After appellant's claim was accepted, the employing establishment physician submitted a report to the Office which stated that appellant had sat on his own super glue pen container, which was not issued and used in his job, and that the incident would not cause hypertension or diabetes mellitus. On further review, the Office found that appellant's emotional condition did not arise out of factors of his federal employment, and that the medical opinion evidence on causal relationship was unrationalized.

An office hearing representative found that the alleged incidents of confrontation and placement of super glue on appellant's chair were not established as factual; that the medical reports of appellant's attending physician were based on an inaccurate history and therefore of little probative value; and that the reports of the physicians of record did not find appellant disabled for his position.

The Board found that the Office met its burden of proof to rescind its acceptance of this claim based on new medical evidence and the provision of new legal rationale that the implicated work related incidents were not established as factual.

When it has been determined that only correct and proper application of personnel and administrative matters were involved in a case accepted for emotional disability, the acceptance may be rescinded based on new legal argument that no employment factors were involved, without the need for new evidence. In those cases the CE will prepare a Memorandum to the Director which will include:

(1) A summary of the development and adjudication of the claim, noting that the Office had not previously considered whether the employment circumstances which caused the claimant's emotional reaction were factors of the employment.

(2) A description of the employment circumstances which caused the claimant's emotional reaction with an explanation of why they do not constitute employment factors, citing pertinent Board decisions.

(3) A recommendation to rescind acceptance of the claim based on new legal argument that, since the circumstances to which the claimant attributes emotional problems do not constitute factors of employment, disability did not arise out of the employment or in the performance of duty, and the employee has not sustained an injury within the meaning of the Act.

If the claimant does not respond to the pre-termination notice, or if the claimant's response is not sufficient to change the Office's position or to require further development of the record by the Office, a formal decision will be issued rescinding acceptance of the claim and terminating benefits on the ground that acceptance of the claim was incorrect because the circumstances to which the claimant attributes his or her emotional disability are not factors of the employment within the meaning of the Act and the claimant's disability did not arise out of in the course of his or her employment and he or she was not injured in the performance of duty.

2-0804-18 Employing Agency Physical Fitness Programs

18. Employing Agency Physical Fitness Programs. A number of employing agencies have instituted structured Physical Fitness Programs (PFPs), which typically include agency-appointed fitness coordinators, physical assessment tests and structured exercise while off duty. If the employee's position requires that a certain level of fitness be maintained, work time may be allocated for exercise. Employees enrolled in PFPs maintain logs of their program exercises and report to fitness coordinators, who have been trained by the agency to monitor progress and to give advice on matters related to physical fitness. Considering the degree of agency management, support and encouragement of PFPs, and the expressed benefits to the government anticipated from employee participation, employees enrolled in a PFP are in the performance of duty for FECA purposes while doing authorized PFP exercise, including off-duty exercises performed under the auspices of the fitness program.

a. Injuries and occupational diseases arising from participation in an employing agency's PFP are compensable under the FECA. Participation will not always occur during regular work hours, and not always on the employing establishment's premises.

b. Employees who are injured while exercising or participating in a recreational activity during authorized lunch or break periods in a designated area of the employing establishment premises have the coverage of the Act whether or not the exercise or recreation was part of a structured PFP. Injuries which occur during the use of fitness and recreational facilities furnished by the employing establishment outside of official work hours, on or off the premises, are not compensable if the employee was not participating in a structured PFP. The mere fact that the employing establishment allows employees to use its facilities on their own time does not create a sufficient connection to the employment to bring any resulting injury within the coverage of the Act.

c. All Forms CA-1 which attribute an injury to PFP activity must be accompanied by a statement from the employee's supervisor indicating that the employee was enrolled in the PFP, and that the injury was sustained while the employee was performing authorized exercises under the program. An assessment test provided as a part of the program or in a related screening process is considered a program-authorized exercise. The employee's supervisor must verify that the facts are as described on Form CA-1. If the statement from the supervisor is not submitted with Form CA-1 it must be requested. The supervisor must obtain this information from the fitness coordinator.

d. Where a Form CA-2 is filed claiming that an occupational disease is causally related to the PFP participation, the employee is required to state specifically what activities caused the condition. A statement must be obtained from the supervisor showing what exercises were approved to ensure that the activities performed were authorized under the program.

e. All employees in a PFP must receive medical clearance to participate. CEs must request a copy of the medical examination report in every case.

2-0804-19 Deleterious Effects of Medical Services Furnished by the Employing Establishment

19. Deleterious Effects of Medical Services Furnished by the Employing Establishment. Public Law No. 79-658, approved August 8, 1946, authorized Federal agencies and government-owned and controlled corporations to establish, by contract or otherwise, health service programs to provide health services for employees under their respective jurisdictions. These services are limited to (1) treatments on-the-job illness and dental conditions requiring emergency attention; (2) pre-employment and other examinations; (3) referral of employees to private physicians and dentists; and (4) preventive programs relating to health.

a. An employee who participates voluntarily in the health service program is considered in the performance of duty on those occasions when such participation causes absence from regular duties for the specific purpose of obtaining the medical service offered by the employer. Deleterious effects such as injury while undergoing periodic medical examination, reaction to agency-sponsored inoculation, or disease contracted from instrumentation are compensable.

b. Coverage for the deleterious effects of employer provided medical services is limited to employees who are voluntary participants in the employer's sponsored health service program and, only for the effects of treatment for on-the-job illness and dental conditions requiring emergency attention. Coverage for deleterious effects does not extend beyond the immediate service contemplated by P.L.-658; therefore it does not follow the employee who is referred for, or obtains, outside medical services.

c. The medical procedures involved in a pre-employment medical examination come within the rule for coverage provided the person has already been appointed or hired when the examination is performed. A prospective employee is not covered for compensation benefits.

d. Deleterious effects of medical services may be unavoidable or may occur because of error or agency failure to report examination results to the employee or to the employee's physician in time to alter the course of a disease. They may also result from an act such as inadvertently administering the wrong drug, or failure to inform an employee of positive test results.

e. Following appropriate development, all cases of this type should be referred to a District Medical Adviser for an opinion on whether the condition claimed was causally related to the agency medical service or was adversely affected by the failure to promptly alert the employee or the employee's physician.

f. This matter was initially addressed in FECA Program Memorandum No. 42 dated March 3, 1966 and was supplemented by Program Memorandum No. 186 dated December 23, 1974 which the Office interpreted as expanding coverage from on-the-job illness and dental conditions requiring emergency attention to any medical treatment given by the employing establishment for a non-employment related condition. The Employee's Compensation Appeals Board criticized this interpretation in Beverly Sweeney, 37 ECAB 651, noting that it exceeded "any authority given under the Act or any other statute as regulations." The Board also stated that "Neither the Office nor the Board has the authority to enlarge the terms of the Act nor to make an award of benefits under any terms other than those specified by law." The Office's interpretation was also contrary to previous Board decisions, several of which were cited in Sweeney.
The procedures set forth in this section conform to the Board's decision in Sweeney.

2-0805 CAUSAL RELATIONSHIP

Paragraph	Subject	Date	Trans. No.
	Table of Contents	07/00	00-08
1	Purpose	06/95	95-23
2	Types of Causal Relationship	06/95	95-23
3	Evidence Needed	07/00	00-08
		06/95	95-23
4	Evaluating Medical Opinions	06/95	95-23
5	Obtaining Additional Medical Opinion	06/95	95-23
6	Consequential & Intervening Injuries	06/95	95-23

7	**Psychological Factors Affecting Medical Condition**	**10/95**	**96-05**
8	**High-Risk Employment**	**10/95**	**96-05**

2-0805-1 Purpose and Scope

1. Purpose and Scope. This chapter contains guidelines for determining the question of causal relationship as it relates to both traumatic injury and occupational illness. (Further information concerning specific diseases is contained in FECA PM 2-806 and MEDGUIDE, while evaluation of medical evidence is discussed in FECA PM 2-810.)

2-0805-2 Types of Causal Relationship

2. Types of Causal Relationship. An injury or disease may be related to employment factors in any of four ways, as follows:

a. Direct Causation. This type of relationship is shown when the injury or factors of employment, through a natural and unbroken sequence, result in the condition claimed. A fractured arm sustained in a fall would be considered a direct result of the fall, and a sensorineural hearing loss might likewise be caused directly by occupational noise exposure over a period of time.

In occupational disease claims, however, the medical evidence needed to support the relationship will likely require greater rationale than in traumatic injury claims. The phrase "proximately caused" is used also to designate this kind of relationship.

b. Aggravation. This kind of relationship occurs if a pre-existing condition is worsened, either temporarily or permanently, by an injury arising in the course of employment. For instance, a traumatic back injury may aggravate a claimant's pre-existing degenerative disc disease, and compensation would be payable for the duration of the aggravation as medically determined.

(1) Temporary aggravation involves a limited period of medical treatment and/or disability, after which the employee returns to his or her previous physical status. Compensation is payable only for the period of aggravation established by the weight of the medical evidence, and not for any disability caused by the underlying disease. This is true even if the claimant cannot return to the job held at time of injury because the pre-existing condition will worsen if he or she does so (see James L. Hearn, 29 ECAB 278).

Temporary aggravations may involve either symptoms or short-term worsening of a condition. For instance, a claim may be accepted for angina, which is essentially a symptom, in which case medical treatment and compensation would be limited to the period of work-related angina and would not encompass treatment or disability due to the underlying condition.

Likewise, a claimant with a psychiatric condition may suffer a short-term worsening of the condition which then reverts to its prior state. Both of these situations qualify as temporary aggravation.

In accepting a case for temporary aggravation of a pre- existing condition, the Claims Examiner (CE) should note on the CA-800 and in the CMF, and in correspondence with the claimant, the fact that the acceptance is limited to temporary aggravation and does not include the underlying condition. It may also be useful to note the specific dates of the aggravation or the date the aggravation ceased.

(2) Permanent aggravation occurs when a condition will persist indefinitely due to the effects of the work-related injury or when a condition is materially worsened such that it will not revert to its previous level of severity. For instance, an allergy which would have persisted in any event may be permanently aggravated by exposure to dust and fumes in the workplace such that subsequent episodes are more severe than they otherwise would have been.

A case should be accepted for permanent aggravation only after careful evaluation of all medical evidence of record. Such a finding provides no additional benefit to the claimant and should not be routinely considered due to the difficulty involved in rescinding it if the claimant's condition improves.

c. Acceleration. An employment-related injury or illness may hasten the development of an underlying condition, and acceleration is said to occur when the ordinary course of the disease does not account for the speed with which a condition develops. For example, a claimant's diabetes may be accelerated by a work schedule which is so erratic that it prohibits the regular food intake required by persons with this condition. An acceptance for acceleration of a condition carries the same force as an acceptance for direct causation. That is, the condition has been accepted with no limitation on its duration or severity.

d. Precipitation. A latent condition which would not have become manifest but for the employment is said to have been precipitated by factors of the employment. For instance, tuberculosis may be latent for a number of years, then become manifest due to renewed exposure in the workplace. The claim would be accepted for precipitation, but the acceptance would be limited to the period of work-related tuberculosis and the OWCP's responsibility for the condition would cease once the person recovered.

Any ensuing episode of the disease would be considered work-related only if medical evidence supported such a continued relationship. In this way acceptance for precipitation may resemble acceptance for temporary aggravation. A claim can also be accepted for precipitation of a condition with no limit on the duration of the acceptance.

2-0805-3   Evidence Needed

3. Evidence Needed.   The question of causal relationship is a medical issue which usually requires reasoned medical opinion for resolution. This evidence must be obtained from a physician who has examined or treated the claimant for the condition for which compensation is claimed.

a. Physicians Qualified to Provide Opinions. As defined by 5 U.S.C. 8101, the term "physician" includes surgeons, osteopathic practitioners, podiatrists, dentists, clinical psychologists, optometrists and chiropractors within the scope of their practice as defined by State law. [See FECA PM 3-100.3(a) and (b).] Clinical psychologists may serve as treating physicians for work-related emotional conditions. A chiropractor's opinion constitutes medical evidence only if a diagnosis of subluxation of the spine is made and supported by X-rays (Loras C. Digmann, 34 ECAB 1049). A claims examiner may request the x-ray or the report of x-ray if there is any indication in the factual or medical evidence that there may not be a subluxation present.

b. Sources of Medical Evidence. A medical report from the attending physician is required to consider the issue of causal relationship. This report should include the physician's diagnosis of the condition found and opinion concerning the relationship, if any, between the condition and the injury or factors of employment claimed. The opinion may appear in Form CA-16, Form CA-20 or 20a, Form CA-5 or 5b, or in other medical forms or narrative reports.

c. Obtaining Medical Evidence.

(1) The CE should determine whether a medical report addressing causal relationship is contained in the file and, if so, whether the opinion is rationalized. (In a few situations, as described in paragraph 3d below, a rationalized opinion is not required.) If no such report is present, the CE should request it from the claimant except as noted below.

(2) If examination or treatment was obtained from a Federal medical facility or from the employing agency, it is the OWCP's responsibility to request reports directly from the physician or hospital involved. Because the OWCP has requested only a report, a prompt payment form need not be forwarded with the request, as would be necessary if treatment has been requested. The agency should be advised that if it fails to provide the requested information, a decision will be made on the basis of available evidence.

(3) Unless the claimant has established a prima facie case, the CE should not communicate with providers who attended the claimant in a private capacity. Where a prima facie case has been established, however, the CE may sometimes find it desirable to request medical evidence directly from a private source.

d. When Medical Opinion is Required.

(1) When the following criteria are satisfied a case may be accepted without a medical report:

(a) The condition reported is a minor one which can be identified on visual inspection by a lay person (e.g., burn, laceration, insect sting or animal bite);

(b) The injury was witnessed or reported promptly, and no dispute exists as to the fact of injury; and

(c) No time was lost from work due to disability.

(2) In clear-cut traumatic injury claims, where the fact of injury is established and is clearly competent to cause the condition described (for instance, a worker falls from a scaffold and breaks an arm), no opinion is needed. The physician's affirmative statement is sufficient to accept the claim.

(3) In all other traumatic injury claims, rationalized medical opinion supporting causal relationship is required.

(4) In occupational illness claims, a rationalized medical opinion should be provided by the attending physician. CEs should use discretion, however, where a condition (such as a ganglion cyst, for example) resulting from only a few days of exposure is involved and the evidence pertaining to causal relationship is straightforward with respect to the amount of rationale required.

(5) In any case where a pre-existing condition involving the same part of the body is present and the issue of causal relationship therefore involves aggravation or precipitation, the attending physician must provide rationalized medical opinion which differentiates between the effects of the employment- related injury or disease and the pre-existing condition. Such evidence will permit the proper kind of acceptance (temporary vs. permanent aggravation, for instance).

(6) Certain other kinds of cases require specialized medical opinions. All claims for hearing loss due to acoustic trauma require an opinion from a Board-certified specialist in otolaryngology, and all claims for pulmonary condition due to exposure to asbestos require an opinion from a Board-certified pulmonary specialist prior to acceptance.

A claim for emotional condition must be supported by an opinion from a psychiatrist or clinical psychologist before the condition can be accepted. Because clinical psychologists are not licensed to treat physical disorders or prescribe medication, an opinion from a psychiatrist must be obtained where a non-mental component is present, a functional overlay is implicated, and/or medication is used.

e. Evidence Needed if an Underlying Condition Exists. When the issue of causal relationship involves aggravation, acceleration, or precipitation of a pre-existing condition, the CE must ensure that the file reflects a full and accurate history of that condition.

(1) From the claimant, the CE should obtain:

(a) Full details of the pre-existing condition, including the approximate date it first appeared, the names and addresses of all physicians who examined or treated the claimant for this condition, and the approximate dates of such examinations and treatment.

(b) Reports from all physicians who examined or treated the claimant for the pre-existing condition.

(2) From the employing agency, the CE should obtain:

(a) A copy of the pre-employment physical examination, if one was performed.

(b) Copies of any other pertinent medical records at the employing agency.

(c) A statement from the immediate superior describing the pre-existing condition, the nature of any complaints made by the claimant, and any handicap suffered by the claimant in performing his or her duties because of this condition.

f. Lack of Evidence or Negative Evidence.

(1) When the attending physician negates causal relationship between the condition and the employment and no medical evidence to the contrary appears in the file, the case may properly be disallowed. No other medical opinion is required to support the denial.

(2) When the attending physician is silent with respect to causal relationship in a primary case, the claim may be denied without further development. The only exception to this rule is where no opinion is required (see paragraph 3d(2) above).

2-0805-4 Evaluating Medical Opinions

4. Evaluating Medical Opinions.

a. Determining Causal Relationship. This process may be fairly simple or very difficult. The degree of difficulty depends mainly on:

(1) The precise employment factors or the nature of the injury which is implicated;

(2) The nature of the disability or the cause of death for which compensation is claimed;

(3) The time which elapsed between the injury and the onset of the condition causing disability or death; and

(4) The employee's medical history.

b. The influence of these factors on the question of causal relationship is shown by the following examples:

(1) An employee is hit by a truck and is immediately taken to a hospital, where a fracture of the right femur is found. It is clear that the fracture was caused by the truck accident, and the report from the attending physician supporting causal relationship would need no medical rationale.

Ninety days after the injury, symptoms of thrombophlebitis appear in the right leg and compensation is claimed for this condition. The passage of this amount of time between the injury and the development of the thrombophlebitis would create doubt about causal relationship. The report from the attending physician would need to include medical rationale to justify an opinion in support of causal relationship.

Six months later, the employee suffers a stroke while sitting quietly in an easy chair at home. The employee claims additional benefits for the stroke, alleging it was caused by the original injury. Two reasons now exist for serious doubt concerning causal relationship: (a) nine months elapsed between the injury and the stroke, and (b) the original injury involved the leg, whereas the stroke resulted from a lesion in the brain, and no apparent physiological connection exists between the two. Any medical opinion in support of causal relationship would have to be well fortified by medical rationale. Otherwise, the claimant's burden of proof would likely not be met.

(2) <u>A nurse becomes disabled by pulmonary tuberculosis</u> after a year of continuous employment on a ward where active tuberculosis patients were housed. If all other factors were negative, any medical opinion supporting causal relationship would require little or no rationale, as it would be apparent that the most probable source of the infection was in the employment.

If, however, investigation had revealed that the employee lived with a spouse in whom an advanced case of active pulmonary tuberculosis had been discovered 60 days before, two probable sources of the infection exist: the hospital where the employee was exposed for 40 hours per week in an atmosphere where the hazard was known and appropriate precautions were taken; and the home, where the hazard was unknown and no precautions were taken and where the contact was much more intimate and far exceeded 40 hours per week.

Under these circumstances, it would be more difficult to find that the employment was a proximate cause of the disease and any medical opinion in support of causal relationship would require a full description of the medical reasons justifying such an opinion.

Another variation involves the supposition of massive exposure at work and no exposure in private life, but with a positive skin test for tuberculosis prior to Federal employment. The major question then would be whether the current illness is a new disease process or a reactivation of an old one. This issue would require careful consideration, and any opinion which did not discuss all relevant factors and contain detailed rationale would not be sufficient to serve as the basis for a decision.

2-0805-5 Obtaining Additional Medical Opinion

5. Obtaining Additional Medical Opinion. When the medical report is prima facie sufficient but the opinion provided is unrationalized or speculative, the CE may find that causal relationship cannot be properly determined on the basis of the medical evidence of record. When this happens, the CE must obtain additional medical evidence. Following is a description of the format such requests should take and the sources from which additional opinions may be requested.

a. Statement of Accepted Facts (SOAF). The CE should prepare an SOAF as a frame of reference (see FECA PM 2-809) and should also state on a separate sheet of paper the specific questions for which medical opinion is desired. These questions should be as precise as possible, and they should be tailored to the particular circumstances of the case and the particular issue at hand.
The CE should avoid asking general questions, those which can be interpreted in more than one way, and those which suggest a certain answer. For instance, the question, "If there was an aggravation, was it temporary or permanent?" is preferable to "When did the temporary aggravation cease?"

b. Avoiding Serial or Piecemeal Handling of Cases. To prevent unnecessary delays in adjudication, the CE should ensure that all medical issues which need resolution are identified before requesting additional opinion. For example, if acceptance of causal relationship will entail a further decision about the extent of disability, the claimant's fitness for duty, or the appropriateness of medical care, these issues should be formulated in precise questions to the physician.

The CE may find it useful to imagine all the possible answers to the initial question and then to consider what information would be needed to take the next action in accordance with each of the possibilities. This exercise may suggest further questions which should be posed to the physician.

c. Additional Medical Opinion. The following may be asked to provide further medical rationale:

(1) Attending Physician. The SOAF and list of questions should be sent to the attending physician.

(2) Second Opinion Specialist. In cases which cannot be adjudicated on the basis of opinions provided by the attending physician, an opinion will be requested from a physician who specializes in the pertinent field of medicine. Form CA-19, Memorandum of Referral to Specialist, may be used to list the questions for the specialist. (FECA PM 3-500.3 discusses such referrals.)

(3) Referee Specialist. A conflict of medical opinion may be created when opinions of approximately equal weight appear in the file. When this occurs, the entire case file is referred to a board-certified specialist in the pertinent field of medicine. (FECA PM 3-500.4 addresses these referrals.)

2-0805-6 Consequential and Intervening Injuries

6. Consequential and Intervening Injuries. Under certain circumstances an injury occurring outside performance of duty may affect the compensability of an already-accepted injury.

a. Consequential Injury. This kind of injury occurs because of weakness or impairment caused by a work-related injury, and it may affect the same part of the body as the original injury or a different area altogether. For instance, a claimant with an accepted knee injury may fall at home because the weakened knee has buckled. This incident will constitute a consequential injury whether the affected part of the body is the knee or some other area, such as the back or arm. Or, a claimant with an injured eye may compensate for loss of functioning by overuse of the other eye, which may result in a consequential injury. If such an injury is claimed, the CE should:

(1) Ask the claimant to explain the details of the second injury and give reasons for believing that it is related to the first;

(2) Ask the claimant to furnish a medical report on the second injury which includes an opinion concerning the relationship between the two injuries;

(3) Obtain an evaluation from the DMA concerning the causal relationship of the second injury to the first.

b. Intervening Injury. An injury occurring outside the performance of duty to the same part of the body originally injured is termed an intervening injury if compensation is claimed subsequent to the second injury. In this case the CE must determine whether the disability is due to the second injury alone, or whether the effects of the first injury still contribute to the disability. Unless the second injury breaks the chain of causation between the original injury and the disability claimed, the disability will be considered related to the original incident.

When an intervening injury has occurred and a subsequent period of disability has been claimed, the CE should obtain the following information from the claimant to resolve the issue of causal relationship:

(1) A statement giving full details of the second incident and copies of all medical reports pertaining to treatment of this injury; and

(2) A medical report containing a reasoned opinion concerning the relationship between the disability currently claimed and both the original injury and the intervening injury.

2-0805-7 Psychological Factors Affecting Medical Condition

7. Psychological Factors Affecting Medical Condition. Unlike psychological conditions which may result from employment factors or from the effects of a specific injury, psychological factors affecting the medical condition express themselves physically in conjunction with an injury or illness. The symptoms have no physical basis, nor are they produced voluntarily. If pain is the only symptom, the term used to designate the condition is "psychogenic pain disorder." If physical functioning is lost or altered, the term "conversion disorder" applies.

In either case, the symptom or pain is quite real to the individual involved although there is no demonstrable physical disorder. (Malingering, on the other hand, is the voluntary presentation of false or exaggerated symptoms in pursuit of an obvious goal, such as avoiding work or obtaining financial compensation.)

Indications that psychological factors may be present include apparent lack of recovery within the usual medical time frame and exaggerated symptoms in comparison with the objective findings. To be compensable, such factors must be related to the employment injury rather than to some other aspect of the claimant's life.

The issue of psychological factors should be developed only if the attending physician indicates that such a component is present and that it is related to the employment injury. Where such a prima facie case is established, the CE should refer the claimant to a Board-certified psychiatrist for evaluation and opinion concerning causal relationship.

2-0805-8 High-Risk Employment

8. High-Risk Employment. Certain kinds of employment routinely present situations which may lead to infection by contact with animals, human blood, bodily secretions, and other substances. Conditions such as HIV infection and hepatitis B more commonly represent a work hazard in health care facilities, correctional institutions, and drug treatment centers, among others, than in Federal workplaces as a whole. Likewise, claims for brucellosis, anthrax, and similar diseases will most often arise among veterinarians and others who regularly work with livestock.

a. Physical Injury and Prophylactic Treatment. For claims based on transmission of a communicable disease where the means of transmission and the incubation period are medically feasible, the CE should do the following:

(1) If the source of infection is a known or probable carrier of the disease, the CE should accept the case for the physical injury involved and authorize prophylactic treatment (see FECA PM 3-400.7a).

(2) If the source of infection is unidentified or the source's status is unknown, the CE should accept the claim for the physical injury involved. Prophylactic treatment for the underlying disease will not be an issue, since a known carrier is not involved.

b. Testing for Presence of Disease. Incubation periods often last for several weeks or months (e.g., it is around 120 days for hepatitis B). Therefore, testing for the presence of the disease following a specific, known exposure may be delayed. Employees in occupations with high risks of exposure to specific diseases are often tested for these diseases at fixed intervals (e.g., a phlebotomist may be tested every three months for HIV infection). If the test results are positive, the CE may accept the case if:

(1) A known carrier is involved, and the claimant had neither a prior history of the disease nor exposure outside of employment; or

(2) A prior test was negative and a physical injury has been accepted, even if a known carrier is not involved, if the claimant's occupation puts him or her at continuous risk for contracting the disease in question and factors unrelated to work have not been identified as a source of infection. If such factors are present, the CE must carefully consider the medical probability of infection both outside and within the sphere of employment, as well as the incubation period of the disease.

2-0806 OCCUPATIONAL ILLNESS

Paragraph	Subject	Date	Trans. No.
Table of Contents		09/97	97-16
1	Purpose and Scope	10/95	96-01
2	Responsibilities	10/95	96-01
3	Kinds of OD Claims	10/95	96-01
		06/96	96-20
4	Developing Factual Evidence	10/95	96-01
5	Developing Medical Evidence	10/95	96-01
6	Aggravation of Medical Condition	10/95	96-01
7	Adjudicating the Claim	10/95	96-01
8	Managing the Claim	10/95	96-01

		09/97	97-16

Exhibits -- Sample Letters

1	To Physician	09/94	94-42
2	To Claimant-Asbestosis	09/94	94-42
		11/96	97-02
3	To Agency--Asbestosis	09/94	94-42
4	To Claimant--Cardiac Condition	09/94	94-42
5	To Agency--Cardiac Condition	09/94	94-42
6	To Claimant--Carpal Tunnel Syndrome	09/94	94-42
7	To Agency--Carpal Tunnel Syndrome	09/94	94-42
8	To Claimant--General	09/94	94-42
9	To Agency--General	09/94	94-42
10	To Claimant--Hearing Loss	09/94	94-42
11	To Agency--Hearing Loss	09/94	94-42
12	To Claimant--Orthopedic Condition	09/94	94-42
13	To Agency--Orthopedic Condition	09/94	94-42
14	To Claimant--Psychiatric Condition	09/94	94-42
15	To Agency--Psychiatric Condition	09/94	94-42
16	To Claimant--Pulmonary Condition	09/94	94-42
17	To Agency--Pulmonary Condition	09/94	94-42
18	To Claimant--Skin Condition	09/94	94-42
19	To Agency--Skin Condition	09/94	94-42
20	To Claimant--Other Conditions	11/95	96-05
21	Nature of Injury Codes	10/95	96-01

2-0806-1 Purpose and Scope

1. Purpose and Scope. This chapter contains procedures for developing, adjudicating and managing claims for occupational disease (OD). It supplements information about developing claims (FECA PM 2-0800); the five basic requirements (FECA PM 2-0801 through 2-0805); weighing medical evidence (FECA PM 2-0810); and case management (FECA PM 2-0600).

2-0806-2 Responsibilities

2. Responsibilities. The purpose of this paragraph is to describe the basic responsibilities of the claimant, the employing agency, and the OWCP in handling OD claims.

a. Claimant. The claimant has the burden of establishing that the claimed condition

is causally related to factors of Federal employment (see 20 CFR 10.100 and FECA PM 2-0805). However, the OWCP should provide the claimant with guidance and assistance.

b. Employing Agency. When issuing a Form CA-2, the supervisor or injury compensation specialist should provide the claimant with a checklist showing the type of evidence which is to be submitted. The checklists are as follows:

(1) General checklist (CA-35A);

(2) Hearing loss (CA-35B);

(3) Asbestos-related illness (CA-35C);

(4) Coronary/vascular conditions (CA-35D);

(5) Skin diseases (CA-35E);

(6) Pulmonary illness other than asbestosis (CA-35F);

(7) Psychiatric illness (CA-35G); and

(8) Carpal tunnel syndrome (CA-35H).

Sample development letters corresponding to the illnesses addressed by the checklists appear as Exhibits 2-19. Sample questions for other conditions are found in Exhibit 20.

c. OWCP. To adjudicate OD claims promptly and manage them effectively, the CE must choose the most efficient, direct, and pro-active approach given the individual circumstances of a claim and the nature of injury.

The CE must advise the claimant of the deficiencies of a claim before adjudicating it. Only one such notification is required, although the CE should attempt to clarify any discrepancies which arise from information already in file or received in response to the first request. If the time allowed for response expires and no reply has been received, the CE may adjudicate the case on the evidence of record.

A Senior Claims Examiner (SrCE) may be assigned to develop and adjudicate a complex OD claim. Such assignment may be desirable where the agency disputes the facts in the case; where conferencing will likely be the most effective means of developing the factual evidence; or where factual discrepancies remain after several attempts to resolve them.

2-0806-3 Kinds of OD Claims

3. Kinds of OD Claims. The purpose of this paragraph is to discuss the level of development required by various kinds of occupational disease claims. The level of development usually corresponds to the nature of injury. Most cases will require limited or no development, while a smaller number will require full-scale, extensive development.

a. Standard Development. Most claims for skin, orthopedic, virological, infectious, and parasitic diseases can be adjudicated with an initial request for information and perhaps a follow-up query for clarification. (Some will clearly address all five basic requirements and may be adjudicated on their face if all necessary evidence is in file). These cases are considered basic OD claims.

(1) Examples. The following situations illustrate the kinds of cases which may be considered basic OD:

(a) A claim for poison ivy where the claimant's employment involves exposure to the plant, and the medical evidence confirms the diagnosis.

(b) A claim for a stress fracture of the foot from a letter carrier who walks a route, where the medical evidence confirms the diagnosis and relates it to extensive walking.

(c) A claim for carpal tunnel syndrome from a postal letter-sorting machine (LSM) operator where medical tests establish the diagnosis.

(d) A claim for brucellosis filed by a meat inspector where medical evidence shows that Brucella was cultured from the employee's blood.

(2) Adjudication. The CE may accept a basic OD case if the file contains a statement describing the employment-related exposure and a medical report which both defines the medical condition and relates it to the claimed exposure. An affirmative opinion on causal relationship, without rationale, will be sufficient to accept most cases. In questionable cases, the CE must determine whether further medical development, such as a letter to the attending physician or a second opinion examination, is needed before adjudication.

(3) Disability. If the medical evidence of record establishes disability, the CE should take the following steps, depending on when the disability occurred:

(a) Disability at the time of acceptance requires the CE to establish the extent and degree of injury-related disability by arranging a second opinion referral with a specialist in the indicated field of medicine. See FECA PM 2-0810 concerning preparation of such referrals. The referral

should include a request to perform any necessary testing.

(b) Disability after acceptance may be due to surgery or worsening of the accepted condition. When a claim is filed, the CE should prepare a Statement of Accepted Facts (SOAF) and ask the attending physician or second opinion specialist how the medical condition changed, whether the disability is employment-related, and when recovery is expected to occur. (These actions are not necessary when surgery for carpal tunnel syndrome is at issue, however, since surgery is often the recommended treatment for this condition).

(4) Potential Expansion of Claim. Where it appears that additional conditions may be claimed, the CE should document the record by requesting full details of exposure and detailed medical opinion concerning any period of total or partial disability. However, the CE should not delay adjudication of the claim for receipt of this information.

c. Extended Development. Most other kinds of OD claims require full-scale development because the nature of exposure is in question, the diagnosis is not clearly identified, or the relationship of the condition to the exposure is not obvious. Such cases include:

(1) Hearing loss and asbestos-related illnesses, which usually require second opinion medical referrals before adjudication.

(2) Stress-related conditions (cardiac, emotional, gastrointestinal). These cases can be classified as basic OD only when the period of disability is closed and in the past and all five basic requirements are clearly addressed.

(3) Other conditions, such as pulmonary conditions; gastrointestinal illnesses due to physical causes; loss of vision, dental conditions, inguinal hernias, nerve injuries, tumors, and pregnancy (in Peace Corps cases).

2-0806-4 Developing Factual Evidence

4. Developing Factual Evidence. The purpose of this paragraph is to identify the kinds of factual evidence specifically needed in occupational illness cases, and how to obtain this evidence.

a. Review Evidence in File. Before making any inquiries, the CE should carefully review all material in file, both to identify evidence needed for adjudication and to avoid requesting evidence already provided or not needed.

If the file contains enough evidence for the CE to write a complete SOAF, no further development of the factual evidence is needed. The CE should refer to MEDGUIDE in Folioviews (Medical Management of Claims under the FECA) for guidance on information needed to support claims for various medical conditions.

b. Identify Sources of Information. The CE should use the telephone to find out the best party to contact if this information not readily apparent. For example, call the agency to determine the name and address of a manufacturer.

(1) Nature of Claim. The claimant should be asked to clarify what condition is being claimed, or whether the claimed condition is due to an occupational disease, a traumatic injury, or a recurrence, If doubt exists.

(2) Description of Job Duties.

(a) The employing agency should be asked to provide position descriptions, including physical requirements, and clarification of job duties.

(b) The claimant should usually be asked to describe the physical and environmental requirements of the job, and the supervisor or injury compensation specialist should review the statement before submission to the OWCP.

(c) However, where the position description accurately describes the factors claimed as the basis of a medical condition, it is not always necessary to request a detailed statement from the claimant describing these factors. For example:

Where aggravation of degenerative disc disease due to repeated heavy lifting is claimed, and the position description states that frequent lifting over 50 pounds is required, it can be accepted that the claimant often lifted heavy objects.

Where an employee claims a reaction to breathing paint fumes, and the position description states that he or she works with paint in poorly ventilated areas, this can be accepted as factual.

(3) Employment History. The employing agency is the best source for a chronological history of employment. For a claimant who is now retired, or who was employed at a now-defunct facility, the CE may request the Official Personnel Folder from the Federal Records Center. The CE may want to coordinate use of the file with the employing agency, which may also require it to provide necessary information.

(4) Exposure to and Identification of Substances. The employing agency is the usually the best source for this data. However, if the specific agent to which the claimant was exposed was clearly encountered in the work place, it is not always necessary to identify the agent. For example, if the case involves a respiratory condition clearly related to exposure to fumes at work, or dermatitis from contact with a cleaning solvent used at work, the agent need not be specified.

(5) Content of Substances. The manufacturer will likely be the best source of information concerning the contents of a substance. If such exposure is claimed, the CE should consider whether potential third-party liability exists. If so, the case must be processed according to FECA PM 2-1100.

(6) Personal History. The claimant is clearly the best source for information concerning off-the-job exposure to potentially injurious conditions or substances. However, medical reports containing history elicited by physicians who have examined the claimant sometimes includes useful factual information. For example, personal or family history may appear in a claim for a psychiatric or heart condition. The CE should ask the claimant to verify any facts obtained from a medical report.

c. Request Information. The CE should use the telephone to obtain information or clarification wherever possible. Otherwise, a letter or conference may be used as follows:

(1) Form Letters. Exhibits 2-19 show sample letters which may serve as initial requests for information to the claimant and the agency. These letters correspond to the OD checklists. For conditions not represented by the sample letters, the CE may use the questions shown in Exhibit 20.

(a) The letters require the CE to state what evidence is already in the case record and why it is not sufficient to make a decision.

(b) The CE must then choose specific paragraphs which request only the information necessary to adjudicate the case at hand.

(c) Where the claimant's statement is essential to understanding the basis of the claim (e.g., in emotional stress cases), the CE should wait until the claimant's statement has been received before sending the letter to the agency.

(2) Narrative Letters. For follow-up requests and situations where form letters will not fully address the needs of the case, the CE should use narrative letters.

(a) The contents of the sample letters may be modified or used as guidelines for writing narrative letters in complex cases.

(b) If further clarification or additional information is needed after the response to the original letter (whether form or narrative) is received, the CE must prepare a narrative letter or contact the indicated party by telephone.

(3) Conferences. In certain situations, conferencing may be necessary to develop the facts (see FECA PM 2-0500). For example:

(1) The evidence clearly shows the claimant cannot communicate in writing.

(2) The agency challenges the claimant's allegations and provides conflicting factual evidence.

(3) The agency has not responded to a written request, or its submission requires clarification.

(4) Attempts to obtain clarification or evidence by telephone or in writing are unsuccessful.

d. Lack of Response. The CE should allow at least 30 days for full replies to all letters.

(1) Where the agency fails to respond to a request for comments on the claimant's allegations, the CE may accept the claimant's statements as factual.

(2) Where the claimant fails to respond, the CE will need to decide whether to adjudicate the claim without the requested information. Often the CE can continue to develop a claim and reach conclusions on the five basic requirements even when some evidence is lacking.

For example, in a claim filed for mental stress due to factors of employment, the attending physician diagnoses depression and states that the claimant was hospitalized for depression three years ago. The CE asks the claimant to submit medical records for the prior hospitalization, but the claimant does not do so.

While records of past medical treatment are helpful, their absence may not prohibit further development of the claim or a decision on causal relationship. If such a decision cannot be made without the missing records, the claim should be denied on the basis that the claimant failed to establish causal relationship, and the decision should explain why causal relationship cannot be accepted without the missing medical records.

2-0806-5 Developing Medical Evidence

5. Developing Medical Evidence. The purpose of this paragraph is to address the nature of the medical evidence needed to adjudicate OD cases, and how to obtain it.

a. Review Evidence in File. For the OWCP to undertake development of the medical evidence, the claimant should submit some medical evidence which states a diagnosis and supports causal relationship. However, the opinion need not be rationalized.

(1) For most conditions, the attending physician's opinion may be considered conclusive for adjudicating the claim if he or she: is a specialist in the indicated field of medicine; has a complete and accurate history of the employment factors; and provides sufficiently detailed information, including the medical reasoning required to determine diagnosis and causal relationship.

(2) For cardiac and psychiatric conditions, the CE must prepare a detailed SOAF and questions for a physician. If the medical evidence submitted by the claimant addresses these questions and meets the requirements stated above, the CE should prepare a memo to file stating where in the medical reports of record the questions have been answered. After completing the memo, the CE may adjudicate the claim.

(3) For hearing loss and asbestosis claims, the OWCP should refer the claimant for examination by a qualified specialist if the report submitted by the claimant does not meet all of the OWCP's requirements for adjudication (see FECA PM 3-0600).

b. Identify Sources of Information. The CE should use the telephone to find out the best party to contact if this information not readily apparent. For instance, if the attending physician is not identified in the file, call the claimant and inquire.

(1) Comprehensive Medical Report. The CE should ask the claimant to submit such a report from the attending physician, except in cases for asbestos and hearing loss, where a report which contains the information noted in paragraph a directly above will suffice.

(2) Medical Records. These may be requested from the employing agency, which maintains the Employee Medical Folder (EMF). For a claimant who is now retired, or who was employed at a now-defunct facility, the CE may request the EMF from the Federal Records Center.

Medical records may also be requested directly from the claimant or physician. If necessary, the CE should send the claimant an authorization for release of records (Form CA-57) to sign and return.

(3) Additional Medical Opinion. The CE may need to obtain additional medical evidence. Unless the medical history of the case demonstrates that an

inquiry to the attending physician will not be productive, it is usually proper to make at least one request to that physician before arranging a second opinion referral.

c. Request Information. Further medical opinion may be requested from attending physicians, second opinion specialists, and referee specialists. The roles of these physicians and the weighing of medical evidence are addressed in FECA PM 2-0810.

(1) Mechanics of Referral. The procedures for referring cases to second opinion and referee specialists are addressed in FECA PM 3-0400.

For referrals to an attending physician, the CE should write directly to the physician and provide the information shown in Exhibit 1. (In psychiatric cases, the CE should ask the physician to provide a copy of the report to the claimant only if he or she feels it would not be detrimental to the claimant.)

The CE should send the claimant a copy of this and all other letters to the attending physician and advise the claimant that it remains his or her responsibility to ensure that the required evidence is submitted, even though the OWCP is attempting to obtain the evidence needed to adjudicate the claim.

(2) Statement of Accepted Facts. If a SOAF is needed, it should describe accepted exposure and distinguish between factors which are accepted as occurring within the performance of duty and those which are not.

(3) Questions to Physicians. The questions should address all unresolved medical issues (see MEDGUIDE for sample questions related to specific diseases). The CE should:

(a) Include questions about diagnosis, causal relationship (with medical reasoning), and nature and extent of injury-related disability for regular and light duty.

With respect to causal relationship, it may be useful to provide the physician with the OWCP's definitions of direct causation, aggravation, etc. (see FECA PM 2-805).

With respect to injury-related disability, the CE should be particularly careful to clarify its extent and duration in cases involving aggravation of an underlying condition.

(b) Word questions without using legal terms such as "causal relationship" and "rationale".

For example, a request for rationale on the relationship between a claimant's heart condition and factors of employment might be phrased as follows: "Please explain the medical connection between lifting heavy boxes in 100 degree weather and the claimant's myocardial infarction two weeks later. Please explain in medical terminology how the two events are related."

d. Lack of Response. Where the CE requests an opinion from the attending physician but receives no reply within a specified period of time, the claim may be adjudicated based on the evidence in file without further development if the CE has:

(1) Provided a SOAF to the attending physician;

(2) Posed specific questions to the attending physician;

(3) Advised the physician that the OWCP will pay for a comprehensive report;

(4) Notified the claimant that the requested medical opinion is necessary to further develop the claim; and

(5) Advised the claimant that he or she is responsible for ensuring that the physician submits the report.

2-0806-6 Aggravation of Medical Condition

6. Aggravation of Medical Condition. The purpose of this paragraph is to discuss the effect of continued exposure to injurious conditions on entitlement to compensation. Where an employee cannot work due to risk of future exposure, the CE must determine whether the susceptibility is due to the employee's exposure on the job site, or if it pre-existed such exposure. Such disability is compensable only if it is due to exposure on the job.

As the ECAB held in Dennis L. O'Neill (29 ECAB 151) and clarified in James L. Hearn (29 ECAB 278), when an employee has suffered a work-related injury which results in permanent residuals, disability for work may result when additional exposure to the implicated employment conditions would further endanger the employee's health, although the residuals of the injury alone might not be disabling.

For instance, since exposure to asbestos dust generally results in permanent and irreversible changes in the pulmonary system, medical evidence may indicate that continued employment in a certain job or work environment is contraindicated due to the dangers of continued exposure. If the employing agency cannot provide employment in an environment that conforms to the medically allowed level, the claimant will be entitled to compensation. If the impairment is

sufficient to disable the individual for the customary employment, the CE should refer the claimant for vocational rehabilitation services.

On the other hand, if employment factors aggravate a pre-existing condition, the claimant is entitled only to compensation for the period of disability related to the aggravation, if the aggravation is temporary and leaves no permanent residuals. This is true even though the claimant is found medically disqualified to continue in his or her regular job because of the effect which the employment factors might have on the pre-existing condition. The claimant's inability to continue working is due to the underlying condition, without any contribution from the employment, and therefore compensation is not payable.

2-0806-7 Adjudicating the Claim

7. Adjudicating the Claim. The purpose of this paragraph is to address the factors leading to acceptance or denial of OD claims.

a. Acceptance.

(1) Conditions. The claim may be accepted if:

(a) The medical condition is demonstrated by objective findings (clinical tests);

(b) The accepted factors of employment are competent to cause or contribute to the diagnosed condition; and

(c) The accepted factors of employment are shown to have caused or contributed to the accepted condition. The CE need not define in detail what portion of the disability is due to employment factors and what is not.

For example, an individual with chronic bronchitis is exposed to fumes at work which aggravate the bronchitis. It is not necessary to determine what portion of the current disability predated the exposure and what did not. (However, it is important to establish when the exposure no longer contributes to the symptoms or disability.

(2) Notification. The CE should advise the claimant by letter of the condition(s) accepted, as required by 20 CFR 10.130. If the acceptance is for aggravation, acceleration, or precipitation of a condition, the CE should so indicate in the letter. It may be helpful to provide the claimant with the relevant definition.

Where the agency has challenged the claim, the CE should discuss the evidence supporting the acceptance and explain how the evidence presented by the agency was considered.

b. Denial.

(1) Conditions. The claim should be denied if:

(a) Either fact of injury or performance of duty is not met.

(b) The medical evidence presented by the claimant's physician supports the fact that the claimed condition or disability is not related to the accepted factors of employment, or the physician fails to provide any opinion on causal relationship following a request from the OWCP.

(2) Notification. See FECA PM 2-1400 for a discussion of disallowances. If one of the five basic requirements is not met because information requested by OWCP was not been received, the decision must explain in detail why the missing evidence is so crucial that the unresolved issue cannot be resolved or further developed without it.

2-0806-8 Managing the Claim

8. Managing the Claim. The purpose of this paragraph is to describe the actions which the CE should take in accepted claims with injury-related disability.

a. Payment of Benefits. Where a case is accepted, the CE should initiate payment of medical and wage loss benefits. The CE should determine the date of return to work according to the medical matrix or by the physician's estimated return to work date, whichever is later. Appropriate letters should be released.

b. Nurse and Vocational Rehabilitation Services. Where the case has been accepted within 90 days of submission, the CE should refer it for OWCP nurse services to assist in medical management and return to work (see FECA PM 2-0600.5). Where the case has been accepted later than 90 days from submission, the CE should consider referral to a nurse if such services would likely be beneficial. Otherwise, the case should be referred for OWCP vocational rehabilitation services to assist in return to work (see FECA PM 2-0813).

(1) If the claimant has not returned to work at the estimated time, an intervention is required. If the physician opines that disability is ongoing, the CE must obtain a progress report questioning the physician as to how long the injury-related component is expected to continue and the level (total or partial) of

the injury-related component.

(2) If permanent impairment has resulted, or is likely to result (either with or without disability for work), it may be necessary to develop the claim further to establish its extent and degree so that a schedule award may be paid.

2-0806 Exhibit 1: Sample Development Letter

Dear NAME OF PHYSICIAN:

I am writing in reference to the claim for benefits under the Federal Employees' Compensation Act (FECA) filed by CLAIMANT NAME for CLAIMED CONDITION, which is claimed to be related to factors of Federal employment. We note that you have treated this claimant for the claimed condition.

For the Office of Workers' Compensation Programs (OWCP) to determine whether benefits under the FECA are payable, your findings and opinion are needed. Please provide us with a detailed, narrative medical report which fully responds to all of the questions on the attached list, and which provides medical reasons for all opinions stated. Also enclosed is a Statement of Accepted Facts which outlines all of the relevant facts which OWCP accepts as accurate in this case. Please use this document as your frame of reference in preparing your response.

Your fee for providing a report which fully answers the questions posed will be paid by the OWCP. Please complete the enclosed Form OWCP-1500, attach it to your original report, and submit both directly to OWCP at the address on the letterhead to ensure prompt payment. Please also send a copy of the report to your patient, CLAIMANT NAME.

Thank you for your assistance. Your full reply within 30 days will be very much appreciated. If you have any questions regarding this request, please call me on TELEPHONE NUMBER.

Sincerely,

CLAIMS EXAMINER

NOTICE TO CLAIMANT: Please be advised that this letter is intended to help you obtain medical evidence needed to decide your claim. However, you are responsible for ensuring that all requested information is provided as soon as possible.

We are committed to making a timely decision on your claim. If we have not received the requested information, a statement that it is forthcoming, or evidence that shows that the information requested is not necessary to decide your claim, we will be required to make a decision on your claim based on the evidence in file.

2-0806 Exhibit 2: Sample Letter to Claimant--Asbestosis

Dear CLAIMANT NAME:

I am writing in reference to your claim for benefits under the Federal Employees' Compensation Act (FECA) for an asbestos-related illness. We have received and reviewed [DESCRIBE WHAT WAS RECEIVED]. This information is not sufficient for us to determine whether you are eligible for benefits because [EXPLAIN WHY EVIDENCE INSUFFICIENT].

Please provide the information requested below to us at the address on the letterhead. Include as much detail as possible. Send a copy of your response to your employer for comments.

1. List your work history by employer, job title, and inclusive dates. Include all employment (Federal and non-Federal) as well as military service. For each job title, describe the work you performed, the type of asbestos material used, locations where exposure occurred, period of exposure, number of hours per day and days per week exposed, and the type and frequency of safety precautions used (mask, respirator, protective clothing, ventilation, etc.)

2. Describe any exposure you have had to other toxic substances affecting the lung. If none are known, so state.

3. Describe all previous pulmonary conditions and allergies, particularly those of a respiratory nature. Have you ever had asthma or bronchitis? Provide all relevant details.

4. Do you smoke cigarettes, cigars or a pipe? How much and for how long have you smoked? If you don't smoke now, have you ever? How much, for how long, and when did you quit?

5. Provide a detailed medical report from your treating physician which describes your symptoms; results of examinations and tests (including chest x-ray report); diagnosis; the treatment provided; the effect of treatment; and the doctor's opinion, with medical reasons, on the cause of your condition. Specifically, if your doctor feels that exposure in your Federal employment contributed to your condition, an explanation of how such exposure contributed should be provided.

OR

5. We have received a medical report from your physician. However, it is not sufficient to support your claim because [EXPLAIN WHY REPORT INSUFFICIENT]. Please provide an additional report which specifically discusses the following: [EXPLAIN WHAT NEW REPORT SHOULD INCLUDE].

6. Give the date you first became aware of your lung condition.

7. Give the date you first related your lung condition to work exposure and explain how you realized this.

8. Have you ever previously filed a workers' compensation claim for a lung condition? If so, give date of claim, name and address where filed, benefits

received, and file number.

9. Submit reports of examination, treatment or hospitalization for any previous pulmonary problem. Include all laboratory test results and X-ray records from previous examinations or health screening program, as well as reports on any examinations, treatment, or period of hospitalization for any previous pulmonary problem.

[In death cases] A copy of the death certificate and any autopsy reports should be submitted.

10. [FREE FLOW IF DESIRED]

We may write directly to a physician or any other party who may be able to provide information which will help us decide your eligibility for benefits. Our efforts are intended to assist you in collecting evidence. Please understand that it is ultimately your responsibility, as the claimant, to provide or ensure the provision of all evidence needed to decide your claim. Whenever we request information, we will send you a copy so you may ensure that the requested information is provided as soon as possible.

We are committed to making a timely decision on your claim. We will allow 30 days for the submission of all requested evidence. If we have not received the requested information, an indication that it is forthcoming, or evidence that the information is not necessary to decide your claim, we will render a decision on your claim based on the evidence in file.

If you do not understand any part of this request, or you cannot provide all requested information for any reason, you should call or write to us immediately and request clarification or assistance.

Sincerely,

NAME OF SIGNER
TITLE

Enclosure(s):

2-0806 Exhibit 3: Sample Letter to Employing Agency--Asbestosis

Dear EMPLOYING AGENCY REPRESENTATIVE:

I am writing in reference to the claim for benefits under the Federal Employees' Compensation Act (FECA) filed by the above-named employee for an asbestos-related illness. We have reviewed the Form CA-2 and all accompanying information. We need the following additional information from you to determine whether the employee is eligible for benefits.

1. Provide comments from a knowledgeable supervisor on the accuracy of all statements provided by the employee relative to this claim. Does the agency concur with the employee's statement? If there are points of disagreement, please explain fully and provide any supporting evidence.

2. If the claimant is still employed by your agency, provide results of air sampling, reported in units of fiber/cc time weighted average. If the claimant's employment terminated more than three months in the past, provide estimates of the limits of exposure during the periods of employment for each job held. Also report concentrations of other pollutants and chemicals. If the nature and extent of exposure are not documented by actual air sample results, describe the exposure using the attached "Asbestos Exposure Summary" form.

3. Give the date the employee was last exposed to asbestos at work. If the employee was removed from exposure, give the circumstances.

4. Provide copies of the employee's job sheet, employment record, and SF-171.

5. Provide the position description with physical requirements for the last job held.

6. Provide the most recent SF-50, Notification of Personnel Action.

7. Provide a copy of pertinent dispensary records, including all laboratory test results and X-ray records from previous examinations or health screening program, as well as reports on any examinations or treatment given by the agency.

8. Describe safety regulations and protective devices used by the employee, with period and frequency of use.

9. [FREE FLOW IF DESIRED]

Title 20 CFR 10.102(b) provides that, in the absence of a full reply from the agency, we may accept the claimant's allegations as factual. Your assistance in ensuring that all requested information is provided to OWCP within 30 days is appreciated.

If clarification of any portion of this request is required, or if you cannot provide any requested information, please contact us immediately. Thank you for your assistance.

Sincerely,

NAME OF SIGNER
TITLE

ASBESTOS EXPOSURE SUMMARY

Employee's Name________________________ Claim No.______________

Job Title	From	To	Asbestos Exposure		
			Nature	Degree	Frequency

Comments:____
____
____

Nature of Exposure

P = Primary: The individual's normal duties required actual manipulation of asbestos and/or asbestos products and generated dust.

S = Secondary: The individual's normal duties regularly involved work alongside others who were primarily exposed or placed the individual in the same confined space on a regular basis.

I = Intermittent: The individual's normal duties irregularly involved entry into locations where asbestos and/or asbestos products were manipulated.

E = Environmental: The individual's normal duties were performed at a location or facility (such as a shipyard) where asbestos was used but the individual had no normal exposure in excess of ambient levels.

Degree of Exposure

H = Heavy: Asbestos dust was usually visible in the air.

M = Moderate: Asbestos dust was generally visible on work surfaces but did not cloud the air.

L = Light: Asbestos was used in the work area but was generally not visible (although detectable). The "light" concentration of asbestos dust conforms to air sample results less than the 2

fiber/cc TWA safety standard.

A = Ambient: Asbestos levels did not exceed normal levels in the air outside the work spaces.

2-0806 Exhibit 4: Sample Letter to Claimant--Cardiac Condition

Dear CLAIMANT NAME:

I am writing in reference to your claim for benefits under the Federal Employees' Compensation Act (FECA) for a cardiac condition. We have received and reviewed [DESCRIBE WHAT WAS RECEIVED]. This information is not sufficient for us to determine whether you are eligible for benefits because [EXPLAIN WHY EVIDENCE INSUFFICIENT].

Please provide the information requested below to us at the address on the letterhead. Include as much detail as possible. Send a copy of your response to your employer for comments.

1. Describe the specific work-related conditions or incidents which you believe contributed to your illness (general statements about stress or strain cannot be accepted). What aspects of your employment did you consider harmful to your health? Identify any relevant dates, locations, duties, co-workers, supervisors, etc. For events or duties which you identify, describe how often they occurred and for how long.

   a. Does your job require strenuous physical activity such as heavy lifting, climbing, etc.? Were you exposed to extreme heat or cold? Provide all relevant details.

   b. Does your job involve any of the following activities?

      (1) Were you required to work overtime or take work home with you to complete your assigned duties? If so, how often and for how long?

      (2) Were you required to travel in your employment? If so, how often and for what purposes?

      (3) Were you adequately equipped to perform your assigned duties? Did you have sufficient training or experience? Were you provided with adequate tools, equipment, office space, etc.?

      (4) Did your job require you to meet deadlines or quotas, or to accomplish tasks within a certain time frame? If so, provide details.

      (5) Were you required to perform other emotionally stressful activities? If so, provide details.

   c. You claim your illness resulted from certain treatment by your employer. Please provide specific descriptions of all practices, incidents, confrontations, etc. which you believe affected your

condition. What happened? How often? What was your reaction?

d. You claim your illness resulted from not receiving a desired promotion, not being transferred to a different position as you requested or not being given different job assignments. Provide details.

e. You claim your cardiac condition was affected by elimination of your job or fear that it would be eliminated. Provide details.

2. Describe all activities outside your Federal employment (e.g., other work, hobbies, or other personal activities) which involve strenuous physical effort, travel, recent personal or family crisis (divorce, illness or death of a loved one, substance abuse, etc.)

3. Describe your smoking history. Do you smoke? If so, how much and for how long? If you don't smoke now, did you? How much, for how long, and when did you quit?

4. Describe the development of the claimed condition. When did you first experience cardiac symptoms? Describe the progression. What treatment has been effective in relieving your symptoms? What makes your condition worse?

5. Provide all details of previous cardiovascular problems, including all incidents of chest pain or angina, heart attack(s), bypass surgery, etc. Have you ever been diagnosed as having coronary artery disease, high blood pressure, or diabetes?

6. Provide medical records from all previous treatment for cardiac symptoms or a heart-related condition.

7. Describe your activities before the onset of the claimed heart attack (or acute symptoms). What were you doing just beforehand, during the previous 24 hours, and during the previous 72 hours?

8. Provide a detailed medical report from your treating physician which describes your symptoms; results of examinations and tests; diagnosis; the treatment provided; the effect of treatment; and the doctor's opinion, with medical reasons, on the cause of your condition. Specifically, if your doctor feels that incidents in your Federal employment contributed to your condition, an explanation of how such incidents contributed should be provided.

9. Provide the name, address and phone number of your attending physician(s).

10. Sign and return a medical release form for each physician or medical facility who has treated you for the claimed condition. Two forms are enclosed for this purpose. This will enable us to correspond directly with your physician(s) if additional information or clarification is necessary.

11. [FREE FLOW IF DESIRED]

We may write directly to a physician or any other party who may be able to provide information which will help us decide your eligibility for benefits. Our efforts are intended to assist you in collecting evidence. Please understand that it is ultimately your responsibility, as the claimant, to provide or ensure the provision of all evidence needed to decide your claim.

Whenever we request information, we will send you a copy so you may ensure that the requested information is provided as soon as possible.

We are committed to making a timely decision on your claim. We will allow 30 days for the submission of all requested evidence. If we have not received the requested information, an indication that it is forthcoming, or evidence that the information is not necessary to decide your claim, we will render a decision on your claim based on the evidence in file.

If you do not understand any part of this request, or you cannot provide all requested information for any reason, you should call or write to us immediately and request clarification or assistance.

Sincerely,

NAME OF SIGNER
TITLE

2-0806 Exhibit 5: Sample Letter to Agency--Cardiac Condition

Dear EMPLOYING AGENCY REPRESENTATIVE:

I am writing in reference to the claim for benefits under the Federal Employees' Compensation Act (FECA) filed by the above-named employee for a cardiac condition. We have reviewed the Form CA-2 and all accompanying information. We need the following additional information from you to determine whether the employee is eligible for benefits.

1. Provide comments from a knowledgeable supervisor on the accuracy of all statements made by the employee relative to this claim. Does the agency concur with the employee's allegations? If there are points of disagreement, please explain fully and provide any supporting evidence.

2. Could aspects of the employee's job be perceived as stressful (e.g., overtime, deadlines, quotas, travel, intensity of work, conflict between the employee and coworkers or supervisors, etc.)?

3. Provide a copy of the employee's position description and physical requirements of the job. If the actual duties varied from the official description, explain how.

4. During the period the employee claims detrimental work factors existed, were there staffing shortages which affected the employee's work load, or extra demands for any reason?

5. Was this employee generally able to perform required duties in accordance with expectations? Were there any performance or conduct problems? Please describe.

6. [FREE FLOW IF DESIRED]

Title 20 CFR 10.102(b) provides that, in the absence of a full reply from the agency, we may accept the claimant's allegations as factual. Your assistance

in ensuring that all requested information is provided to OWCP within 30 days is appreciated.

If clarification of any portion of this request is required, or if you cannot provide any requested information, please contact us immediately. Thank you for your assistance.

Sincerely,

NAME OF SIGNER
TITLE

2-0806 Exhibit 6: Sample Letter to Claimant--Carpal Tunnel Syndrome

Dear CLAIMANT NAME:

I am writing in reference to your claim for benefits under the Federal Employees' Compensation Act (FECA) for carpal tunnel syndrome. We have received and reviewed [DESCRIBE WHAT WAS RECEIVED]. This information is not sufficient for us to determine whether you are eligible for benefits because [EXPLAIN WHY EVIDENCE INSUFFICIENT].

Please provide the information requested below to us at the address on the letterhead. Include as much detail as possible. Send a copy of your response to your employer for comments.

1. Describe in detail the work-related activities which you believe contributed to your condition. Specifically describe all duties which required exertion or repeated motion of the wrist(s) or hand(s).

2. How often did you perform the activities described? How long did you perform the activity before taking a break or doing something else?

3. Describe all activities outside your Federal employment, i.e., in other work, at home, or with any hobbies, which involve repetitive hand or wrist movement. Do you play tennis, racquetball, or a musical instrument?

4. Describe the development of your condition. When did you first notice it? Has it come and gone or has it been present continuously? What symptoms have you experienced? What seems to make it worse? Better? What treatment has been effective in controlling or curing it?

5. Describe all previous injuries to the hand, arm, or wrist. Have you ever been diagnosed as having gout, arthritis, hypothyroidism, or diabetes? If so, provide details.

6. Provide a detailed medical report from your treating physician which describes your symptoms; results of examinations and tests (including Phalen's and Tinel's signs and results of any nerve conduction or EMG studies); diagnosis; the treatment provided; the effect of treatment; and the doctor's opinion, with medical reasons, on the cause of your condition. Specifically, if your doctor feels that work activities in your Federal employment contributed to your condition, an explanation of how such exposure contributed

should be provided.

7. Provide the name, address and phone number of your attending physician(s).

8. Sign and return a medical release form for each physician or medical facility who has treated you for the claimed condition. Two forms are enclosed for this purpose. This will allow us to correspond directly with your physician(s) if additional information or clarification is necessary.

9. [FREE FLOW IF DESIRED]

We may write directly to a physician or any other party who may be able to provide information which will help us decide your eligibility for benefits. Our efforts are intended to assist you in collecting evidence. Please understand that it is ultimately your responsibility, as the claimant, to provide or ensure the provision of all evidence needed to decide your claim. Whenever we request information, we will send you a copy so you may ensure that the requested information is provided as soon as possible.

We are committed to making a timely decision on your claim. We will allow 30 days for the submission of all requested evidence. If we have not received the requested information, an indication that it is forthcoming, or evidence that the information is not necessary to decide your claim, we will render a decision on your claim based on the evidence in file.

If you do not understand any part of this request, or you cannot provide all requested information for any reason, you should call or write to us immediately and request clarification or assistance.

Sincerely,

NAME OF SIGNER
TITLE

2-0806 Exhibit 7: Sample Letter to Agency--Carpal Tunnel Syndrome

Dear EMPLOYING AGENCY REPRESENTATIVE:

I am writing in reference to the claim for benefits under the Federal Employees' Compensation Act (FECA) filed by the above-named employee for carpal tunnel syndrome. We have reviewed the Form CA-2 and all accompanying information. We need the following additional information from you to determine whether the employee is eligible for benefits under the FECA.

1. Provide comments from a knowledgeable supervisor on the accuracy of all statements provided by the employee relative to this claim. Does the agency concur with the employee's allegations? If there are points of disagreement, please explain fully and provide any supporting evidence.

2. What tasks did the employee perform which involved repetitive hand and wrist movements? What was the frequency and duration of these activities?

3. Describe in detail the specific work area implicated by the claimant in the development of the claimed condition. (A diagram may be submitted for reference).

a. Describe desk, type of chair, location/height/alignment of keyboard and VDT, height and location of items for which the employee routinely reached, etc.

4. What precautions were taken to minimize the effects of these activities, e.g., rest breaks, alternate duties?

5. Provide a copy of this employee's position description and physical requirements of the job. If the actual duties varied from the official description, explain how.

6. [FREE FLOW IF DESIRED]

Title 20 CFR 10.102(b) provides that, in the absence of a full reply from the agency, we may accept the claimant's allegations as factual. Your assistance in ensuring that all requested information is provided to OWCP within 30 days is appreciated.

If clarification of any portion of this request is required, or if you cannot provide any requested information, please contact us immediately. Thank you for your assistance.

Sincerely,

NAME OF SIGNER
TITLE

2-0806 Exhibit 8: Sample Letter to Claimant--General

Dear CLAIMANT NAME:

I am writing in reference to your claim for benefits under the Federal Employees' Compensation Act (FECA) for [CONDITION OR LOCATION OF ILLNESS]. We have received and reviewed [DESCRIBE WHAT WAS RECEIVED]. This information is not sufficient for us to determine whether you are eligible for benefits because [EXPLAIN WHY EVIDENCE INSUFFICIENT].

Please provide the information requested below to us at the address on the letterhead. Include as much detail as possible. Send a copy of your response to your employer for comments.

1. Describe the work-related exposure or contact which you believe contributed to your condition:

a. To what were you exposed?

b. How were you exposed? What tasks did you perform which required the claimed exposure or contact?

c. How often were you exposed? For how long on each occasion?

2. Describe all exposure outside your Federal employment, i.e. in other work, at home, or with any hobbies, which is similar to the working conditions which you believe led to your illness.

3. Describe the development of the claimed condition. When did you first notice it? Has it come and gone or has it been present continuously? What symptoms have you had? What seems to make the condition worse? Better? What treatment has been effective in controlling or curing it?

4. Describe all previous similar conditions.

5. Provide a comprehensive medical report from your treating physician which describes your symptoms; results of examinations and tests; diagnosis; the treatment provided; the effect of treatment; and the doctor's opinion, with medical reasons, on the cause of your condition. Specifically, if your doctor feels that exposure or incidents in your Federal employment contributed to your condition, an explanation of how such exposure contributed should be provided.

6. Provide the name, address and phone number of your attending physician(s).

7. Sign and return a medical release form for each physician or medical facility who has treated you for the claimed condition. Two forms are enclosed for this purpose. This will allow us to correspond directly with your physician(s) if additional information or clarification is necessary.

8. [FREE FLOW IF DESIRED]

We may write directly to a physician or any other party who may be able to provide information which will help us decide your eligibility for benefits. Our efforts are intended to assist you in collecting evidence. Please understand that it is ultimately your responsibility, as the claimant, to provide or ensure the provision of all evidence needed to decide your claim. Whenever we request information, we will send you a copy so you may ensure that the requested information is provided as soon as possible.

We are committed to making a timely decision on your claim. We will allow 30 days for the submission of all requested evidence. If we have not received the requested information, an indication that it is forthcoming, or evidence that the information is not necessary to decide your claim, we will render a decision on your claim based on the evidence in file.

If you do not understand any part of this request, or you cannot provide all requested information for any reason, you should call or write to us immediately and request clarification or assistance.

Sincerely,

NAME OF SIGNER
TITLE

2-0806 Exhibit 9: Sample Letter to Agency--General

Dear EMPLOYING AGENCY REPRESENTATIVE:

I am writing in reference to the claim for benefits under the Federal Employees' Compensation Act (FECA) filed by the above-named employee for a/an [CONDITION OR LOCATION OF ILLNESS]. We have reviewed the Form CA-2 and all accompanying information. We need the following additional information from you to determine whether the employee is eligible for benefits under the FECA.

1. Provide comments from a knowledgeable supervisor on the accuracy of all statements provided by the employee relative to this claim. Does the agency concur with the employee's allegations? If there are points of disagreement, please explain fully and provide any supporting evidence.

2. What tasks did the employee perform which resulted in the exposure or contact? What was the frequency and duration of exposure?

3. What precautions were taken to minimize effects of exposure?

4. Provide a copy of this employee's position description and physical requirements of the job.

5. [FREE FLOW IF DESIRED]

Title 20 CFR 10.102(b) provides that, in the absence of a full reply from the agency, we may accept the claimant's allegations as factual. Your assistance in ensuring that all requested information is provided to OWCP within 30 days is appreciated.
If clarification of any portion of this request is required, or if you cannot provide any requested information, please contact us immediately. Thank you for your assistance.

Sincerely,

NAME OF SIGNER
TITLE

2-0806 Exhibit 10: Sample Letter to Claimant--Hearing Loss

Dear CLAIMANT NAME:

I am writing in reference to your claim for benefits under the Federal Employees' Compensation Act (FECA) for hearing loss. We have received and reviewed [DESCRIBE WHAT WAS RECEIVED]. This information is not sufficient for us to determine whether you are eligible for benefits because [EXPLAIN WHY EVIDENCE INSUFFICIENT].

Please provide the information requested below to us at the address on the

letterhead. Include as much detail as possible. Send a copy of your response to your employer for comments.

1. List your employment history by employer, job title, and inclusive dates. Include all employment (Federal and non-Federal) as well as military service. For each job title, describe source(s) of noise, number of hours of exposure per day, and use of any safety devices (such as ear defenders) to protect against noise exposure. If used, state the approximate number of hours per day and days per week they were used.

2. Are you still exposed to hazardous noise at work? If not, give the date you were last exposed.

3. Give the date you first noticed your hearing loss.

4. Give the date you first related your hearing loss to work exposure and explain how you realized this.

5. Have you ever previously filed a workers' compensation claim for hearing loss or an ear condition? If so, give date of claim, name and address of the agency where filed, benefits received, and file number.

6. Describe all previous ear or hearing problems. If you have been examined or treated by a doctor for an ear or hearing problem, provide copies of all medical reports and audiograms.

7. Describe any hobbies which involve exposure to loud noise.

8. [FREE FLOW IF DESIRED]

We may write directly to a physician or any other party who may be able to provide information which will help us decide your eligibility for benefits. Our efforts are intended to assist you in collecting evidence. Please understand that it is ultimately your responsibility, as the claimant, to provide or ensure the provision of all evidence needed to decide your claim. Whenever we request information, we will send you a copy so you may ensure that the requested information is provided as soon as possible.

We are committed to making a timely decision on your claim. We will allow 30 days for the submission of all requested evidence. If we have not received the requested information, an indication that it is forthcoming, or evidence that the information is not necessary to decide your claim, we will render a decision on your claim based on the evidence in file.

If you do not understand any part of this request, or you cannot provide all requested information for any reason, you should call or write to us immediately and request clarification or assistance.

Sincerely,

NAME OF SIGNER
TITLE

2-0806 Exhibit 11: Sample Letter to Agency--Hearing Loss

Dear EMPLOYING AGENCY REPRESENTATIVE:

I am writing in reference to the claim for benefits under the Federal Employees' Compensation Act (FECA) filed by the above-named employee for hearing loss. We have reviewed the Form CA-2 and all accompanying information. We need the following additional information from you to determine whether the employee is eligible for benefits under the FECA.

1. Provide comments from a knowledgeable supervisor on the accuracy of all statements provided by the employee relative to this claim. Does the agency concur with the employee's allegations? If there are points of disagreement, please explain fully and provide any appropriate supportive evidence.

2. Provide locations of job sites where exposure allegedly occurred.

3. Describe the sources of exposure to noise (machinery, etc.)

4. Provide the decibel and frequency level (noise survey report) for each job site. If no tests are available, please arrange for them to be made if possible. If no tests can be made, advise whether the employee was or was not exposed to injurious noise.

5. Provide the period of exposure, hours per day, and days per week.

6. Describe the type(s) of ear protection provided. If noise attenuation (in decibels) is known, please furnish it also.

7. Provide copies of the employee's job sheet, employment record and SF-171.

8. Provide a copy of all medical examinations pertaining to hearing or ear problems, including pre-employment examination and all audiograms.

9. If the employee is no longer exposed to hazardous noise, give the date of last exposure and the pay rate in effect on that date.

10. [FREE FLOW IF DESIRED]

Title 20 CFR 10.102(b) provides that, in the absence of a full reply from the agency, we may accept the claimant's allegations as factual. Your assistance in ensuring that all requested information is provided to OWCP within 30 days is appreciated.

If clarification of any portion of this request is required, or if you cannot provide any requested information, please contact us immediately. Thank you for your assistance.

Sincerely,

NAME OF SIGNER

2-0806 Exhibit 12: Sample Letter to Claimant--Orthopedic Condition

Dear CLAIMANT NAME:

I am writing in reference to your claim for benefits under the Federal Employees' Compensation Act (FECA) for [CONDITION OR LOCATION OF ILLNESS]. We have received and reviewed [DESCRIBE WHAT WAS RECEIVED]. This information is not sufficient for us to determine whether you are eligible for benefits because [EXPLAIN WHY EVIDENCE INSUFFICIENT].

Please provide the information requested below to us at the address on the letterhead. Include as much detail as possible. Send a copy of your response to your employer for comments.

1. Describe in detail the work-related activities which you believe contributed to your condition. Were you required to perform heavy lifting, pushing, pulling, bending, stooping, or other strenuous physical movements on a repeated basis?

2. How often did you perform the activities described? For how long on each occasion?

3. Describe all activities outside your Federal employment, i.e. in other employment, at home, or with any hobbies, which involve lifting, pushing, pulling, bending, stooping, or other strenuous physical activities.

4. Describe the development of the claimed condition. When did you first notice it? Has it come and gone or has it been present continuously? What symptoms have you experienced? What seems to make it worse? Better? What treatment has been effective in controlling or curing it?

5. Describe all previous orthopedic injuries such as sprains, strains, fractures, dislocations, etc. Have you ever been diagnosed as having arthritis, or degenerative joint or disc disease?

6. Provide a comprehensive medical report from your treating physician which describes your symptoms; results of examinations and tests; diagnosis; the treatment provided; the effect of treatment; and the doctor's opinion, with medical reasons, on the cause of your condition. Specifically, if your doctor feels that exposure or incidents in your Federal employment contributed to your condition, an explanation of how such exposure contributed should be provided.

7. Provide the name, address and phone number of your attending physician(s).

8. Sign and return a medical release form for each physician or medical facility who has treated you for the claimed condition. Two forms are

enclosed for this purpose. This will enable us to correspond directly with your physician(s) if additional information or clarification is necessary.

9. [FREE FLOW IF DESIRED]

We may write directly to a physician or any other party who may be able to provide information which will help us decide your eligibility for benefits. Our efforts are intended to assist you in collecting evidence. Please understand that it is ultimately your responsibility, as the claimant, to provide or ensure the provision of all evidence needed to decide your claim. Whenever we request information, we will send you a copy so you may ensure that the requested information is provided as soon as possible.

We are committed to making a timely decision on your claim. We will allow 30 days for the submission of all requested evidence. If we have not received the requested information, an indication that it is forthcoming, or evidence that the information is not necessary to decide your claim, we will render a decision on your claim based on the evidence in file.

If you do not understand any part of this request, or you cannot provide all requested information for any reason, you should call or write to us immediately and request clarification or assistance.

Sincerely,

NAME OF SIGNER
TITLE

2-0806 Exhibit 13: Sample Letter to Agency--Orthopedic Condition

Dear EMPLOYING AGENCY REPRESENTATIVE:

I am writing in reference to the claim for benefits under the Federal Employees' Compensation Act (FECA) filed by the above-named employee for a/an [CONDITION OR LOCATION OF ILLNESS]. We have reviewed the Form CA-2 and all accompanying information. We need the following additional information from you to determine whether the employee is eligible for benefits under the FECA.

1. Provide comments from a knowledgeable supervisor on the accuracy of all statements provided by the employee relative to this claim. Does the agency concur with the employee's allegations? If there are points of disagreement, please explain fully and provide any supporting evidence.

2. What tasks did the employee perform which required physical exertion such as lifting, pushing, pulling, bending or stooping? What was the frequency and duration of these activities?

3. What precautions were taken to minimize effects of the activities, e.g., rest breaks, alternate duties, special tools or equipment?

4. Provide a copy of this employee's position description and physical requirements of the job. Explain how the actual duties varied from the official description.

5. [FREE FLOW IF DESIRED]

Title 20 CFR 10.102(b) provides that, in the absence of a full reply from the agency, we may accept the claimant's allegations as factual. Your assistance in ensuring that all requested information is provided to OWCP within 30 days is appreciated.
If clarification of any portion of this request is required, or if you cannot provide any requested information, please contact us immediately. Thank you for your assistance.

Sincerely,

NAME OF SIGNER
TITLE

2-0806 Exhibit 14: Sample Letter to Claimant--Psychiatric Condition

Dear CLAIMANT NAME:

I am writing in reference to your claim for benefits under the Federal Employees' Compensation Act (FECA) for an emotional condition. We have received and reviewed [DESCRIBE WHAT WAS RECEIVED]. This information is not sufficient for us to determine whether you are eligible for benefits because [EXPLAIN WHY EVIDENCE INSUFFICIENT].
Please provide the information requested below to us at the address on the letterhead. Include as much detail as possible. Send a copy of your response to your employer for comments.

1. Describe the specific work-related conditions or incidents which you believe contributed to your illness (general statements about stress or strain cannot be accepted). What aspects of your employment did you consider harmful to your health? Identify any relevant dates, locations, duties, co-workers, supervisors, etc. For events or duties which you identify, describe how often they occurred and for how long. Provide names, addresses and phone numbers of any person who can verify your statements.

   a. Were you adequately equipped to perform your assigned duties? Did you have sufficient training or experience? Were you provided with adequate tools, equipment, office space, etc.?

   b. Were you required to meet deadlines or quotas, or to accomplish tasks within certain time frames? If so, provide details.

   c. Were you required to work overtime or take work home with you to complete your assigned duties? If so, how often and for how long?

   d. You claim your illness resulted from certain treatment by your employer. Please provide specific descriptions of all practices, incidents, confrontations, etc. which you believe affected your

condition. What happened? How often? What was your reaction?

e. You claim your illness resulted from not receiving a promotion. Provide details. Were you not selected for a specific position? What position and when?

f. You claim your illness resulted from not being given a transfer to another position or not being given different job assignments. Provide details.

g. You claim your health was affected by elimination of your job or fear that your job would be eliminated. Provide details.

h. You claim your health was affected by disputes with your supervisor over leave usage. Provide details. What were the circumstances surrounding your not being granted leave?

i. Were you required to perform other emotionally stressful activities? If so, provide details.

j. Have you filed any grievance, EEO complaint, or any other action related to the working conditions cited in this claim? If so, provide copies of all relevant documents, including conclusions of fact-finders and final decisions if available. If not available, when do you anticipate they will be?

2. Describe all sources of stress outside your Federal employment. Have you recently experienced stressful situations in your personal life, such as substance abuse, divorce, death or illness of a loved one? Describe your hobbies and any outside employment.

3. Describe the development of the claimed condition. When did you first notice it? Has it come and gone or has it been present continuously? What symptoms have you experienced? What seems to make it worse? Better? What treatment has been effective in controlling or curing it?

4. Provide details of all prior emotional conditions which you have experienced.

a. Have you ever been under the care of a psychiatrist, psychologist, or other counselor? If so, for what reason? What benefit did you receive? Provide all relevant details.

b. Have you ever been hospitalized for an emotional condition? If so, when and where?

c. Do you now take, or have you ever taken medication for an emotional condition? If so, when and what medication?

5. Why do you feel that your job activities contributed to your condition?

6. Provide medical records from all prior treatment for an emotional condition.

7. Provide a comprehensive medical report from your treating physician which describes your symptoms; results of examinations and tests; diagnosis; the treatment provided; the effect of treatment; and the doctor's opinion, with medical reasons, on the cause of your condition. Specifically, if your doctor feels that exposure or incidents in your Federal employment contributed to your condition, an explanation of how such exposure contributed should be provided.

8. Provide the name, address and phone number of your attending physician(s).

9. Sign and return a medical release form for each physician or medical facility who has treated you for the claimed condition. Two forms are enclosed for this purpose. This will enable us to correspond directly with your physician(s) if additional information or clarification is necessary.

10. [FREE FLOW IF DESIRED]

We may write directly to a physician or any other party who may be able to provide information which will help us decide your eligibility for benefits. Our efforts are intended to assist you in collecting evidence. Please understand that it is ultimately your responsibility, as the claimant, to provide or ensure the provision of all evidence needed to decide your claim. Whenever we request information, we will send you a copy so you may ensure that the requested information is provided as soon as possible.

We are committed to making a timely decision on your claim. We will allow 30 days for the submission of all requested evidence. If we have not received the requested information, an indication that it is forthcoming, or evidence that the information is not necessary to decide your claim, we will render a decision on your claim based on the evidence in file.

If you do not understand any part of this request, or you cannot provide all requested information for any reason, you should call or write to us immediately and request clarification or assistance.

Sincerely,

NAME OF SIGNER
TITLE

2-0806 Exhibit 15: Sample Letter to Agency--Psychiatric Condition

Dear EMPLOYING AGENCY REPRESENTATIVE:

I am writing in reference to the claim for benefits under the Federal Employees' Compensation Act (FECA) filed by the above-named employee for an emotional condition. We have reviewed the Form CA-2 and all accompanying information. We need the following additional information from you to determine whether the employee is eligible for benefits under the FECA.

1. Provide comments from a knowledgeable supervisor on the accuracy of all

statements provided by the employee relative to this claim. Does the agency concur with the employee's allegations? If there are points of disagreement, please explain fully and provide any supporting evidence.

2. Could aspects of the employee's job be perceived as stressful (e.g., overtime, deadlines, quotas, travel, intensity of work, conflict between the employee and coworkers or supervisors, etc.)?

3. Has the agency made accommodations to reduce stress for this employee (e.g., reassignment, training, deadline adjustments)? If so, what are they?

4. Provide a copy of this employee's position description and physical requirements of the job. If the actual duties varied from the official description, explain how.

5. During the period the employee claims detrimental work factors existed, were there staffing shortages which affected this employee's workload, or extra demands for any reason?

6. Was this employee generally able to perform required duties in accordance with expectations? Were there any performance or conduct problems? If so, please describe.

7. [FREE FLOW IF DESIRED]

Title 20 CFR 10.102(b) provides that, in the absence of a full reply from the agency, we may accept the claimant's allegations as factual. Your assistance in ensuring that all requested information is provided to OWCP within 30 days is appreciated.
If clarification of any portion of this request is required, or if you cannot provide any requested information, please contact us immediately. Thank you for your assistance.

Sincerely,

NAME OF SIGNER
TITLE

2-0806 Exhibit 16: Sample Letter to Claimant--Pulmonary Condition (Not Asbestosis)

Dear CLAIMANT NAME:

I am writing in reference to your claim for benefits under the Federal Employees' Compensation Act (FECA) for a pulmonary condition. We have received and reviewed [DESCRIBE WHAT WAS RECEIVED]. This information is not sufficient for us to determine whether you are eligible for benefits because [EXPLAIN WHY EVIDENCE INSUFFICIENT].

Please provide the information requested below to us at the address on the letterhead. Include as much detail as possible. Send a copy of your response to your employer for comments.

1. Describe in detail the work-related exposure or contact which you

believe contributed to your illness.

a. To what were you exposed, e.g., smoke, fumes, dust? How did you realize you were exposed? Could you detect the substance on work surfaces, in the air?

b. Describe your exposure. How often were you exposed? Approximately how many hours per day and days per week? Did it vary over time? If so, how?

c. Did you use protective equipment such as a respirator or a mask? What tasks did you perform which required the claimed exposure or contact? Were you aware of any precautions to take, or hazards of use identified by the manufacturer or your employer?

2. Describe all exposure to pulmonary irritants outside of your Federal employment, i.e. in other employment, at home, or with any hobbies.

3. Describe the development of the claimed condition. When did you first notice it? Has it come and gone or has it been present continuously? What symptoms have you experienced? What seems to make it worse? Better? What treatment has been effective in controlling or curing it?

4. Describe all previous pulmonary conditions and all known allergies. Have you ever had asthma or bronchitis before? Provide all relevant details.

5. Do you smoke cigarettes, cigars or a pipe? How much and for how long have you smoked? If you don't smoke now, have you ever? How much, for how long, and when did you quit?

6. Provide a comprehensive medical report from your treating physician which describes your symptoms; results of examinations and tests; diagnosis; the treatment provided; the effect of treatment; and the doctor's opinion, with medical reasons, on the cause of your condition. Specifically, if your doctor feels that exposure in your Federal employment contributed to your condition, an explanation of how such exposure contributed should be provided.

7. Provide the name, address and phone number of your attending physician(s).

8. Sign and return a medical release form for each physician or medical facility who has treated you for the claimed condition. Two forms are enclosed for this purpose. This will enable this Office to correspond directly with your physician(s) if additional information or clarification is necessary.

9. [FREE FLOW IF DESIRED]

We may write directly to a physician or any other party who may be able to provide information which will help us decide your eligibility for benefits. Our efforts are intended to assist you in collecting evidence. Please understand that it is ultimately your responsibility, as the claimant, to provide or ensure the provision of all evidence needed to decide your claim. Whenever we request information, we will send you a copy so you may ensure that the requested information is provided as soon as possible.

We are committed to making a timely decision on your claim. We will allow 30 days for the submission of all requested evidence. If we have not received the requested information, an indication that it is forthcoming, or evidence that the information is not necessary to decide your claim, we will render a decision on your claim based on the evidence in file.

If you do not understand any part of this request, or you cannot provide all requested information for any reason, you should call or write to us immediately and request clarification or assistance.

Sincerely,

NAME OF SIGNER
TITLE

2-0806 Exhibit 17: Sample Letter to Agency--Pulmonary Condition (Not Asbestosis)

Dear EMPLOYING AGENCY REPRESENTATIVE:

I am writing in reference to the claim for benefits under the Federal Employees' Compensation Act (FECA) filed by the above-named employee for a pulmonary condition. We have reviewed the Form CA-2 and all accompanying information. We need the following additional information from you to determine whether the employee is eligible for benefits under the FECA.

1. Provide comments from a knowledgeable supervisor on the accuracy of all statements given by the employee relative to this claim. Does the agency concur with the employee's allegations? If there are points of disagreement, please explain fully and provide any appropriate supporting evidence.

2. To what potentially harmful substances has the employee been exposed? Include any fumes, dust, chemicals, etc. Provide the results of any air samples (if available). What levels of concentration are considered safe? Provide a copy of the safety data sheet provided by the supplier if applicable.

    a. If air samples are not available, please explain in detail the air circulation/ventilation of the claimant's work area (i.e., size of room, fans, overhead air ducts, windows, etc., and where located in relation to the claimant's work area).

3. What tasks did the employee perform which resulted in the exposure or contact? What were the frequency and duration of exposure?

4. What precautions were taken to minimize effects of exposure (e.g., a mask or respirator)?

5. Provide a copy of this employee's position description and physical requirements of the job. If the actual duties varied from the official description, explain how.

6. [FREE FLOW IF DESIRED]

Title 20 CFR 10.102(b) provides that, in the absence of a full reply from the agency, we may accept the claimant's allegations as factual. Your assistance in ensuring that all requested information is provided to OWCP within 30 days is appreciated.

If clarification of any portion of this request is required, or if you cannot provide any requested information, please contact us immediately. Thank you for your assistance.

Sincerely,

NAME OF SIGNER
TITLE

2-0806 Exhibit 18: Sample Letter to Claimant--Skin Condition

Dear CLAIMANT NAME:

I am writing in reference to your claim for benefits under the Federal Employees' Compensation Act (FECA) for a skin condition. We have received and reviewed [DESCRIBE WHAT WAS RECEIVED]. This information is not sufficient for us to determine whether you are eligible for benefits because [EXPLAIN WHY EVIDENCE INSUFFICIENT].

Please provide the information requested below to us at the address on the letterhead. Include as much detail as possible. Send a copy of your response to your employer for comments.

1. Describe in detail the work-related exposure or contact which you believe contributed to your skin condition.

   a. Were you exposed to a chemical substance such as paint, dyes, fumes, solvents, etc.? Provide the trade name, generic name, ingredients and manufacturer if known.

   b. During the performance of your work, were you exposed to intense sunlight, extremes of temperature, or other unusual physical factors?

   c. Describe your exposure. How often were you exposed and for approximately how many hours per day and days per week? Did it vary over time? If so, how?

   d. What tasks did you perform which required the claimed exposure or contact? Were you aware of any precautions to take? If so, did you use protective measures such as glove, mask, etc.? Were the hazards of use identified by the manufacturer or your employer?

2. Describe exposures to chemicals and physical factors such as prolonged sunlight, outside your Federal employment (other job, hobbies, recreation, etc.)

3. Describe the development of the claimed condition. When did you first

notice it? Has it been a continuous problem or does it come and go? What specific symptoms have you experienced? What seems to make it worse? Better? What treatment has been effective in controlling or curing it?

4. Describe any previous skin conditions and any known allergies.

5. Provide a comprehensive medical report from your treating physician which describes your symptoms; results of examinations and tests; diagnosis; the treatment provided; the effect of treatment; and the doctor's opinion, with medical reasons, on the cause of your condition. Specifically, if your doctor feels that exposure in your Federal employment contributed to your condition, an explanation of how such exposure contributed should be provided.

6. Provide the name, address and phone number of your attending physician(s).

7. Sign and return a medical release form for each physician or medical facility who has treated you for the claimed condition. Two forms are enclosed for this purpose. This will enable us to correspond directly with your physician(s) if additional information or clarification is necessary.

8. [FREE FLOW IF DESIRED]

We may write directly to a physician or any other party who may be able to provide information which will help us decide your eligibility for benefits. Our efforts are intended to assist you in collecting evidence. Please understand that it is ultimately your responsibility, as the claimant, to provide or ensure the provision of all evidence needed to decide your claim. Whenever we request information, we will send you a copy so you may ensure that the requested information is provided as soon as possible.

We are committed to making a timely decision on your claim. We will allow 30 days for the submission of all requested evidence. If we have not received the requested information, an indication that it is forthcoming, or evidence that the information is not necessary to decide your claim, we will render a decision on your claim based on the evidence in file.

If you do not understand any part of this request, or you cannot provide all requested information for any reason, you should call or write to us immediately and request clarification or assistance.

Sincerely,

NAME OF SIGNER
TITLE

2-0806 Exhibit 19: Sample Letter to Agency--Skin Condition

Dear EMPLOYING AGENCY REPRESENTATIVE:

I am writing in reference to the claim for benefits under the Federal Employees' Compensation Act (FECA) filed by the above-named employee for a skin condition. We have reviewed the Form CA-2 and all accompanying

information. We need the following additional information from you to determine whether the employee is eligible for benefits under the FECA.

1. Provide comments from a knowledgeable supervisor on the accuracy of all statements given by the employee relative to this claim. Does the agency concur with the employee's allegations? If there are points of disagreement, please explain fully and provide any supporting evidence.

2. To what potentially harmful substances has the employee been exposed? Include any fumes, solvents, chemicals, etc. Provide the trade name, generic name, manufacturer and ingredients. Provide a copy of the safety data sheet furnished by the supplier if applicable.

3. What tasks did the employee perform which resulted in the exposure or contact? What was the frequency and duration of exposure?

4. What precautions were taken to minimize effects of exposure (e.g., gloves, a mask)?

5. Provide a copy of this employee's position description and physical requirements of the job. If the actual duties varied from the official description, explain how.

6. [FREE FLOW IF DESIRED]

Title 20 CFR 10.102(b) provides that, in the absence of a full reply from the agency, we may accept the claimant's allegations as factual. Your assistance in ensuring that all requested information is provided to OWCP <u>within 30 days</u> is appreciated.
If clarification of any portion of this request is required, or if you cannot provide any requested information, please contact us immediately. Thank you for your assistance.

Sincerely,

NAME OF SIGNER
TITLE

2-0806 Exhibit 20: Sample Questions--Other Conditions

Factual evidence for the following conditions should include the information listed below. Medical questions are stated in Chapter 4 of "Medical Management of Claims under the FECA".

<u>Dermatitis</u>

1. The employment-related exposure to the irritant, including identification of the irritant. In straightforward cases, identification of the plant or the substance is sufficient. In more complex cases, a description of the chemical content of the substance

may be necessary.

2. The chronological onset of symptoms.

3. Exposure to irritants outside the work place.

4. Prior history of dermatitis or other skin disorders, including any known allergies, according to the claimant.

5. Any protective equipment furnished the employee and whether or not the employee used it.

Hepatitis

1. Description of the employment-related source of the contact, and whether it is known to contain the hepatitis microorganism.

2. Date of contact.

3. Detailed description of any transfusion, surgery, dental surgery, or other medical procedure which the employee has undergone during the year prior to diagnosis.

4. Description of any possible exposure outside the workplace, including whether any immediate family members had hepatitis (history of tattoos, use of illegal drugs).

5. Details of any previous liver disease or other serious illness.

Staphylococcus Infections

1. The source of the contact and the extent to which the employee was exposed to the infected patient.

2. All known exposure to staph infection outside the workplace.

3. Whether the employee suffered any previous staph infections.

Pulmonary Tuberculosis

1. Particular work factors contributing to the development of the condition, including contaminated work areas, materials, and individuals; and the nature and duration of the contact by the claimant. (For employees of the Veterans Administration, the agency should submit detailed evidence, including all factual background and medical history. This is known as "tuberculosis cause data".)
Where the claimant is employed in a high-risk setting for exposure to TB, such as a health care facility, prison, drug treatment center, or law enforcement agency, it is not necessary to identify the specific contaminated persons or articles believed to be the source of the infection. It is only necessary to show that the claimant routinely came into contact with populations such as prisoners, hospital patients, or intravenous drug users, and/or with contaminated articles.

2. All known exposure to TB outside of the workplace. Including the identification of all family members, living or dead, who suffered from TB, and the approximate dates of the illness and the nature and extent of the employee's association with the identified individuals. Description of association with other persons known to have TB.

3. Whether the employee has any history of prior TB or any other respiratory disease, including all relevant details.

4. Any other serious illnesses suffered by the employee, including all relevant details.

Brucellosis

For veterinarians and meat inspectors employed by the Department of Agriculture, it may be assumed that working around cattle, pigs, or goats in slaughterhouses, and in disease testing and prevention programs on farms, exposure to brucellosis has occurred. Where the Department of Agriculture forwards a "bru- cellosis statement", and the file contains no indication of non-employment exposure, no further factual documentation is needed.
For other employees, a description of the work-related exposure to which the disease is attributed should be obtained. The description should include the following:

1. The dates of exposure.

2. Details of any off-duty exposure, including the names of any family members who have suffered from the disease.

3. Whether or not the employee consumed raw milk during the six months prior to the onset of symptoms.

4. Whether any other employee contracted this disease, and if so, was he or she exposed to the same source?

5. Past medical history, including details of any prior episodes of brucellosis and any other serious illness.

2-0806 Exhibit 21: Nature of Injury Codes

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.

(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
```

2-0807 CONTINUATION OF PAY AND INITIAL PAYMENTS

Paragraph	Subject	Date	Trans. No.
	Table of Contents	03/04	04-04
1	Purpose	03/04	04-04
2	Statutory Provisions	03/04	04-04
3	COP Defined	03/04	04-04
4	Traumatic Injury	03/04	04-04

5 Employee Status	03/04	04-04
6 Period of Entitlement	03/04	04-04
7 Employee Responsibility	03/04	04-04
8 Employing Agency Responsibility	03/04	04-04
9 Controversion	03/04	04-04
10 Adjudicating the Claim for COP	03/04	04-04
11 Regular Pay	03/04	04-04
12 Delayed Disability	03/04	04-04
13 Recurrence of Disability	03/04	04-04
14 Interruption, Suspension and Termination of COP	03/04	04-04
15 Relationships between Leave Usage, COP and Compensation	03/04	04-04
16 Light Duty Offers	03/04	04-04
17 Timely Payment of Compensation	03/04	04-04

2-0807-1 Purpose

1. Purpose. The purpose of this chapter is to furnish information and instructions necessary for the Claims Examiner (CE) to understand and implement the provisions of the FECA pertaining to continuation of pay (COP), which are found at 5 U.S.C. 8118, and to make initial payments in a timely manner.

2-0807-2 Statutory Provisions

2. Statutory Provisions. Effective September 7, 1974, the FECA was amended to authorize the employing agency to continue an employee's pay for a period not to exceed 45 calendar days of disability, pending the OWCP's determination of the employee's claim for compensation. COP applies only to traumatic, disabling injuries occurring on or after November 6, 1974 and reported on an OWCP claim form within 30 days.

The intent of the COP provision is to eliminate interruption in the employee's income for the period immediately following a job-related traumatic injury, not to increase the amount of compensation. The COP provision eliminates interruption of pay for the great majority of employees injured on or after November 6, 1974.

2-0807-3 COP Defined

3. COP Defined. COP is the continuance of the employee's regular pay for a period not to

exceed 45 calendar days of disability. 20.C.F.R. 10.200.

a. Disability. The employee is entitled to continued pay when he or she is totally disabled for work, or partially disabled for work, with reassignment by personnel action to a lower grade or position with lower rate of pay.

b. Lost Elements of Pay. If the effects of the injury require that an employee lose elements of pay (e.g., the assignment of a night shift worker to a day shift in order to perform prescribed light duty), COP should be granted for the lost elements of pay (e.g., the night differential).

c. Light Duty. Informal assignment of light or restricted duties, without a personnel action and without loss of pay, is not counted as continued pay under section 8118 and does not decrease the number of days available to the claimant. 20 C.F.R. 10.217.

d. Relationship to Compensation. COP during the 45-day period is not considered compensation as defined by 5 U.S.C. 8101(12) and therefore is subject to income tax, retirement and other deductions. 20 C.F.R. 10.200(a). Other benefits provided under the FECA during the 45-day period, however, such as medical care and transportation, are considered compensation.

2-0807-4 Traumatic Injury

4. Traumatic Injury. A traumatic injury is defined as a condition of the body caused by a specific event or incident, or series of events or incidents, within a single workday or shift. Such condition must be caused by external force, including stress or strain, which is identifiable as to time and place of occurrence and member or function of the body affected. 20 C.F.R. 10.5(ee). Such an injury is distinguishable from an occupational disease or illness in that the latter is produced by systemic infection; continued or repeated stress or strain; exposure to toxins, poisons, or fumes; or other continued or repeated exposure to conditions of the work environment over more than one work day or shift. 20 C.F.R. 10.5(g).

The following examples should aid in distinguishing between a traumatic injury and an occupational illness:

a. Traumatic Injury. If an air traffic controller was issuing instructions to the pilot of an airplane which subsequently crashed, and the controller developed a medical condition following the crash because of "emotional stress," it must be concluded that the employee suffered a "traumatic injury." The airplane crash was a specific incident which occurred within a single day or work shift, which accords with the definition of "traumatic injury" contained in 20 CFR 10.5(ee).

b. Occupational Disease. If an air traffic controller develops a medical condition

because of daily pressures, adverse effects of shift changes, or harassment by supervisors, the claim would be based on occupational illness.

2-0807-5 Employee Status

5. Employee Status. The eligibility of certain groups of employees to receive COP is determined by statute and regulation:

a. Statutory Exclusions. Persons appointed to serve on the office staff of a former President are considered to be Federal employees, but they are specifically excluded from entitlement to COP. Persons listed in subsections "i" through "iv" of 5 U.S.C. 8101(1)(E) are expressly excluded from COP because they are not employees within the meaning of the Act.

b. Separate Legislation. Persons whose entitlement to FECA benefits depends on separate legislation are also excluded from COP. In many of these cases, entitlement to compensation begins from the date such persons are discharged from the programs in which they are enrolled, such as the Peace Corps, Job Corps, and Youth Conservation Corps. In other instances, the employment status and/or pay rate is too uncertain to make specific determinations (i.e., Work Study students, Civil Air Patrol Volunteers, and non-Federal law enforcement officers), 20 C.F.R. 10.200(c).

c. Individuals Serving Without Pay or for Nominal Pay. Persons whose employment status for compensation purposes is determined under 5 U.S.C. 8101(1)(B) (e.g., consultants and volunteers) work without pay or for nominal pay, and they are generally not carried in a regular, continuing pay status. While these individuals render personal service to the United States similar to civil officers and employees, they are not entitled to COP, 20 C.F.R. 10.200(c).

d. Non-Citizens and Non-Residents. Persons who are not citizens or residents of the United States or Canada, and who are injured while working outside the continental United States or Canada, are covered under the provisions of 5 U.S.C. 8137 and are excluded from COP, 20 C.F.R. 10.220(b).

Panamanian nationals employed by any agency of the U. S. government, including the Panama Canal Commission, before October 1, 1979 are entitled to COP. Those hired on or after that date, however, are not entitled to COP.

e. Jurors. Any person serving as a petit or grand juror subject to Chapter 121 of Title 28 is entitled to coverage under the FECA, whether or not he/she is also a Federal employee. In order to be entitled to COP, however, the juror must be a Federal employee, 20 C.F.R. 10.200(c).

f. Temporary Employees. Persons in this category are civil employees of the Federal government and are included under the provisions of 5 U.S.C. 8118. The fact that their employment would not have continued is not considered sufficient reason to exclude them from coverage. (See paragraph 14.c below). Like any other employee, however, a temporary employee who first reports a traumatic injury after the employment is terminated is not entitled to COP, 20 C.F.R. 10.220(d).

2-0807-6 Period of Entitlement

6. Period of Entitlement. The 45 days during which pay may be continued are calendar days, not work days, 20 C.F.R. 10.215.

a. Beginning of Period. If the employee has stopped work due to the disabling effects of a traumatic injury, the period begins with the first full day or shift of the disability, provided that it begins within 45 days of the injury. The employing agency will keep the employee in a pay status or grant administrative leave for any fraction of a day or shift lost on the date of injury, with no charge to the 45-day period. Only if the injury occurs before the beginning of the work day may the date of injury be charged to COP. The following examples are provided to assist the CE in determining when the 45-day period begins:

(1) An employee is injured on Friday afternoon, stops work and obtains medical treatment. The employee performs no work on Saturday or Sunday (since those are regular days off), but returns to work on Monday and works four hours of a usual eight-hour shift. If medical information shows the employee was disabled on Saturday, the 45-day period began on Saturday. Monday (a day when the employee is only partially disabled) would also be charged as a full day against the 45-day period.

(2) The employee is only partially disabled following the injury, and continues to work several hours each work day. The 45-day period would commence the day following the date of injury. Thereafter, each day or partial day of absence from work is chargeable against the 45-day period.

b. Portion of Day. If the employee stops work for a portion of a day or shift other than the day of injury, such day or shift will be counted as one calendar (full) day for purposes of tolling the 45 days. The employee, however, is not entitled to COP for the entire day or shift if work is available for the remaining partial shift. For instance, an employee who is scheduled to work an eight-hour day and who must lose three hours in order to receive physical therapy for the effects of the injury will be charged COP as follows:

(1) If work is available for the rest of the day, the employee is entitled to three hours of COP for that day or shift even though one full calendar day will be charged against the 45-day limit. If the employee is absent for all or any portion of the remaining five hours, the absence would be covered by leave, LWOP, AWOL, etc., as appropriate, since absence beyond the time needed to obtain the physical therapy cannot be charged to COP.

(2) If the employing agency does not allow the employee to work a partial shift, the employee is entitled to COP for the entire shift. For example, rural letter carriers are often not allowed to work partial shifts due to the nature of their work. Therefore, if they obtain medical care for employment-related injuries during work hours, they will likely be absent for the entire shift, and will therefore be entitled to COP.

c. End of Period. The claimant's entitlement to COP must begin within 45 days of the date of injury, whether its use results from disability due to the original injury or the need for medical care. However, where continuing days of COP bridge the 45th day, pay may be continued until entitlement is exhausted or the claimant returns to work. (See paragraph 13 below concerning payment of COP during recurrences of disability.)

2-0807-7 Employee Responsibility

7. Employee Responsibility. The injured employee or someone acting on his or her behalf is responsible for the following:

a. Notice of Injury. The employee must provide a written report on Form CA-1 to the employing agency within 30 days of the injury. 20 C.F.R. 10.210(a). Another OWCP-approved form, such as Form CA-2, CA-2a, or CA-7, which contains words of claim, can be used to satisfy timely filing requirements.

(1) The employee's submission of a sick leave slip or any form of leave request other than Form CA-1 or CA-2 to the employing agency may not be construed as an election of leave for disability resulting from a traumatic injury.

(2) The Employees' Compensation Appeals Board held, in the case of William E. Ostertag, 33 ECAB 1925 (1982), that 5 U.S.C. 8122(d)(3), which provides that failure to file claim in a timely fashion may be excused for exceptional circumstances, does not apply to claims for COP.

b. Medical Evidence. The employee must present the employing agency with medical evidence supporting disability resulting from the claimed traumatic injury within 10 calendar days after filing a claim for COP. 20 C.F.R. 10.210(b). The employing agency may continue the employee's pay absent such evidence if the nature and severity of the injury warrant the continuation. COP may be reinstated retroactively if payment was not initially authorized but supporting medical evidence is received later, 20 C.F.R. 10.222(a)(1).

c. Advising the Physician. Where the agency has advised the employee that a specific alternative position exists, the employee must furnish a description of the position to the physician and inquire whether and when he or she will be able to perform such duties. Likewise, where the agency has advised that it is willing to accommodate the employee's work limitations, the employee must so advise the attending physician and ask him or her to specify the limitations imposed by the injury. In both instances the employee must provide the agency with a copy of the physician's response.

d. Return to Duty. The injured employee must return to work upon notification by

the attending physician that he or she is able to perform regular work or light duty and the agency has advised that such suitable work is available. If the employee refuses to do so, the continued absence from work may result in an overpayment. COP may also be terminated if the employee refuses to respond to the agency's offer of suitable work within five work days of receipt of the offer. The agency may make the offer to the employee over the telephone, but must confirm the offer in writing as soon as possible thereafter.

e. Claiming Compensation. If medical evidence shows that disability is expected to continue beyond 45 days, the employee should complete Form CA-7 and submit it to the employing agency on the 40th day of COP.

2-0807-8 Employing Agency Responsibility

8. Employing Agency Responsibility. When an employee has suffered an employment-related traumatic injury, the employing agency should take action with respect to the following:

a. Authorizing Medical Care. The agency should promptly authorize medical care on Form CA-16 and provide OWCP-1500, required for billing by the physician, to the claimant, 20 C.F.R. 10.211(a). If the supervisor is not certain that the injury occurred in the performance of duty, item 6B on Form CA-16 should be checked.

b. Providing Notice of Injury. The supervisor should furnish Form CA-1 to the employee or to someone acting on his or her behalf for completion of the employee's portion of the form and return to the employee the "Receipt of Notice of Injury." 20 C.F.R. 10.211(a)

c. Right of Election. The agency will notify the employee of the right to elect COP or to use annual or sick leave or LWOP if the injury is disabling, and that leave used counts against the 45-day COP period, 20 C.F.R. 10.211(b).

d. Need for Medical Evidence. The agency will notify the employee of the need to submit medical evidence of a disabling traumatic injury within 10 calendar days of the date disability begins or pay may be terminated. It will also supply the employee with copies of Form CA-17 for completion by the physician providing medical care.

e. Controversion. The agency will inform the employee whether COP will be controverted and, if so, whether pay will be terminated, and the basis for such action (the reasons must conform with those indicated in paragraph 9 below). The agency will also explain the basis for controversion (if any) on Form CA-1 or by separate narrative report, 20 C.F.R. 10.211(c).

f. Submission of Information. Form CA-1, fully completed by both the employee

and employing agency, together with all other pertinent information and documents, must be submitted to OWCP by the employing agency within 10 working days (20 C.F.R. 10.211(d)) following the agency's receipt of the completed form from the employee. In addition, the official superior shall make any additional reports which OWCP requires.

g. Claim Forms. The agency should provide Form CA-7 to the employee on the 35th day of COP if disability is expected to exceed 45 days and submit the completed form to OWCP on the 40th day of COP with supporting medical evidence.

h. Return to Duty. The agency is responsible for advising the claimant of his/her obligation to return to work as soon as possible in accordance with the medical evidence.

i. Termination of COP. The agency will terminate COP when disability ends, the 45-day period expires, or the employee returns to work, 20 C.F.R. 10.222.

2-0807-9 Controversion

9. Controversion. 20.C.F.R. 10.221. The employing agency may controvert a claim on the basis of the information submitted by the employee or secured on investigation ("controvert" means to dispute, challenge, or deny the validity of the claim). The agency may controvert a claim by completing the indicated portion of Form CA-1 and submitting detailed information in support of the controversion to OWCP. Even though a claim is controverted, the employing agency must continue the employee's regular pay unless at least one of the conditions set forth below is met, in which case the employing agency shall not pay COP:

a. The disability is a result of an occupational disease or illness, not a result of a traumatic injury, 20 C.F.R. 10.220(a);

b. The claimant's status as an employee is defined by 5 U.S.C. 8101(1)(B) or (E);

c. The employee is neither a citizen nor a resident of the United States or Canada (i.e., a foreign national employed outside the United States or Canada), 20 C.F.R. 10.220(b);

d. The injury occurred off the employing agency's premises and the employee was not engaged in official "off-premises" duties, 20 C.F.R. 10.220(e);

e. The injury resulted from the employee's willful misconduct, the employee's intention to bring about the injury or death of himself or herself or of another person, or the employee's intoxication by alcohol or illegal drugs, which includes any controlled substance obtained or used without proper medical prescription, 20.C.F.R. 10.220(f);

f. The injury was not reported on a form approved by OWCP within 30 days

following the injury, 20 C.F.R. 10.220(c);

g. Work stoppage first occurred 45 days or more following the injury, 20 C.F.R. 10.220(g);

h. The employee initially reported the injury after employment was terminated, 20 C.F.R. 10.220(d); or

i. The employee is enrolled in the Civil Air Patrol, Peace Corps, Job Corps, Youth Conservation Corps, a Work Study Program, or a similar group, 20 C.F.R. 10.200(c).

In all other cases, the employing agency may controvert an employee's right to COP, but the employee's regular pay shall not be interrupted during the 45-day period unless the controversion is sustained by OWCP and until the employing agency is so notified.

2-0807-10 Adjudicating the Claim for COP

10. Adjudicating the Claim for COP. The CE should give priority to "terminated pay" cases and determine whether the employing agency's action is correct, taking the following steps:

a. If additional information is needed, the CE shall release an appropriate letter requesting additional information.

b. If COP is denied, the CE will release a decision denying COP.

c. If COP is approved, the CE will release an acceptance letter, which indicates the accepted condition and notifies the claimant of the procedures to follow if compensation is claimed. Once a claim is received, the CE will take prompt action on it; see paragraph 17 below. If the employing agency controverted the claim, it is entitled to know why the specific objections were not upheld. The CE must make a finding on the issues raised by the employer, and include an explanation of the decision on COP.

d. If only a portion of the period of COP can be approved because the employee did not meet his or her responsibilities as described in paragraph 7 above, the decision should state the dates for which COP is approved, and explain why other dates claimed are denied.

e. In a case where a juror who is also a Federal employee is eligible for COP, the CE should forward a copy of Form CA-1 to the employing agency advising it to continue the employee's pay beginning the day after the date of the employee's termination of service as a juror.

The Correspondence Library contains letters that can be used for development and adjudication

of COP.

2-0807-11 Regular Pay

11. Regular Pay. An employee's regular pay is his or her average weekly earnings, including premium, night or shift differential, holiday pay, Sunday premium pay except to the extent prohibited by law, or other extra pay, including FLSA pay for firefighters, emergency medical technicians, and others who earn and use leave on the basis of their entire tour of duty, 20.C.F.R. 10.216(a).

a. Overtime Pay. Overtime pay may not be included in computing the pay rate for COP purposes, 20 C.F.R. 10.216(a)(1).

b. Within-Grade Increases and Promotions. Additional money which the employee would have received but for the injury is included since COP is payment of salary and not compensation. In situations where the pay rate is computed on the basis of average weekly earnings during the one year prior to the date of injury, the weekly pay rate of COP should be increased by the percentage of increase in the employee's actual wage, 20 C.F.R. 10.216(a)(2).

c. Employees with Regular Schedules. 20 C.F.R. 10.216(b)(1). For a full-time or part-time employee, either permanent or temporary, in the regular work force who works the same number of hours per week, the weekly pay rate equals the number of hours regularly worked each week times the hourly pay rate on the date of injury, in accordance with the following formula:

H = Hours regularly worked each week
R = Hourly pay rate on date of injury
H x R = Employee's average weekly earnings.

d. Employees with Irregular Schedules. 20 C.F.R. 10.216(b)(2). For a part-time employee, whether permanent or temporary, in the regular work force who does not work the same number of hours per week, the weekly pay rate is the average of the weekly earnings for the year prior to the date of injury, in accordance with the following formula:

P = Total pay earned during one year period prior to injury (excluding overtime)
W = Total number of weeks worked
P/W = Employee's average weekly earnings.

For the purposes of this computation, a partial work week is counted as an entire week.

e. Employees Who Work Intermittently. 20 C.F.R. 10.216(b)(3). For an intermittent, irregular, or WAE worker who is not a part of the agency's regular full-time or part-time work force, the weekly pay rate is the average of the employee's earnings in Federal employment during the year prior to the injury. The average annual earnings, however, must not be less than 150 times the average daily wage earned within one year prior to the date of injury (the daily wage is the hourly rate times 8). The pay rate should be computed using both of the formulas shown below; the higher result should be accepted as the pay rate.

(1) Establish the average of the employee's weekly earnings during the year prior to the injury according to the following formula:

P = Total pay earned during one year prior to injury (excluding overtime)
W = Total number weeks worked
P/W = Employee's average weekly earnings.

This equation avoids any distortion of the employee's earning power.

(2) Determine the weekly pay rate by multiplying the average daily wage earned within the year prior to the date of injury by 150:

P = Total pay earned during one year prior to injury (excluding overtime)

H = Total number hours worked

P/H = Y (Average hourly pay rate)

Y x 8 x 150/52 = Average weekly earnings.

f. National Guard and Military Reserve. Where membership in the National Guard or the military reserve is a condition of employment, COP includes military drill and field training pay only in the limited circumstances where there is an actual loss of military pay. For example, an individual who at the end of the year has not completed the physical training requirements sustains an injury and loses military pay, such loss of military pay must be included in the pay rate for COP purposes. On the other hand, if the agency is able to provide alternative military training activities to injured federal employees, so that these injured employees do not actually "lose" military pay during the 45-day COP period, it is proper not to include such constructive military pay for COP purposes.

g. Jurors. The pay rate of jurors is computed in accordance with paragraphs a-e above.

h. Incorrect Pay Rates. Where the agency continues pay at a rate OWCP subsequently finds incorrect, the CE shall notify the agency of the correct pay rate and the agency will make the necessary adjustment.

2-0807-12 Delayed Disability

12. Delayed Disability. An injury which does not immediately disable the employee or require medical care may later cause disability and/or require medical treatment. In such cases:

a. The employee should complete Form CA-1 in the same manner as if the injury were immediately disabling and indicate on the form that he or she is continuing to work. The form should be submitted to the supervisor, who will complete and return the "Receipt of Notice of Injury."

b. The supervisor will complete the employing agency's portion of Form CA-1 except items which concern work stoppage, and place the CA-1 in the employee's personnel folder. If disability subsequently occurs, the supervisor will retrieve the Form CA-1 and complete items concerning work stoppage, noting on the form the date these items were completed to clarify the reason for the delay in submitting the form. The

form should be transmitted to OWCP in the usual manner, and pay should be continued as described above, as long as 45 days have not elapsed from the date of injury.

2-0807-13 Recurrence of Disability

13. Recurrence of Disability. 20 C.F.R. 10.207. If an employee returns to work following a work stoppage, without using all 45 days of COP, and then suffers a recurrence of disability within 45 days of the first return to duty, he or she should submit a completed Form CA-2a, and may elect to use the remaining days of COP.

Time lost on the day of injury that is charged to administrative leave is considered a work stoppage, whether the time is used to obtain medical treatment or for disability. If the time away from work is so minimal that no administrative leave is charged, such as a brief visit to the health unit, this is not considered a work stoppage for the purpose of tolling time. If the 45-day entitlement has been exhausted, however, or the recurrence begins more than 45 days after the employee first returned to work, the employing agency may not pay COP. Rather, the employee should claim compensation for wage loss on Form CA-7.

For example, an employee is injured on January 1. The employing agency provides several hours of administrative leave, enabling the employee to obtain medical attention. On January 2, the employee works a full day. The employee is not disabled due to the injury until February 10, but is disabled and off work February 10, 11, and 12 and receives COP for those three days. The employee returns to work on February 13 and does not lose any further time from work due to the injury until March 17; but on March 17, 18 and 19 he again loses time from work due to the disability. The 45-day period begins to run when the employee returned to work on January 2 because work stoppage occurred at the time of injury, even though it was covered by administrative leave. The employee is entitled to COP for the time lost in February, but is not entitled to COP for time lost in March as it is more than 45 days since the first return to work.

COP is paid for the entire period of any continuous disability which extends beyond the 45-day limit as long as the 45 days have not been used. Any valid period of entitlement to COP for the injury must begin, however, within 45 days of the injury or of the first return to work after the injury.

2-0807-14 Interruption, Suspension and Termination of COP

14. Interruption, Suspension and Termination of COP.

a. Effect of Disciplinary Action. 20 C.F.R. 10.222(b). COP may be terminated when

a preliminary notice of disciplinary action is issued before the injury and becomes final during the COP period. The CE must ensure that the case file contains documentation that the preliminary notice of termination was in fact issued prior to the date of injury. Where these conditions are not met, the CE must advise the agency to continue pay.

b. Effect of Refusal/Obstruction of Medical Examination. If an employee refuses to submit to or obstructs an examination required by the Office under the provisions of 5 U.S.C. 8123(a), COP paid or payable during the period of the refusal is forfeited and is subject to recovery by the employing agency. Action to deny payment of COP and any subsequent compensation may be taken only if the claimant was advised of the provisions of 20 CFR 10.323 and 5 U.S.C. 8123(d) when the appointment was arranged. If a suspension occurs during the COP period, the CE must notify the agency immediately of the suspension and its effective date 20 C.F.R. 10.223.

c. Criteria for Termination. COP should not be terminated until one of the following circumstances occurs:

(1) OWCP advises the agency that pay should be terminated. Where termination of COP in a specific case depends upon the termination date of temporary or seasonal employment, the CE should determine the ending date of employment in accordance with the following:

(a) Seasonal Firefighters--the end of the fire season in the geographical area as determined by the U.S. Forest Service.

(b) Emergency Firefighters--the date on which other Emergency Firefighters in the employee's work group would be terminated due to cessation of activities.

(c) Census Enumerators--the date on which the employee's assignment was completed. This is usually the date of completion of the short-term enumerating project or survey for which the employee was hired.

(d) Temporary Postal Workers--the date the assignment would have ended were it not for the injury.

(e) Other seasonal or temporary workers--the date the assignment would have ended were it not for the injury.

(2) The 45-day period expires, except that an employee who is scheduled to be separated and suffers a traumatic injury on or before the separation date shall be separated regardless of the injury. The employee is not entitled to COP after the date of termination.

(a) In the case of permanent employees, the date of termination must be established in writing prior to the injury.

(b) In the case of temporary employees, the notice of appointment often indicates the date on which the appointment expires. If a temporary worker's term of employment is changed, written notice of the change is necessary to support termination of COP at an earlier date.

(3) The agency is advised by the attending physician that the employee is no longer disabled.

(a) The phrase "no longer disabled" applies to regular work. Obviously, COP should be discontinued when an employee returns to full regular duty.

(b) The employing agency should also terminate COP when a partially disabled employee returns to full-time suitable light duty without official reassignment and without pay loss.

(c) When the physician's report indicates the employee is capable of performing light duty, the employee is required to accept any reasonable offer of suitable light or limited duty. If the employee refuses to accept the work offered, COP should be terminated. OWCP will then resolve the dispute on the basis of evidence submitted (see paragraph 16.b below.

d. Absence of Medical Evidence.

(1) The employing agency may terminate COP or refuse to retroactively convert previously used leave to COP for the reason that medical evidence which on its face supports disability due to a work-related injury is not received within 10 calendar days after the claim is submitted (unless the employer's own investigation shows disability to exist). Where the medical evidence is later provided for the period in question, the CE should send a copy of it to the agency with instructions to reinstate COP retroactive to the date of termination, or to convert and restore previously used leave, 20 C.F.R. 10.222(a)(1).

(2) The decision to terminate COP rests primarily with the official superior, who may have particular knowledge of the circumstances of the injury and choose not to terminate COP even if medical evidence has not been submitted. Therefore, the CE should not direct the agency to terminate COP ten calendar days after the employee claimed COP. The CE is still responsible, however, for advising the employee to submit supporting medical evidence and to deny the claim on burden of proof if the evidence is not submitted in a timely manner.

e. Effect of Intoxication. In order to uphold the termination of COP on the basis of intoxication by alcohol or illegal drugs, it must be established that the use of the substance was the proximate cause of the injury. Where use of an illegal drug is alleged, it must also be shown that the substance was controlled and that it was obtained or used illegally. If these conditions are not met, the CE should advise the agency to pay COP on a retroactive basis.

2-0807-15 Relationships Between Leave Usage, COP and Compensation

15. Relationships Between Leave Usage, COP and Compensation.

a. An employee may use annual or sick leave to cover all or part of an absence due to injury but the employee's compensation for disability does not begin, and the waiting period specified by 5 U.S.C. 8117(1) does not begin to run, until COP terminates and any use of leave ends.

b. If an employee elects sick or annual leave, entitlement to COP is not preserved. Each full or partial day for which the employee is absent from work due to a disability will be counted as one day against entitlement to COP, regardless of whether sick or annual leave is used. Therefore, while an employee may use COP intermittently along with sick or annual leave, entitlement is not extended beyond 45 days of combined absences.

c. An election of sick or annual leave during the 45-day period is not considered irrevocable. If an employee has elected sick or annual leave for the period and then wishes to elect COP, the agency is required to make such a change on a prospective basis (from the date of the employee's request). The employee may also receive COP in lieu of previously requested annual or sick leave, provided the request is made within one year of the date the leave was used or the claim was approved, whichever is later. The claimant must provide medical evidence of disability (see paragraph 7b above). Where timely request is made, the employing agency is to convert the leave used to COP and restore the leave to the employee.

d. If the leave balance of an employee who first elects leave is not sufficient to cover all disability during the 45-day period, COP may be elected retroactive to the date that the leave ran out and wage loss began. The employing agency should not wait, however, for a disabled employee to change the election from leave to COP. When leave runs out the agency is required to convert the employee to COP status immediately.

e. If OWCP denies a claim for COP, the amount paid will be charged to sick or annual leave at the option of the employee or shall be deemed an overpayment within the meaning of 5 U.S.C. 5584. 20 C.F.R. 10.224

2-0807-16 Light Duty Offers

16. Light Duty Offers. Employing agencies are expected to try to provide light duty during COP, and claimants are expected to accept suitable offers of work.

a. Acceptance of Job. If such a job is accepted, the following considerations apply:

(1) COP is chargeable only when the claimant has been formally assigned to an established job which is normally paid at a lower salary and would otherwise result in loss of income to the employee. COP must be charged against the employee's 45-day entitlement if personnel action has been taken to:

(a) Assign or detail the employee to an identified position which is classified at a lower salary level than that earned by the employee when injured.

(b) Change the employee to a lower grade, or to a lower rate of basic pay.

The employee must be furnished with documentation of the personnel action prior to its effective date.

(2) The agency should report return to work at a light duty assignment. Form CA-3 may be used for this purpose, but is not required. If the employee worked at a lower paying job but received the full pay of his or her normal job, the difference between the employee's regular pay and the pay for the light duty job represents COP paid.

b. Refusal of Job. Where the claimant refuses or fails to respond to an offer of work, the CE must determine the suitability of the offered work and, where indicated, provide the employee an opportunity to submit his or her reasons for the refusal. The following guidelines should be used with respect to the payment of compensation following the 45-day COP period if the agency's written job offer (including the description and physical requirements of the job) is received prior to or with Form CA-7:

(1) If the duties and physical requirements of the offered work are not compatible with the employee's work restrictions as established by the employee's attending physician, the employing agency should be so advised and instructed to reinstate COP retroactive to the date of termination. Compensation should be initiated, if appropriate, at the expiration of the COP period. If the work restrictions established by the attending physician are not on file, the employing agency should be asked by telephone to submit the report as soon as possible.

(2) If the job is found to be suitable, the employee must be provided with the opportunity to submit his or her reasons for the refusal within 30 days. Compensation need not be initiated at the end of the COP period pending resolution of the issue, even if the claimant's response indicates the need for further development by the CE (e.g., the claimant makes an unauthorized change in physicians and submits prima facie evidence from the second physician

indicating that he or she cannot perform the offered work).

(a) If the claimant responds and the refusal is found to be justified, the agency should be instructed to reinstate COP retroactively, and compensation should be paid for any period of disability after COP ended.

(b) If the refusal is not found to be reasonable or justified (or the claimant does not respond within the 30-day period), a formal decision terminating entitlement to both COP and compensation is to be issued. Termination of entitlement is effective the date the agency terminated COP rather than the date of the formal decision. The date of the agency's termination of COP should be the date the job was available to the employee.

(3) If the employing agency has terminated COP based on the employee's refusal of an offer of suitable work but the written job offer (including the description and physical requirements of the job) is not received prior to or with Form CA-7, compensation should be initiated as claimed. Once initiated, compensation should continue, as appropriate, until a final determination is made concerning the refusal of the offered work.

(4) If it is determined subsequently that the refusal was not reasonable, a formal decision should be issued which denies COP as of the date the agency terminated pay (since the agency's action was proper) and terminates the employee's entitlement to compensation as of the beginning date of the next periodic roll cycle.

If payment was made on the daily roll, the date of termination should be the date of the employee's refusal (or, if the employee did not respond, the end of the 30-day period allowed for response), provided compensation has not been paid beyond that date. If compensation has been paid beyond that date, it should be terminated as of the end of the last period for which payment was made.

2-0807-17 Timely Payment of Compensation

17. Timely Payment of Compensation. In order to ensure that claimants are not without income during the period immediately following payment of continuation of pay, the CE must advise claimants and employing agencies promptly of actions needed to claim compensation and process any claims on file.

a. Notification of Employee. When a traumatic injury case is accepted, the CE may notify the claimant of the acceptance, with a copy to the agency. Such notification must be provided in all cases in which the employing agency has controverted the claim and should include an explanation (see paragraph 10.c above). Notification need not be provided in the following situations:

(1) The claim for compensation is received prior to acceptance of the case.

(2) No time has been lost beyond the date of injury.

(3) Form CA-1 shows that the claimant returned to duty prior to the expiration of the COP period.

(4) The medical evidence clearly establishes that the employee will return to work before the 45th day.

The claimant is primarily responsible for submitting medical evidence and claims for compensation. The Office is not obligated to continue paying compensation where no further claim is made and no medical evidence demonstrating continued disability appears in file.

b. Monitoring the Claim.

(1) If Form CA-7 has not been received, the CE should place a call-up (code T) for the 45th day of COP at the time of acceptance where COP is being paid and disability will likely extend beyond the COP period. When the call-up expires, the CE should contact the agency to determine whether the claimant has returned to work and to request submission of the claim for compensation.

(2) Whether or not a Form CA-7 is on file, the CE is expected to use the authority provided by the FECA to approve a 15-day payment if disability for the period is supported and wage loss is verified by the agency. The CE should call the agency to obtain or verify the information needed to approve payment, requesting written confirmation of information provided verbally. The employee and agency should be advised that further payment requires a formal claim and appropriate supporting evidence.

c. Medical Evidence. Absent information that the claimant has returned to duty, the CE may authorize the payment of compensation for wage loss based on medical evidence of injury-related disability for the period claimed or the period for which compensation is being authorized.

(1) Medical evidence may take the form of:

(a) Form CA-16, Form CA-20 or Form CA-17 with a period of disability indicated.

(b) Medical notes from the attending physician indicating that the claimant is not to work until the next scheduled office visit, at which time he/she will be reevaluated.

(c) Hospital records indicating disability for the period in question.

(d) A current narrative medical report indicating disability for the period in question or projecting disability through the period claimed.

(2) Payment should not be authorized if the attending physician states that the employee can return to duty, but the employee does not return, makes an unauthorized change in physicians, and subsequently submits medical evidence of disability from the second physician.

d. Period of Payment. To determine the period for which compensation is payable, the CE must evaluate the medical evidence and determine whether the daily or periodic roll should be used. See FECA PM 2-811.

(1) Payment may be approved even though the Form CA-7 was signed in advance of the period claimed, but approval of a claim submitted in advance should be limited to a period of not more than 30 days from the date of signature. If the claim was submitted in advance, the CE should verify by telephone that the employee has not returned to work.

(2) The three-day waiting period must be considered when payments are approved. Where the period ends on the date the CE is setting up payment, and medical evidence clearly establishes that disability will extend 15 days or more after the beginning of wage loss, the CE may extend the period approved for payment through the 15th day if such an extension will eliminate the need to withhold waiting days.

(3) When approving payment in advance, the CE must keep in mind the ACPS cutoff and payment schedule. If the 15-day period ends subsequent to the cutoff date of the current ACPS payment cycle, the payment will be processed in the next cycle, and the check will be dated and released a week later.

e. Pay Rate Information.

(1) CEs should be alert to situations where entitlement of a dependent may be questionable. For instance, the claimant may have reported two different dates of

birth for a child now near 18 years of age, or it may not be clear from the evidence of record whether a child has been adopted formally or remains a foster child. In such situations, the CE should request substantiation of dependent status by way of certified copies of birth certificates, adoption proceedings, or other documentation before augmented compensation is paid.

(2) Occasionally, the pay rate information furnished by the agency is insufficient to establish the proper pay rate for compensation purposes. However, where a usable pay rate appears, it should be used on an interim basis to avoid delays in making payment. The CE should write to the agency, with a copy to the employee, advising of the pay rate being used and requesting the information needed so that adjustment can be made.

(3) If the Form CA-7 shows that the claimant received premium pay, shift or night differential, but the evidence is insufficient to compute the amount of pay for compensation purposes, compensation should be paid using the base pay, pending receipt of the requested information on extra pay.

(4) If conflicting information appears concerning the salary or pay rate (e.g., Form CA-1 and Form CA-7 show different pay rates), compensation should be paid using the lower of the two pay rates until the matter is resolved.

(5) If the case involves intermittent employment and additional information to establish the proper pay rate is needed, compensation should be paid using the "150 times" formula until the needed information is received. Since the "150 times" formula is the method of last resort, the CE must attempt to establish a pay rate in accordance with 5 U.S.C. 8114 which reasonably represents the earning capacity of the injured employee.

(6) If the information is insufficient to establish even a daily pay rate, the CE should call the agency to obtain at least a minimum figure which can be used as the basis for the "150 times" formula. The CE should then develop evidence to establish the correct pay rate.

2-0808 SCHEDULE AWARDS & PERMANENT DISABILITY CLAIMS

Paragraph	Subject	Date	Trans. No.
1	**Purpose and Scope**	**11/98**	**99-05**
2	**Impairment and Disability**	**03/95**	**95-14**
3	**Evaluating Potential Permanent Disability or Impairment**	**03/95**	**95-14**
4	**Permanent Total Disability**	**03/95**	**95-14**
5	**Entitlement to Schedule Awards**	**03/95**	**95-14**
6	**Evaluation of Schedule Awards**	**08/02**	**02-12**
7	**Payment of Schedule Awards**	**03/95**	**95-14**
		11/98	**99-05**
8	**Disfigurement**	**08/02**	**02-12**

2-0808-1 Purpose and Scope

1. Purpose and Scope. This chapter describes the procedures for developing claims which have resulted or may result in permanent disability or impairment. Entitlement may include

awards for:

a. Permanent total disability, as provided by 5 U.S.C. 8105;

b. Permanent partial disability which results in loss of wage-earning capacity, as provided by 5 U.S.C. 8106; or

c. Permanent impairment, either total or partial, for which a schedule award may be paid, as provided by 5 U.S.C. 8107.

This chapter also includes procedures for making awards for disfigurement of the face, head or neck.

2-0808-2 Impairment and Disability

2. Impairment and Disability. Impairment is a medical concept, and any evaluation of impairment must rest on medical evidence. Disability, on the other hand, is an economic concept which reflects a claimant's inability to earn wages comparable to those received before the injury. The degree of impairment is a major factor in evaluating disability, but it is not the only one; others include age, education, and work history. The kinds of permanent disability and impairment are as follows:

a. Permanent Total Disability (PTD). Claimants are rarely considered to have disability which is permanent in nature and total in quality. Only in catastrophic injuries or long-standing chronic conditions should this course be considered, and then only after all attempts to reemploy and/or rehabilitate the claimant have been exhausted.

b. Permanent Partial Disability (PPD). In disability which is permanent in nature but only partial in quality, compensation is based on the difference between the wages earned at the time of injury, disability, or recurrence, and the wages the claimant is capable of earning after the injury. This difference is called loss of wage-earning capacity (LWEC). Reemploying injured workers and establishing LWEC are discussed in FECA PM 2-813 and 2-814.

c. Permanent Impairment. This term is defined as the loss or loss of use of a part of the body, whether total or partial. The degree of impairment is established by medical evidence and expressed as a percentage of loss of the member involved. Permanent impairment may originate either within the affected member or in another part of the body. For instance, a back injury may result in impairment to a leg, for which a schedule award would be payable. A claimant may also receive an award for more than one part of the body in connection with a single injury.

2-0808-3 Evaluating Potential Permanent Disability or Impairment

3. Evaluating Potential Permanent Disability or Impairment. Case management procedures require that call-ups be set at appropriate intervention points according to the medical evidence. The purpose of this procedure is to ensure, among other things, that the claimant's potential for return to duty is carefully monitored. Likewise, the Claims Examiner (CE) should monitor medical reports for the possibility of eventual impairment to a schedule member and the date by which maximum medical improvement is expected. If it appears that a schedule award may be payable, the CE should advise the claimant via Form CA-1053 of his or her possible entitlement to such an award.

2-0808-4 Permanent Total Disability

4. Permanent Total Disability. The FECA provides that loss of both hands, arms, feet, or legs, or the loss of sight of both eyes is prima facie evidence of permanent total disability. It does not necessarily follow, however, that a claimant in this medical condition should be declared permanently and totally disabled. Some individuals may be able to work despite such severe handicaps, and the possibility of rehabilitation and/or reemployment should be explored before any declaration is made.

In very few other cases is it necessary or desirable to make a determination of permanent and total disability. Such an award confers no additional benefit on the claimant and it can result in forfeiture of other rights that a claimant may possess under other Federal laws. It is usually sufficient to continue payments for temporary total disability, even where efforts to reemploy and/or rehabilitate the claimant have failed.

In the rare instance where such a finding is appropriate, it should be based on the evaluations of the attending physician, other physicians who have examined the claimant, and the opinion of the DMA. Such an award does not supersede any award which may be payable for a schedule disability. Whenever a case involves both total disability and schedule impairment, the CE should make the schedule award and make or continue the award for permanent and total disability at the expiration of the schedule award.

2-0808-5 Entitlement to Schedule Awards

5. Entitlement to Schedule Awards. Permanent impairment to certain parts of the body will entitle the claimant to an award of compensation payable for a set number of weeks.

a. General Considerations.

(1) The length of the award is determined by the provisions of 5 U.S.C. 8107,

which also lists the parts of the body which may be considered for such an award. Additional parts of the body which may be considered are listed in 20 CFR 10.304.

(2) In some instances a schedule award may be payable even if the claimant had a pre-existing loss or loss of use of 100 percent of a member or function of the body. Cases of this type should be developed to determine the prior usefulness of the member or function and whether the injury in Federal employment has diminished any such usefulness, in whole or in part.

(3) A schedule award is payable consecutively but not concurrently with an award for wage loss for the same injury. However, a schedule award may be paid concurrently with salary reimbursement under the Assisted Reemployment Program. If the injury occurred on or after September 13, 1957, the schedule award may be paid concurrently with benefits under the U. S. Civil Service Retirement Act.

(4) A schedule award for one injury may be paid concurrently with compensation for wage loss paid for another injury, as long as the two injuries do not involve the same part of the body.

b. History of Entitlement. Entitlement to schedule awards has been affected by various legislative changes over the years. Following is a description of coverage afforded by the FECA during various periods according to date of injury:

(1) Prior to December 7, 1940. No provision for schedule award.

(2) December 7, 1940 to September 12, 1957. Schedule award for 100 percent loss or loss of use of major members only; injury must be to schedule member itself. No entitlement to compensation for loss of wage-earning capacity after expiration of the award. (On October 14, 1949, the law was amended such that schedule awards were payable retroactively to October 14, 1948 for "minor" impairments, such as simple fractures, and retroactive to January 1, 1940 for "major" impairments, such as amputations of hands or feet or loss of vision.)

(3) September 13, 1957 to July 3, 1966. Broadened coverage such that schedule impairment did not have to be the only residual of the injury. Permanent impairment had to be confined to the schedule member, however, so that if any other "significant disability" existed (i.e., any which would require treatment or cause loss of wage-earning capacity), no schedule award was payable.

(4) July 4, 1966 to September 6, 1974. Increased coverage to compensate for loss of wage-earning capacity after schedule award ended; schedule was payable regardless of location of other "significant disability."

(5) September 7, 1974 to present. Schedule awards payable for internal organs specified by the Secretary in addition to those indicated in the FECA.

2-0808-6 Evaluation of Schedule Awards

6. Evaluation of Schedule Awards.

Impairment, Fifth Edition (effective February 1,2001), and to report findings in accordance with those guidelines except as noted below. (Also, see PM 3-700.)

(1) Impairment to the lungs should be evaluated in accordance with the Guides insofar as possible. The percentage of "whole man" impairment will be multiplied by 312 weeks (twice the award for loss of function of one lung) to obtain the number of weeks payable; all such awards will be based on the loss of use of both lungs.

In cases involving anatomical loss by traumatic injury or surgery the evaluation will also be based on loss of lung tissue by weight or volume, and the award will be based on these factors if it results in a greater percentage of loss than one based on loss of respiratory function. Anatomical loss awards will be made for one or both lungs as appropriate.

(2) Injuries sometimes leave objective or subjective impairments which cannot easily be measured by the AMA Guides. Some examples are:

(a) Pain
(b) Atrophy
(c) Deformity
(d) Loss of sensation
(e) Loss of strength
(f) Marked sensitivity to heat or cold
(g) Soft tissue damage (scarring, discoloration)

The effects of any such factors should be explicitly considered along with the impairment measurable by the AMA Guides and correlated as closely as possible with the factors set forth there. This approach, combined with thorough rationale from the DMA as to the percentage of loss chosen, has been supported by the ECAB in decisions concerning schedule award determinations for factors not defined in the Guides. (See Thomas F. Gauthier, 34 ECAB 1060, and Arnulfo Aguayo Zepeda, Docket No. 84-1590, as discussed in PM 3-700, Exhibit 2.)

Whenever pain, discomfort, or loss of sensation is present due to nerve injury or nerve dysfunction (e.g.leg impairment due to a spinal disc injury), the evaluating physician should include these factors in arriving at a percentage of impairment. Chapter 15 of the Guides discusses evaluations of pain in general.

b. Evidence Required. To support a schedule award, the file must contain competent medical evidence which:

(1) Shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred ("date of maximum medical improvement" or DMI);

(2) Describes the impairment in sufficient detail for the CE to visualize the character and degree of disability; and

(3) Gives a percentage evaluation of the impairment (in terms of the affected member or function, not the body as a whole, except for impairment to the lungs). In members with dual functions, the physician should address both functions according to the AMA Guides.

c. Obtaining Medical Evidence. The attending physician should make the evaluation whenever possible. The report of the examination must always include the following:

(1) A detailed description of the impairment which includes, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent description of the impairment.

(2) Form CA-1303 may be used to advise the physician of the information needed to determine permanent impairment and request submission of an appropriate report. If examination will be necessary, the claimant should be notified by Form CA-1311.

(3) Except in uncomplicated amputations, the report should include an estimate of the impairment in terms
of percentage. Where this information is missing, the CE may ask the attending physician to provide it; if this fails, the CE may ask the District Medical Adviser (DMA) to calculate the percentage. Where the AMA Guides allow for expression of this percentage within a range, the physician may be asked why he or she assigned a particular percentage of impairment.

d. OWCP Medical Review. After obtaining all necessary medical evidence, the file should be routed to the DMA for opinion concerning the nature and percentage of impairment.

(1) The percentage should be computed in accordance with the AMA Guides, fifth edition. As a matter of course, the DMA should provide rationale for the percentage of impairment specified. When more than one evaluation of the impairment is present, however, it will be especially important for the DMA to provide such medical reasoning.

(2) The CE should review the DMA's findings and, if he or she believes that the impairment has not been correctly described or that the percentage is not reasonable, a new or supplemental evaluation should be obtained. The CE should not attempt to assign a different percentage of impairment without benefit of further medical advice.

2-0808-7 Payment of Schedule Awards

7. Payment of Schedule Awards.

a. Computing Awards. The procedures for computing schedule awards are detailed in FECA PM 2-901.14. The CE should complete Form CA-203, ACPS Schedule Award Payment, as described in FECA PM 5-306.5, and prepare Form CA-181, Award of Compensation, for the signature of the Senior CE.

The CE should keep in mind the following considerations in setting up a schedule award:

(1) The DMI is determined solely on the basis of the medical evidence. A subsequent date may be chosen to start the award, however, if the DMI falls within a period of compensable disability such that converting disability payments into a schedule award would be disadvantageous to the claimant (see the decision in Franklin L. Armfield, 28 ECAB 445).

If a date in the past will result in conversion of a period paid for temporary total disability (TTD) into payment for schedule award, it may not be chosen unless the record contains persuasive proof that maximum medical improvement had in fact been reached on that date. The claimant must be informed of the right to receive benefits from the Office of Personnel Management (OPM) during the period (see Marie J. Born, 27 ECAB 623).

(2) Any previous impairment to the member under consideration is included in calculating the percentage of loss except when:

(a) The prior impairment is due to a previous work-related injury, in which case the percentage already paid is subtracted from the total percentage of impairment; or

(b) The VA has already paid a claimant for a previous impairment to the same member, in which case an election will be required if the VA has increased the percentage payable due to the injury in civilian employment. In this instance an election will be between the entire schedule award and all VA benefits prior to any increase, on the one hand, and all VA benefits subsequent to the increase, on the other. Such an election should) be offered only for the period of the schedule, as any determination of LWEC will involve different entitlement and require a separate election.

(3) If a recurrence is accepted for a period which overlaps a schedule award, it will be necessary to interrupt the schedule in order to pay for the period of recurrence. If a recurrent pay rate is established, the claimant will be entitled to that rate for the balance of the schedule award after the period of disability attributable to the recurrence has ceased.

(4) Where the schedule award represents the first payment for compensable disability, the claimant's entitlement to CPIs does not begin until one year after the award begins (see Franklin J. Armfield, 28 ECAB 445). Compensable disability includes any period of continuation of pay (COP) authorized for disability, so that a claimant who has received COP but not payment of compensation will be entitled to receive CPIs one year from the effective date of the pay rate.

(5) A claimant who enters a vocational rehabilitation program during the course of a schedule award is entitled to receive compensation at the rate for TTD. This entitlement is satisfied by schedule award payments as well as those for temporary total disability. It is therefore not necessary to interrupt a schedule award for payment of TTD unless the claimant is also receiving an annuity from OPM. In this case the payments must be converted to TTD and an election must be obtained, as vocational rehabilitation services cannot be provided to an individual in receipt of such an annuity.

(6) If a claimant dies during the course of a schedule award from a cause other than the injury, payment for the remainder of the award may be made to his or her dependents as specified in 5 U.S.C. 8109. Such payment must be made at the rate of 2/3 rather than 3/4 for the portion of the award that runs after the date of death. If no eligible dependents remain, the balance of the award may not be paid to the estate. If the claimant dies of a cause related to the injury, death benefits may be paid in accordance with 5 U.S.C. 8133, but the balance of the award is not payable to the survivors.

(7) If payment for TTD is interrupted to make a schedule award, such payments must be resumed at the end of the schedule if the claimant has not been reemployed or rated for LWEC at the time the award ends (see Goldie Washington, 31 ECAB 239). Therefore, it is extremely important to establish the claimant's earning capacity before the award ends.

(8) If a schedule award extends for more than one year, a periodic roll review should be conducted annually. At a minimum, this review should consist of releasing Form CA-1032 to determine the status of any dependents. Medical review will be needed if the claimant has not returned to work.

b. Claims for Increased Schedule Award. Such claims may be based on incorrect calculation of the original award, or on additional exposure.

(1) If it is determined after payment of a schedule award that the claimant is entitled to a greater percentage of loss, an amended award should be issued. The pay rate will remain the same, and the revised award will begin on the day following the end of the award issued previously.

(2) If, on the other hand, the claimant sustains increased impairment at a later date which is due to work-related factors, an additional award will be payable if supported by the medical evidence. In this case, the original award is undisturbed and the new award has its own date of maximum medical improvement, percent and period. Instructions for payment of amended and additional awards are provided in FECA PM 5-306.3(d) and (e).

(3) In some instances, particularly in hearing loss cases, a claim for an additional schedule award will be based on an additional period of exposure. This constitutes a new claim and should be handled as such. Where a schedule award is paid before exposure terminates, no additional award will be paid for periods of less than one year from the beginning date of the last award or the date of the last exposure, whichever comes first.

If the claimant requests review of such a case, he or she must be asked to clarify whether the request is for review of the award or for additional compensation subsequent to the prior award.

(a) If the claimant is requesting review of the award, the case will be processed as a request for reconsideration, hearing, or appeal, whichever is applicable.

(b) If the claimant is requesting additional compensation, the CE will inform the claimant that a new claim should be filed one year after the beginning date of the last award or the date of last exposure, whichever occurs first.

(4) If a claimant who has received a schedule award calculated under a previous edition of the AMA Guides is entitled to additional benefits, the increased award will be calculated according to the fifth edition. Should the subsequent calculation result in a percentage which is less than the original award, the claim for an additional award should be denied but an overpayment should not be declared. Similarly, awards made prior to February 1, 2001 (the effective date of the fifth edition) should not be reconsidered merely on the basis that the Guides have changed. (All permanent partial impairment calculations made on or after the effective date of the Guides must be based on the fifth edition.)

Between March 7, 1977 and February 23, 1986, the OWCP used only the frequencies of 1000, 2000, and 3000 cps to determine an award. Decisions on claims being appealed will be based on the formula in use at the time when the claim was initially decided.

2-0808-8 Disfigurement

8. Disfigurement. If an injury causes serious disfigurement of the face, head, or neck of a character likely to handicap a claimant in securing or maintaining employment, a schedule award is payable under 5 U.S.C. 8107(c)(21) if the claimant is employed or employable. (A claimant who is permanently and totally disabled because of an employment-related injury is not entitled to a disfigurement award.) Cases of this type should remain open until it is clearly established whether or not permanent disfigurement of the face, head or neck has occurred.

Where the evidence shows that the employment injury has caused a permanent scar, blemish or some other type of deformity or defect, the CE will notify the claimant of the right to apply for an award.

A claimant who expresses a desire or intent to claim an award for disfigurement will be sent the proper forms and instructions even if the evidence of record seems to indicate no permanent disfigurement has occurred.

A claimant who expresses a desire or intent to claim an award for disfigurement will be sent the proper forms and instructions even if the evidence of record seems to indicate no permanent disfigurement has occurred.

a. When to Consider a Disfigurement Award. Disfiguring marks on the body tend to heal slowly, and scars and blemishes that remain after healing tend to fade and become less prominent with time. Therefore, an award for disfigurement should not be considered until at least six and preferably 12 months after the last medical treatment. If a claimant chooses to undergo additional surgery or other treatment, consideration of an award will be deferred until the additional treatment is completed.

b. Notification to Claimant. When the evidence shows disfigurement after healing, the claimant should be notified by Form CA-1094 of the right to apply for an award. The claimant must complete the front of the form, while the attending physician should complete the lower portion of the reverse. A new application is required in any instance where the claimant files for an award prematurely.

c. Other Information Required. Form CA-7 should be submitted if one has not been filed previously. Only the front of the form need be completed if a disfigurement award is the only benefit claimed. With the CA-1094 the claimant must submit two photographs taken within five days of the date of the application, each showing different views of the disfigurement fairly and accurately portrayed. The claimant may be reimbursed for the cost of the photographs.

d. OWCP Medical Evaluation. After the CE has gathered the required evidence, the case will be referred to the District Medical Advisor (DMA). The DMA will review the photographs submitted along with the medical evidence of record and place a memorandum in the file describing the disfigurement and stating whether maximum improvement has occurred. If not, final action on the application for disfigurement will be deferred.

If the DMA finds maximum improvement has occurred, the concurrence of the Assistant District Director (ADD) or the District Director (DD) must be obtained. The parties evaluating the disfigurement will place a memorandum in the file which states their findings and decision with supporting rationale. The case will then be returned to the CE for payment of the award or denial of the application.

e. Payment of Award. An award for disfigurement may be paid concurrently with compensation for temporary total disability. Whether an award is made alone or in conjunction with another benefit, the payment will need to be made using the "less previously paid" program of ACPS.

f. Payment of Award. An award for disfigurement may be paid concurrently with compensation for temporary total disability. Whether an award is made alone or in conjunction with another benefit, the payment will need to be made using the "less previously paid" program of ACPS.

2-0809 STATEMENTS OF ACCEPTED FACTS

Paragraph	Subject	Date	Trans. No.
1	Purpose and Scope	06/95	95-27
2	Introduction	06/95	95-27
3	Definitions	06/95	95-27
4	Nature of SOAF	06/95	95-27
5	Responsibilities of the Claims Examiner	06/95	95-27
6	Need for SOAF	06/95	95-27
7	Length of SOAF	06/95	95-27
8	Form of SOAF	06/95	95-27
9	Number of SOAFs	06/95	95-27
10	Weighing Factual Evidence and Drawing Conclusions	06/95	95-27
11	Requirements for SOAFs	06/95	95-27
12	Essential Elements	06/95	95-27

13	Additional Elements	06/95	95-27
14	Exclusions from SOAFs	06/95	95-27

2-0809-1 Purpose and Scope

1. Purpose and Scope. This chapter contains guidelines for the preparation of statements of accepted facts (SOAFs). Because this preparation depends on properly identifying the issue to be resolved and developing evidence pertinent to the issue, these aspects of claims examining are also discussed.

For more information about the development of particular issues, refer to FECA PM 2-800, Development of Claims, and the ensuing chapters addressing the five basic requirements, or to FECA PM2-700, Death Claims.

For a discussion of formulating medical questions and forwarding cases for medical opinion when the SOAF is completed, refer to FECA PM 2-810, Developing and Weighing Medical Evidence, FECA PM Part 3, Medical, and MEDGUIDE.

2-0809-2 Introduction

2. Introduction. The SOAF is one of the most important documents a Claims Examiner (CE) prepares. Because the outcome of a claim may depend on its completeness and accuracy, the SOAF must clearly and fairly address the relevant information.

Given the great variation in the factual events surrounding compensation claims, the issues to be resolved, and the course of medical development, the CE will need to assess the relevance of factual evidence and how it should be presented in the SOAF. While some elements will be common to all SOAFs, inclusion of others will depend on the issue to be resolved and the history of the injury.

2-0809-3 Definitions

3. Definitions. In developing the evidence and deciding what evidence is factual, the CE will need to be familiar with certain terms and their meanings:

a. Probative value is the quality which describes facts, evidence or testimony which prove other facts or support conclusions drawn. The statement of an eyewitness to an injury which supports the claimant's description of the incident has probative value. The fact that a claimant was on annual leave on the date of an alleged injury has probative value in establishing that the injury was not sustained in the performance of duty. Such statements or facts stand unless refuted by other facts or testimony.

b. Weighing evidence is the assessment of all information relevant to a particular issue to determine which evidence has the greater probative value. When testimony or facts are unrefuted and/or additional information is not submitted, the CE need only "try" or "weigh" that evidence to decide whether it is plausible.

When more than one testimony is submitted and the "facts" as asserted by the testifiers are contradictory, the CE must assess the evidence to determine what the facts are. In this latter usage, "facts" are events known with certainty or, in other words, the events which the CE accepts as true. In making this assessment the CE must determine which evidence has the greater probative value and make findings based on that evidence.

2-0809-4 Nature of SOAF

4. Nature of SOAF.

a. The SOAF is the written summary of the CE's findings of facts pertinent to resolving a particular medical issue. Proper identification of the necessary information should result in a complete and accurate statement.

b. The SOAF provides a frame of reference for the physician reviewing the medical evidence and/or examining the claimant. It allows the physician to place the medical questions posed in the larger context of the mechanism of injury, the requirements of the claimant's job, or the conditions which prevailed in the workplace. It may also provide the physician with a chronology of events after the injury.

c. The SOAF is also the means by which factual findings, which are the sole responsibility of the CE, are separated from medical findings and opinions, which are the province of the medical professional. This separation of functions will ensure that the CE does not inadvertently make medical decisions. Similarly, properly drawn SOAFs should preclude physicians from making their own findings of facts.

2-0809-5 Responsibilities of the CE

5. Responsibilities of the CE. The CE has certain obligations both before and during preparation of the SOAF.

a. The CE must first recognize that a medical issue(s) needs resolution and concisely define that issue. Issues may vary during the life of any claim, and a case may need multiple referrals for medical opinion.

b. The CE must define the information needed to form a complete frame of

reference for the physician(s) who will review the medical evidence. Evidence which may be pertinent to the resolution of one issue may not have any bearing on the resolution of another.

For instance, information about the physical requirements of a claimant's job would have no bearing on whether a slip and fall on the ice resulted in a wrist fracture, whereas a description of the claimant's activities at the time of injury and of the weather and conditions of the pavement would be relevant. A description of the physical requirements of the job would be necessary, however, in determining whether the claimant is disabled for work. While the CE may want to determine the physical requirements at the outset, he or she should recognize when defining the issue for resolution that the material should not be part of the SOAF.

c. The CE must request information in clear and simple language. Letters should state precisely what information is needed and why, since evasiveness in stating the reasons for requesting information or in posing questions can result in unsatisfactory responses. The language used should be geared to the educational level of the recipient.

d. When allegations are made or conflicting evidence is received, the CE must provide the interested parties an opportunity to comment on the testimony and offer evidence to refute that testimony. In addition to ensuring that the facts are known to the parties, this process is also a useful vehicle for developing the claim, refining the issues for the CE, and assisting in the resolution of conflicts prior to making findings of fact.

e. Whenever possible, the CE should help the claimant and other parties to the claim by describing the information needed, identifying where it may best be obtained, and recommending the format in which it should be presented.

f. The CE must reach decisions based on the evidence which is received. As adjudicator of the claim, the CE may not abdicate this responsibility to others, either within or outside the OWCP. Paragraph 10 below addresses the means by which evidence is assessed and decisions are reached.

g. The CE must set forth his or her findings in a clear, concise and orderly statement which is complete with respect to essential details and free of extraneous material. Format is discussed in paragraph 8 below, while inclusions and exclusions are covered in paragraphs 11 through 14.

2-0809-6 Need for SOAF

6. Need for SOAF. In certain circumstances SOAFs are required, and in other situations the CE may elect to prepare them:

a. All issues requiring a medical opinion for resolution, except for those which do not depend on the facts of the claim, must have SOAFs. Issues commonly referred for medical opinion include causal relationship, extent and duration of disability, percentage of impairment and appropriateness of care.

b. The CE may elect to assist an attending physician in formulating an opinion by providing a SOAF when the facts as related by the physician differ from those accepted by OWCP, or when the OWCP has evidence, such as exposure data, which is not readily available to the physician.

2-0809-7 Length of SOAF

7. Length of SOAF. The length will vary depending on the issues to be resolved and the facts of the case. The test is whether the statement covers all material facts in sufficient detail to provide the physician with a complete picture of the claim without including unnecessary detail.

a. In simple cases, a brief SOAF will usually suffice. For instance, where the only outstanding issue is determining a schedule award, the impairment is clearly related to the accepted injury, and there is no dispute concerning the medical evaluations for making the rating, the SOAF may be as short as two or three sentences.

b. In more complex cases, the SOAF will need to be longer so that the CE can fully explicate the pertinent facts. The statement may thus be two to three typed pages in length, though most issues can be adequately addressed in one page.

2-0809-8 Form of SOAF

8. Form of SOAF.

a. The SOAF is usually a narrative, and the most effective approach to organizing it is to present the facts in chronological order. Using this method, the CE is less likely to omit important facts or present them out of order, and the reviewer can visualize the sequence of events.

b. For some types of claims, such as hearing loss and asbestosis, specific reporting forms have been developed. In psychiatric cases a different kind of SOAF is needed (see paragraph 13 below), and in other cases, the CE may need to combine a narrative statement with attachments which provide exposure data. Wherever possible, however, exposure data, job descriptions or duties, and leave records should be condensed to essential information and incorporated in the body of the statement.

2-0809-9 Number of SOAFS

9. Number of SOAFs.

a. Only one SOAF is required for each medical question. The use of additional statements should be avoided unless the first one is incorrect or deficient, or if evidence changing the material facts is received after the first SOAF is prepared. When a second statement is prepared, the CE should clearly show whether it replaces or amends the first one. The CE should also note on any previous SOAFs that they are superseded, and initial and date the notation.

b. Where a second medical question arises, the CE will need to prepare a new or supplemental statement if the first one does not include all facts that are material or relevant to the new issue. If an addendum cannot be made without disrupting the sense of the SOAF, the entire statement should be rewritten to incorporate the new material.

2-0809-10 Weighing Factual Evidence and Drawing Conclusions

10. Weighing Factual Evidence and Drawing Conclusions.

a. The CE is responsible for determining the facts in a case by weighing the evidence which has been developed and drawing conclusions based on that evidence. When the relevant information has been received and the parties to the claim have had a chance to refute any disputed evidence, the CE is ready to evaluate the evidence for credibility and validity.

b. Evidence can be classified as direct or indirect. The value of each varies and is not fixed for all circumstances. For instance, while direct evidence is generally regarded as superior, it may be overridden by indirect evidence which is more plausible or consistent with all the other facts in a case. For this reason the CE must exercise discretion and logic in drawing conclusions or making inferences based on the factual information in a claim.

(1) Direct evidence is typified by the accounts of eyewitnesses to an injury or statements from a supervisor that certain alleged orders or job requirements were imposed. Testimony about events observed at the scene of an injury or death either at the time or shortly after the occurrence is direct evidence if it reflects actual observations. Because direct evidence is a first-hand account, it must ordinarily be assigned greater probative value than other evidence. Direct evidence is also referred to as positive evidence.

(2) Indirect evidence is circumstantial, and its value depends largely on how

far the provider of the evidence is removed in time, place or telling from the actual events. The CE need not reject evidence because it bears the label "circumstantial," but should scrutinize it closely to ensure that it is internally consistent and that it either corresponds with or is more probative than any direct testimony available.

If indirect evidence conflicts with direct evidence, and all other factors such as the testifiers' veracity are equal, direct evidence must be assigned greater value. Three common types of indirect evidence are described below:

(a) Negative evidence is based upon a failure to recollect, an absence of records, or statements as to what did not occur. Examples of this type of evidence are: "I don't recall the claimant's working late the night before his heart attack"; or, "records do not indicate the reason for the claimant's absences from work during that period"; and, "if the medical records do not mention any adverse reaction to the shots he was given in the health unit, he must not have had one." (See Edward Gardner, 3 ECAB 93.)

These statements might contribute to a CE's findings that a claimant did not work overtime, was not disabled due to an alleged injury, or did not have an adverse reaction to a shot, but they are not conclusive proof by themselves. Such evidence as these statements present must be evaluated in light of other facts or testimony. If enough evidence exists to prove the opposite conclusion, the CE must disregard the negative evidence in favor of the more persuasive evidence.

(b) Conclusions or opinions of others are statements which are unexplained or which lack sufficient facts to confirm or deny the existence or occurrence of an event.

For example, a witness may state that a claimant was injured during a fight which arose from a work-related dispute because he had heard the two participants arguing about having to work side by side on a work crew. This conclusion may or may not be valid, but the statement contains little to establish the truth. Further investigation might show that the animosity stemmed not from work but from a gambling debt owed one worker by the other.

As with negative evidence, the value of this type of evidence depends on the degree to which it supports or refutes direct evidence and is logically consistent with known events.

(c) Hearsay evidence is based on the reports of others, not first-hand observation. Hearsay is generally inferior to direct evidence on two

grounds: first, the further removed the testifier is from the originator of the evidence, the greater the likelihood that facts will be distorted; and second, by its very nature it affords no opportunity for cross-examination. When using such evidence as a basis for a decision, a CE must exercise care that the hearsay is persuasive and not founded on rumor or gossip.

c. Some evidence may serve in a dual capacity in a claim; i.e., it may be both direct and indirect. For instance, questions arise as to whether the claimed injury occurred in the manner and at the time alleged. Upon inquiry as to when the claimant first obtained medical care for the injury, the CE learns from the occupational health nurse that the employee was seen on the day of the alleged injury at the infirmary and walked with a limp. This statement would serve as direct evidence that the claimant sought timely treatment for the injury (assuming the treatment was for a leg injury), and as indirect evidence that the injury occurred at the time and in the manner alleged (because the claimant was limping).

d. In making findings, the CE is obliged to apply certain principles of logic and evidence. By doing so, the CE ensures that the conclusions drawn are supportable and that the outcome is just. These guidelines for fact-finding are based on legal principles of evidence, Larson's Workmen's Compensation Law, OWCP policies and ECAB decisions.

(1) An injury or death need not be witnessed for a CE to find that it occurred as described by the claimant or to make inferences as to how it occurred.

(2) The CE must make findings which take into account all relevant evidence. Disregarding factual information will diminish the validity of the SOAF even though the omission might not have materially affected the outcome. The ECAB has remanded cases because facts were omitted and the OWCP could not prove that the decision was not compromised as a result (see Richard A. Sroka, 35 ECAB 209). A greater injustice may be done if a benefit is denied as the result of selective incorporation of evidence, and the case is not appealed.

(3) The CE must include in the findings evidence which might be labeled subjective, as well as evidence which lends itself to observation or objective confirmation. For example, if a claimant cites personal reactions or describes feelings associated with an incident, such as pain, anxiety, fear, palpitations, etc., the inclusion of these experiences as facts is altogether fitting. Subjective evidence, however, must meet all the tests imposed on other forms of evidence, including probity and consistency with the facts of the claim and the actions of the claimant.

2-0809-11 Requirements for SOAFs

11. Requirements for SOAFs.

a. All evidence on which the statement is based must be part of the case record. The CE may not make findings based on an undocumented conversation or an investigative report which is not subject to examination or refutation. The CE must also avoid making findings based on similar evidence found in other case files (e.g., position descriptions).

b. Facts should be correctly stated. A medical opinion based on an accurate SOAF has enhanced probative value, whereas an opinion based on incorrect findings is of diminished or no value.

c. Facts should be complete in all essentials. Omission of a critical fact diminishes the validity of a medical opinion or decision as much as an incorrect statement. (See paragraph 10d(4) above.)

d. Facts should be specific as to time of occurrence and such matters as weight of objects lifted, numbers of hours worked over particular periods of time, frequency and types of stress and confrontations in the workplace, etc.

Whenever possible, workplace factors should be quantified so the physician can correlate the exposure with medical or scientific data on causality.

Quantification might include decibel levels of noise, concentrations of asbestos fibers in the air, levels of noxious substances, the (approximate) number of times that a repetitive task was performed, altitudes and pressures to which an employee was exposed, etc. Terms such as light, heavy, undue, severe, and abnormal are to be avoided, since they are subject to great differences of interpretation.

e. Facts should be clearly stated. Simple words and direct statements reduce the potential for ambiguity or misinterpretation. Use of legal terms and OWCP jargon should be avoided, since they are unfamiliar to physicians. The SOAF should present a vivid picture of the circumstances of a claim so that the reader will clearly understand them.

f. Facts should be stated positively wherever possible. A statement that the claimant worked six days per week once a month is more significant than the finding that the claimant did not always work six days per week. This does not mean that a statement may not contain a negative. For example, where the claimant contends that she was required to perform certain tasks which in truth were not required of her, the CE should state that the tasks were not required.

g. Facts should be presented in an orderly manner. Usually the best approach is to

relate facts in chronological order, but other approaches are also proper. For example, where stress is implicated, the CE may elect to describe the job requirements before listing events which the claimant relates to the injury. The CE may also choose to describe an immediately precipitating event before recounting contributory stresses or strains over a period of years. The CE should avoid out-of-sequence descriptions and excessive reliance on addenda.

2-0809-12 Essential Elements

12. Essential Elements. For a physician to form a general impression of the individual or evidence to be evaluated, the CE must provide the following information in the SOAF:

a. Date of Injury--allows the physician to estimate elapsed time and recovery.

b. Claimant's Age or Date of Birth--permits the physician to factor in any additional healing time if necessary.

c. Job Held on Date of Injury--permits the physician to visualize the setting of the injury if it occurred during normal duties and possibly to make judgments about the claimant's potential for returning to duty. Detailed descriptions are not necessary unless the issue is whether the claimant is able to perform normal duties. (See paragraph 13a(7) below.)

d. Name of Employing Agency--supplements information about the position held.

e. Mechanism of Injury--helps the physician to form an opinion on the relationship of the condition(s) diagnosed to the alleged injury and the severity or extent of the injury. In occupational illness cases this information would include factors of employment and exposure data.

f. Condition(s) Claimed or Accepted--allows the physician to assess whether the diagnoses given in the medical evidence to be reviewed are consistent with the conditions for which the claim is filed or has been accepted.

2-0809-13 Additional Elements

13. Additional Elements.

a. Other elements may be included in the SOAF, as described below, depending on the nature of the condition claimed and the issues to be resolved. Virtually all of them should be included when adjudicating an occupational illness claim, particularly where stress is implicated.

(1) Prior medical history.

(2) Employment history, including periods of wage loss and returns to full or light duty for the present claim.

(3) Medical treatment received (but not recitation of medical opinions or findings).

(4) Personal habits such as smoking or drinking.

(5) Off-duty activities, employment and hobbies.

(6) Family circumstances and potential off-duty stress factors.

(7) Requirements of the claimant's work (mental, physical and environmental). However, a copy of the position description should not be used verbatim, since at best it will provide only general information.

b. The CE will need to distinguish between those workplace activities and circumstances which are factors of employment and those which are outside the scope of employment for purposes of compensation. The CE must determine whether the situations alleged actually existed or occurred and present these to the physician. The CE shall ask the physician to give an opinion on work-relatedness and refer to specific factors of the work as detailed in the SOAF.

c. To aid the physician, the CE should divide any SOAF containing both work-related and non-work-related elements into three parts labeled as follows:

(1) Incidents Which Occurred in Performance Of Duty.

(2) Incidents Which Occurred That Are Not Factors of Employment.

(3) Incidents Alleged Which the Office Finds Did Not Occur.

Each incident should be numbered consecutively within the section to which it belongs.

2-0809-14 Exclusions from a Statement of Accepted Facts

14. Exclusions from SOAFs. Not all information contained in a case file bears on the issues to be resolved in connection with the SOAF. Some information is irrelevant, while other material is inappropriate, prejudicial or better discussed elsewhere. The following items should

not be included in the SOAF:

a. Evidence. The CE is responsible for making decisions on raw evidence and incorporating the findings in the SOAF.

b. Justifications or Reasons for Conclusions Reached. The CE's findings should be supported by the evidence of record. Any explanation of the findings should be made in a memorandum to the file or a memorandum to the Director, not in letters to reviewing physicians.

c. Medical Opinions. However, such opinions should not be confused with the medical history of the claim, which may properly be included. Chronologies of care and nature of treatment received are facts surrounding the medical aspects of a claim, but are not themselves medical opinions.

d. Descriptions of Benefits Received, Including Compensation Paid by OWCP and Annuities Paid by OPM. However, an exception to this rule can be made be where the claimant has alleged to physicians that he or she is not receiving any income. Here the CE should state when benefits began and whether they continue or were terminated.

e. Issues for Determination. Factual issues belong in memoranda to the Director. Medical issues to be resolved are properly addressed in the memorandum or letter to the physician.

f. Definitions of Terms. If a CE needs to define such terms as aggravation, precipitation or acceleration, he or she should do so in a letter to the physician along with the questions to be answered.

g. Discussion of Legal Issues. These should be discussed in a memorandum to the Director.

h. Appeals and Administrative Actions. Histories of appeals, remands, and administrative actions of the OWCP, such as requests for investigations, do not help to resolve medical issues and may actually prejudice the outcome of a claim.

2-0810 DEVELOPING AND EVALUATING MEDICAL EVIDENCE

Paragraph	Subject	Date	Trans. No.
	Table of Contents	07/00	00-08

1	Purpose and Scope	04/93	93-19
2	Introduction	04/93	93-19
3	General Criteria for Weighing Medical Evidence	04/93	93-19
4	Practical Considerations in Weighing Medical Evidence	04/93	93-19
		09/93	93-44
5	Sources of Medical Evidence	09/93	93-44
		04/93	93-19
6	Content of a Medical Report	04/93	93-19
		09/95	95-34
7	Reviews by District Medical Advisers (DMAs)	04/93	93-19
8	Requesting Clarification from the Attending Physician	04/93	93-19
9	Second Opinion Examinations	03/95	95-15
		04/93	93-19
10	Obtaining Second Opinions for Surgery	04/93	93-19
		08/97	97-20
11	Referee Specialist Examinations	04/93	93-19
12	Weighing Medical Evidence in Memoranda and Decisions	04/93	93-19
13	Exclusion of Medical Evidence	04/93	93-19
		09/95	95-34
		08-97	97-20
14	Suspension of Benefits	07/00	00-08
		11/98	99-05
15	Health Facility Membership and Special Equipment	07/00	00-08
		04/93	93-19
16	Physical Therapy	04/01	01-06
		03/94	94-14
17	Authorization for Diagnostic Testing	04/93	93-19
18	Transfer of Medical Care	04/93	93-19
19	Claimants in Prison	12/93	94-05
20	Functional Capacity Evaluations (FCEs)	11/96	97-03

Exhibits

1	Sample Request for Information from Treating Physician re Health Club/Spa Membership	10/94	95-02

2	Sample Request for Information from Claimant re Health Club/Spa Membership	10/94	95-02
3	General Guidelines for Review of Non-Emergency Back Surgery	10/94	95-02
4	Instructions for Orthopedic Surgeons, Neurologic Surgeons and Neurologists Who Review Cases Where Authorization for Back Surgery Has Been Requested	10/94	95-02
5	Sample Paragraph Authorizing Physical Therapy	10/94	95-02
6	Sample Letter to Physician Requiring Additional Medical Justification	10/94	95-02
7	Sample Letter of Warning to Physician Who Fails to Supply Requested Information or Who Furnishes Inappropriate Treatment	10/94	95-02

2-0810-1 Purpose and Scope

1. Purpose and Scope. This chapter discusses the Claims Examiner's (CE's) function in developing and evaluating medical evidence and provides guidelines for weighing varying and conflicting medical opinions.

2-0810-2 Introduction

2. Introduction. The purpose of this paragraph is to describe briefly the sources of medical evidence and some of the factors involved in evaluating it.

a. Proper development and weighing of medical evidence is essential to the sound adjudication of claims for benefits, and to the comprehensive management of accepted disability cases. Medical evidence in disability cases consists of four major types:

(1) Evidence from the attending physician (or from consultants chosen by him or her).

(2) Evidence from District Medical Advisers (DMAs) whose evaluation is limited to a review of the case record.

(3) Evidence from "second opinion" physicians, who examine both the claimant and the case record at the request of the OWCP.

(4) Referee medical evaluations.

Any or all of these four types of medical evidence may be found in a particular case. The CE is responsible for obtaining the appropriate types of medical evidence, evaluating it, and weighing it to resolve inconsistencies and conflicts in medical opinions. This chapter defines and discusses the terms and procedures involved in the weighing process, and provides examples of common situations in accepted disability cases where medical development and weighing are needed.

b. It is the claimant's responsibility to submit initial medical evidence in support of the claim. However, if the claimant submits a clear supporting medical opinion, it becomes the CE's responsibility to assist the claimant in developing additional evidence, or to develop further evidence by obtaining a consultation as second opinion. It is frequently necessary, especially in occupational disease cases or cases of traumatic injury involving minimal objective findings, to seek verification and/or additional details which may be lacking in the reports originally submitted. Such additional reports and opinions, including input from the District Medical Advisor (DMA), must first be obtained and then evaluated and compared, or weighed.

c. An important principle in developing and weighing medical evidence in an accepted disability case is that:

> Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation. After the Office has determined that an employee has disability causally related to his employment, the Office may not terminate compensation without establishing that the disability has ceased or is no longer related to the employment.

(Robert R. Henderson, 30 ECAB 549).

d. A second principle is that resolving the issue of whether disability has lessened or ceased or is no longer causally related to the employment rests primarily within the realm of the medical expert (Eloise L. Berry, 25 ECAB 61). This is why development and weighing of medical evidence are both so important in accepted disability cases. A thorough understanding of how to weigh medical evidence will assist the CE in determining when and how further medical development should be undertaken and in assigning weight to the medical evidence received.

2-0810-3 General Criteria for Weighing Medical Evidence

3. General Criteria for Weighing Medical Evidence. The purpose of this paragraph is to define the factors involved in weighing medical evidence, which is the process of evaluating one or more items of medical information. When medical evidence is present from more than one

source, as in most cases, this process consists of determining the relative value, or merit, of each piece of medical evidence.

a. General Considerations. The Employees' Compensation Appeals Board (ECAB), in evaluating the merits of medical reports, has repeatedly stressed certain concepts. For instance, the ECAB assigns greater value to a "well-reasoned" or "well-rationalized" opinion. It assigns greater value to a "comprehensive" report than to an incomplete report. It assigns greater value to an opinion that is "well-founded" or "non-equivocal" than to one that is "speculative" or "equivocal." It assigns greater value to an opinion "based on a complete factual and medical background" than to one based on an incomplete or inaccurate background. It assigns greater value, in general, to a report which reflects actual examination of the claimant by the physician than to one written without such examination.

b. Qualifications of the Specialist. The ECAB has indicated that the physician's qualifications may have a bearing on the probative value of his or her opinion. Thus the opinion of a specialist in the appropriate field of medicine often will carry more weight than the opinion of a nonspecialist or a specialist in an unrelated field.

Various medical specialty boards exist. Each such board conducts a certification program in an effort to ensure quality of medical services by adherence to standards of medical training and practice in the specialty. Although any licensed physician may limit his or her practice to a certain specialty, a Board-certified specialist has met the minimum standards of training and competency in the field, as set by the Board. Some medical boards also award certifications in subspecialties. For instance, a physician certified by the American Board of Internal Medicine may also be certified in a subspecialty such as cardiology.

Board-certified specialists may also be known as Diplomates. For example, a Diplomate of the American Board of Orthopedic Surgery, also known as a Board-certified orthopedic surgeon, is acknowledged to have competency in evaluating and treating medical conditions in that specialty.

(Board certification should not, however, be confused with board eligibility, which simply means that a physician has completed the educational requirements for taking certification examinations but confers no special status.)

The opinion of a Board-certified specialist in the appropriate field usually will carry more weight than that of a specialist who is not Board-certified or who is certified in an unrelated field. The opinion of a Board-certified specialist of professorial rank in a medical school or teaching hospital, or of a specialist who is an acknowledged expert or author on the specific medical problem, will carry added weight.

c. Rationale. The term "reasoned" or "rationalized" medical opinion means that the

statements of the physician are supported by a medical explanation. In some situations no explanation is required. For example, where a twisted knee is incurred during performance of duty and the claimant obtains prompt medical care, a simple affirmative answer by the physician as to causal relationship will suffice.

In most cases, however, rationale will be required. An occupational disease case or a traumatic injury case with preexisting or subsequent injury to the same part of the body will require, in addition to the physician's affirmative opinion, an explanation of the causes of the condition claimed and a discussion of these factors in relation to the claimant's condition. This explanation and discussion are what constitute medical "reasoning" or "rationale." Sufficient objective data (findings on examination, test results) must be present so that a reviewer can see on what the medical conclusions were based.

d. Factual Basis. When based on an accurate and complete medical and factual background, a reasoned medical opinion has probative value or weight. By the same token, a reasoned or rationalized medical opinion based on an inaccurate or incomplete medical and factual background has little or no probative value or weight.

For example, a physician may indicate that a torn cartilage is due to a work-related fall in a situation where ten days earlier the claimant had developed knee pain after playing basketball off the job. In this situation, the physician's opinion relating the cartilage tear to the work injury, even with explanation or rationale, will not have much value or weight since it is not based on all pertinent facts.

When two physicians give reasoned but differing opinions concerning causal relationship and one physician's opinion is based on inaccurate or incomplete factual or medical background, the opinion based on accurate factual or medical history has more probative value.

e. Consistency with Physical Findings. A well-reasoned medical opinion must be consistent with the findings upon examination. For example, a physician might state that a claimant has a back sprain causally related to a work injury 10 years ago without citing physical findings to support this conclusion. The physician explains that the claimant's injury is causally related to the past injury because prior to the incident the claimant had no complaints of back pain, whereas since the injury he or she has continued to complain of back pain. An "explanation" such as this, not supported by physical findings, will not constitute well-rationalized medical opinion. The ECAB has affirmed cases where benefits have been denied because there is no objective medical evidence of disability (Thomas D. Petrylak, 39 ECAB 276.)

f. Comprehensiveness. A comprehensive report is one which reflects that all testing and analysis necessary to support the physician's final conclusions were performed. An opinion based on a cursory or incomplete examination will have less

value compared to an opinion based on a more complete evaluation. The ECAB has remanded cases where a physician has indicated that further testing or evaluation is necessary to resolve an issue and the OWCP has not arranged for the required testing or evaluation.

g. Equivocalness. Opinions which can be characterized as equivocal, speculative or conjectural are those which contain language which is unclear or vague. Terms such as "could," "may," or "might be" indicate that the report is equivocal, speculative or conjectural and has less probative value compared to positively expressed medical opinions. The term "probably" is less speculative, and should be viewed in the context of the rest of the medical report and the factual evidence.

2-0810-4 Practical Considerations in Weighing Medical Evidence

4. Practical Considerations in Weighing Medical Evidence. The purpose of this paragraph is to describe the steps a CE should take to weigh medical evidence.

a. In weighing medical reports, the CE should ask the following questions with respect to each report:

(1) Is the physician a specialist in the appropriate field? The opinions of physicians who have training and experience in a specialized medical field have greater probative value concerning medical questions pertaining to that field than the opinions of other physicians. An extension of this criterion would be whether the physician is Board-certified, an acknowledged author or expert in the field, or a faculty member of a medical school.

(2) Is the physician's opinion based upon a complete and accurate medical and factual history? An incomplete or inaccurate history reduces the probative value of medical opinions based on that history. The lack of any history in a report also diminishes the value of the report. However, in such cases it is appropriate to ask the physician to state the history upon which the opinion is based.

(3) What are the nature and extent of findings on examination? Generally, greater probative value is given to a medical opinion based on an actual examination. The value of this criterion may change with the issue being addressed. For example, actual examination would be of greater importance in determining permanent impairment than in rendering an opinion on causal relationship.

Other things being equal, the probative value of an opinion increases when the physician reports specific detailed findings, based on a full and careful physical examination, X-ray studies, appropriate laboratory and clinical tests, and use of consultants. Opinions not supported by medical findings, or otherwise indicative

of cursory examinations, carry little weight compared to opinions based on detailed examinations and findings. Further, the opinions and conclusions reached by the physician should be consistent with the examination and test results.

(4) Is the physician's opinion rationalized? A rationalized opinion is of greater probative value than an opinion which is not rationalized. The physician should generally explain the basis for the opinion. This is of particular importance where the question involves a difficult medical problem, or where there is conflicting opinion.

(5) Is the opinion speculative or equivocal? Such opinions are frequently couched in terms such as "might be," "could be," or "may be." Medical opinions which are speculative or equivocal in character have little probative value. Terms such as "probably" or "most likely" need not constitute a speculative opinion, depending upon the context of usage. Such words may mean that the physician believes that the medical condition is related to employment with reasonable certainty, as opposed to absolute certainty. If the physician's meaning is in question, he or she should be asked to explain the basis for any doubt, and to state with reasonable certainty whether or not the disability is related to employment.

b. In weighing medical evidence, the CE must determine to his or her satisfaction the merit of each opinion. The value of the evidence cannot be established by making a "checklist" or counting the "pros" and "cons" for each criterion. No individual factor standing alone necessarily determines the weight of medical evidence.

c. Once all opinions are evaluated, they must be compared. For example, two reports are submitted: both reports are from Board-certified surgeons; both reports are based on an accurate medical and factual background; and both are rationalized. However, they offer differing opinions as to causal relationship: one physician physically examined the claimant while the other did not. Based on the overall comparison of the reports, the weight of the opinions is equal, and there is a conflict of opinion requiring resolution by referral to an impartial specialist.

The fact that one physician examined the claimant while the other did not is insufficient to tip the scale either way. However, had the opinion of the physician who examined the claimant not been rationalized, the opinion of the physician who had not examined the claimant would have represented the weight of the medical evidence since it was rationalized. In a particular case, the fact that the physician had not examined the claimant may be mitigated by the fact that the issue of causal relationship is frequently not one that requires physical examination.

2-0810-5 Sources of Medical Evidence

5. Sources of Medical Evidence. The purpose of this paragraph is to describe the sources of medical reports likely to be found in the case file. While this list is not exhaustive, most medical reports will fall into one of the following categories. Regardless of the source of the report, the CE must consider all medical reports in file when weighing the medical evidence.

a. Hospital or Emergency Facility. Hospital in-patient reports, such as the admission history and physician examination, the doctors' progress notes and the discharge summary, along with emergency and out-patient reports, are frequently valuable in documenting the time of injury and associated factual circumstances bearing on job-relatedness (from the date and time of admission and the history recorded), the nature and extent of injury, and the duration of disability anticipated. However, it is usually not possible to obtain opinions if needed to clarify whatever reports and physicians' and nurses' notes are submitted.

b. Claimant's Physician. The attending physician is the primary source of medical evidence in most cases. That physician usually sees the claimant soon after the injury or the onset of symptoms. He or she may also be familiar with the claimant's medical history and therefore may know of any preexisting condition which may be responsible for the symptoms, or which may have been temporarily aggravated by the incident or employment factor claimed. The CE should carefully study reports for discrepancies in the history given by the claimant to the physician and reported on Form CA-1 or CA-2.

The quality of attending physicians' reports will vary greatly. Sometimes reports are lacking in detail because the physician is unaware of the type of information required to meet our needs in a given case. If reports from the claimant's physician lack needed details and opinion, the CE should always write back to the doctor, clearly state what is needed, and request a supplemental report. A copy of the CE's request to the physician should be sent to the claimant (and to any representative) for informational purposes. Alternatively, if an RN is involved in the case, the CE may ask the RN to make the contact with the claimant's physician and request the information needed by the CE.

c. District Medical Adviser (DMA). Furnishes opinions, guidance and advice based upon review of the case file and familiarity with FECA requirements.

d. Second Opinion Specialist. At the request of the Office, provides examination, indicated diagnostic testing, and rationalized medical opinion when a detailed, comprehensive report and opinion is needed from a specialist in the appropriate field.

e. Referee Specialist. Examines claimant, arranges diagnostic tests and furnishes rationalized medical opinion to resolve conflicts between a claimant's physician and a physician of the United States where the weight of medical evidence is equally balanced.

2-0810-6 Content of a Medical Report

6. Content of a Medical Report. The purpose of this paragraph is to describe the elements which a medical report should ordinarily contain.

a. History.

(1) A medical opinion is only as good as the "frame of reference" on which it is based. In other words, the record must show whether the history obtained by the doctor is substantially in accord with the facts of the accident or accepted employment conditions.

(2) Sound judgment and common sense must be applied. If Form CA-1 shows concurrence of the employer with a report of fractured ankle due to falling off a ladder, and this history is repeated in the emergency room report of treatment soon after the time of injury, there is no need to question a subsequent attending physician's report which fails to record a history.

(3) It is also essential that the history given a hospital or physician agree with the substantive facts. For example, the attending orthopedist records a history of lifting a 100 pound sack at work, with positive medical findings to support a low back strain, and concludes that the disability resulted from the lifting incident. The opinion is of diminished value if the factual evidence shows that the sack weighed 25 pounds. In this case, the history given the physician was not accurate, and it is quite possible that the claimant injured his back in some other activity, not necessarily in Federal civil employment.

b. Findings. The value of a medical report is no greater than the scope of the examination, which is revealed by the findings in the report. The scope of findings reported will vary with the type of medical problem and the existence of any diagnostic problem. Adjudicatory needs requiring a detailed report of findings also will vary. Only minimal findings need to be reported for a traumatic amputation of a finger, but the doctor should be required to set forth a detailed account of the findings where the nature of injury, causal relationship to employment and extent of disability is not so apparent, as in many low back or occupational disease claims. The three general classes of findings are:

(1) Physical findings, which are noted by the doctor's visual inspection, palpation and manipulation of the body. They include readings of temperature, pulse, respiration, blood pressure, etc.

(2) Laboratory findings such as blood tests, urine and tissue samples, etc.

(3) Diagnostic procedures such as X-rays, computerized axial tomography (CAT), magnetic resonance imaging (MRI), electrocardiograms (ECG or EKG), electroencephalograms (EEG), electromyogram (EMG), audiograms, treadmill stress tests, cardiac catheterization, intravenous pyelogram, and similar techniques of visualizing or recording physiological conditions.

Tests requiring cooperation by the patient, such as visual, hearing and pulmonary function tests, should be accompanied by a comment from the person administering the test on the extent of patient cooperation, to estimate the validity of the results.

c. Evaluation. To be acceptable as medical evidence, a laboratory test or diagnostic procedure must be performed by or under the supervision of a person licensed to perform it in the state or local jurisdiction where it was done. Reports of such tests and procedures must contain the patient's name, date of the test, the objective data obtained, and the signature of the person responsible for performance of the test or procedure.

Where appropriate, reports should include the physician's interpretation of laboratory tests and diagnostic procedures. Tests for which such interpretation is necessary include, but are not limited to, X-rays, EKG, EEG, EMG, cardiac and pulmonary stress tests, pulmonary function tests, biopsy or surgical specimen pathology reports, ultrasound, visual field, echocardiograms, intravenous pyelograms, MRIs, and CAT scans.

d. Medical Opinion with Rationale.

(1) Not all medical opinions require rationale. In a simple traumatic injury, such as a knife cut which is reported to and seen by the physician promptly, there is no need to obtain a rationalized explanation of causal relationship.

(2) When the relationship is not obvious or when there may have been an intervening non-occupational cause, it is essential that the physician give his or her medical reasons for relating the condition to the history obtained. A rationalized opinion is also necessary, and should be requested, when disability appears to last beyond the time frame anticipated for an injury of the type accepted (see the OWCP Medical Matrices, which are available on Folioviews in MEDGUIDE).

(3) A medical opinion couched in such terms as "might be," "could be," or "may be" does not have as much probative value as an opinion stated unequivocally. However, if a sound medical reason is also given for the opinion, these expressions may sometimes represent the physician's mode of expression and should not be taken as reflecting a lack of conviction, whether for or against the claim.

Some physicians adhere more strongly than others to scientific methodology and prefer to use qualified terminology. The word "probably" can nearly always be taken as a redundancy, e.g. "probably related" means "related" and "probably preexisting" means "preexisting." If there is any doubt, the District Medical Adviser should be consulted, and clarification should be sought from the report physician if needed.

2-0810-7 Reviews by District Medical Advisers (DMAs)

7. Reviews by District Medical Advisers (DMAs). The purpose of this paragraph is to discuss the use of DMAs' services.

a. DMAs have two broad technical medical functions:

(1) Evaluation of medical evidence and the rendering of medical opinions in the DMA's own right. In this capacity the DMA may advise whether an accepted condition continues, whether a newly claimed condition is employment-related, whether the length of disability seems appropriate, or whether a recommended procedure or treatment is useful or necessary.

(2) Interpretation and clarification of other physicians' reports. In this capacity the DMA may evaluate a report for determination of the percentage of permanent partial impairment, interpret test results, or "translate" technical language.

b. The DMA's performance of these functions does not lessen the CE's responsibility in case management. The CE must always maintain responsibility for the case and should use the services of the DMA only for direction. The CE needs a good understanding of how to weigh medical opinions if the DMA's services are to be properly used. For example:

(1) Where an attending physician certifies continuing disability while there are few physical findings, the CE may suspect a "problem" situation that needs further medical evaluation. A DMA at this point may be asked to give his or her reasoned opinion on the problem.

(2) Where, after an extended period of time, a physician still certifies total disability and states maximum improvement has not been reached, the CE may suspect that this is not reasonable and may request guidance on the issue from the DMA.

(3) Two medical reports being compared may be referred to DMA for review

and comment if the CE needs advice on unfamiliar or medically technical issues. For example, the CE may ask the DMA to discuss whether the tests performed by the physician are appropriate and complete and whether the test results support the physician's opinion.

The DMA should, however, be used only where the CE truly needs medical guidance to weigh the reports in file. If the CE can determine on his or her own that a discrepancy exists between reported disability status and physical findings or between the nature of injury and the degree or duration of reported disability, other action may be appropriate. Such action may take the form of writing to the attending physician or arranging for second opinion evaluation.

c. The DMA's function of evaluating and clarifying the reports of other physicians may take several forms. For example, in a claim for a schedule award the medical evidence of record indicates maximum medical improvement has been reached and describes the permanent partial impairment of the affected member in accordance with the current edition of the AMA Guides to the Evaluation of Permanent Impairment. (If it does not, the CE should obtain this evidence prior to DMA review, either from the examining physician or, if this were unsuccessful, through independent evaluation.)

The DMA must review the report to verify correct application of the AMA Guides and confirm the percentage of permanent impairment and the date maximum improvement was reached. The DMA should specify his or her reasons for assigning a certain percentage of loss of use to the measurements or factors provided by the examining physician. Where factors other than actual measurements are involved, the CE should ask for a detailed explanation of the percentage assigned.

The evaluative and interpretive functions of the DMA are separate. The CE seeks evaluation from the DMA in order to proceed with developing and weighing the medical evidence. The CE seeks interpretation from the DMA only where the medical evidence is complete and sufficient prior to such review. In either case, the comments or opinions of the DMA should be explained or rationalized. The unrationalized or unexplained opinions of a DMA are as lacking in probative value as the unrationalized or unexplained opinions of any other physician.

d. The DMA has no authority to decide the facts in a case. However, the DMA may state whether an accepted incident was competent to produce the injury claimed. The DMA must be presented with a Statement of Accepted Facts (SOAF) to use as a framework for the medical opinion requested. Where the DMA finds that a determination pertinent to the medical opinion has been omitted, he or she should inform the CE of the additional factual determination needed to place the case in posture for a rationalized medical opinion.

SOAFs and questions for referral to the DMA must not be entered on pre-printed forms.

Such forms offer structured questions which often do not meet the needs of the case, and they provide limited space for SOAFs and rationale for medical opinions.

e. The ECAB has affirmed that a DMA may create a conflict in medical opinion necessitating referee medical evaluation under the provisions of 5 U.S.C. 8123(a) (Harold Travis, 30 ECAB 1071). The CE must ensure, however, that the DMA's opinion is rationalized, and thus that it creates a true conflict. For example, an unexplained "no" by a DMA to the question of whether work-related disability continues is not sufficient. The rationalized opinion of the DMA will ensure that a conflict in medical opinions of approximately equal weight truly exists. The value of any report from a referee examination will be enhanced to the degree that well-reasoned opinions, both "pro" and "con," are provided for review.

f. A DMA may provide an opinion which is not strong enough to constitute a conflict with the opinion of the treating physician, but which is nevertheless of sufficient value to warrant additional action. For instance, where an attending physician may state that a claimant is still disabled from a work-related back strain six months post-injury, the DMA may state that a two-month recovery period should have been sufficient. In this instance, referral for a second opinion examination would be appropriate.

g. While a DMA may create a conflict in medical opinion, he or she may generally not resolve it. Furthermore, a reasoned opinion by a DMA will not usually constitute the weight of the medical evidence in an accepted disability case, even if the DMA is a Board-certified specialist in the appropriate field of medicine and the attending physician is not a specialist and offers no rationale. This is because the DMA has not examined the claimant while the attending physician has, a critical function in determining extent and duration of injury-related disability.

h. In some instances, however, the DMA's opinion can constitute the weight of the medical evidence. This occurs in schedule award cases where an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the AMA Guides. In this instance a detailed opinion by the DMA which gives a percentage based on reported findings and the AMA Guides may constitute the weight of the medical evidence (James Massenburg, 29 ECAB 850).

As long as the DMA explains his or her opinion, shows values and computation of impairment based on the AMA Guides, and considers each of the reported findings of impairment, his or her opinion may constitute the weight. The CE must ensure, however, that the DMA properly considers all reported findings, gives rationale and uses the AMA Guides correctly in computing the percentage. (See Susie Hall, 34 ECAB 1311, for a discussion concerning the weight of medical evidence from physicians who have not examined the claimant.)

2-0810-8 Requesting Clarification from the Attending Physician

8. Requesting Clarification from the Attending Physician. This paragraph addresses when and how the CE should obtain further medical information from the attending physician.

a. Sound medical decision-making will often require the CE to request clarification from the attending physician rather than review by the DMA. Moreover, the attending physician will be a primary source of contact regarding medical status, treatment plans, return to work projections and descriptions of work limitations. For example, because of a discrepancy between complaints of disability and objective findings of disability the CE questions whether or not an injury-related disability continues; the appropriate first line of medical development may be a query to the attending physician. If an OWCP Nurse (RN) is involved in the case, the CE may confer with the RN regarding specific questions to be asked, and may also ask the RN to contact the attending physician.

The advantage of this method of development is that a satisfactory reply from the attending physician may neatly and quickly dispose of the issue. The CE must ensure, however, that the attending physician's reply really does dispose of the issue (if the CE has doubts, referral of the issue to the DMA would be appropriate). Other issues which may require such inquiry are the extent of permanent impairment and disability, date of maximum improvement, work tolerance limitation, and course of medical treatment.

b. If an examination, evaluation, or other specific service is requested, prompt pay procedures must be followed. If the physician could provide information based on a review of records and familiarity with the patient, the Prompt Payment Act is considered not to apply.

c. The time allowed for the attending physician's reply should be carefully monitored. If the reply is not received within 45 days, or if the reply is equivocal, the CE should consider obtaining a second opinion.

2-0810-9 Second Opinion Examinations

9. Second Opinion Examinations. The purpose of this paragraph is to describe when and how the CE should request a second opinion examination.

a. A second opinion examination may be recommended by an RN, or the decision to make such referral may originate with the CE, whether or not an RN is involved. A second opinion specialist should be selected who is administratively qualified as discussed in FECA PM Chapter 3-500.3.

The specialist should be provided with a SOAF, copies of all medical reports from the

case record, and a blank Form OWCP-5. The physician should also be given a numbered "Prompt Pay" billing form (Form HCFA-1500/OWCP-1500a) which includes the CPT-4 code for the service requested. The codes for requested services are:

Case review without exam:	CNSLT
Independent consultant exam (second opinion):	SECOP
Referee medical exam or case review to resolve conflict:	IMPAR

b. A physician who performed a fitness for duty examination of the claimant for the employing agency may not be considered a second opinion specialist for purposes of creating a conflict in medical evidence or for reducing or terminating benefits based on the weight of medical evidence. A report from such a physician must receive due consideration, however, and if its findings or conclusions differ materially from those of the treating physician, the CE should make an immediate second opinion referral.

c. The second opinion examination should constitute a complete evaluation of the claimant. The specialist should be asked to submit a report which includes: history of injury, description of objective findings, the claimant's subjective complaints, the results of X-rays and other tests, identification of any underlying or preexisting condition(s), diagnosis, prognosis, the recommended course of treatment to be followed, any medically warranted restrictions or limitations (using Form OWCP-5) and the condition(s) causing the restrictions, and a clinical estimate of the date of partial and/or full recovery.

d. If the case has not yet been accepted and causal relationship is at issue, the specialist should be asked for an opinion with medical rationale confirming or negating a causal relationship between any condition found and the accepted incident or accepted factors of employment, referring to the SOAF. This opinion should be requested in addition to the information required in paragraph 9b, above.

e. In cases involving a preexisting or underlying condition, the specialist should be asked to provide a rationalized opinion as to whether the preexisting or underlying condition was aggravated by the employment incident or factors and, if so, whether the aggravation was temporary or permanent. If temporary, the specialist should also state when the aggravation ceased or can be expected to cease. This information should be requested in addition to that required in paragraph 9c, above.

f. If the case has been accepted and the second opinion referral is undertaken while the RN is participating, either at the CE's direction or on the RN's initiative, the RN may assist in composing questions to be addressed by the second opinion specialist and/or schedule the examination.

g. The information described above should give the CE a clear picture of the nature

and extent of the claimant's disability and its relationship to the accepted condition(s). It should also allow the CE to determine the next logical intervention in the case. Should there be a subsequent need for an independent specialist's opinion, the CE's questions to the specialist should be specific to the issue at hand. The same specialist used for the initial examination may be used to obtain subsequent opinions. The CE should not refer second opinion examination reports to the DMA for review.

h. The findings or opinions of an independent specialist will often differ from those of the claimant's attending physician. If of equal weight, the differing opinions would constitute a conflict requiring referral to a third physician. This is a time-consuming process which is not always necessary. Frequently a decision can be reached by weighing the medical evidence of record without referral to a referee specialist. The following are examples of situations in which differences of opinion can in all probability be resolved without impartial referral.

(1) The attending physician (a general practitioner) and the "second opinion" physician (a Board-certified specialist in the appropriate specialty) differ with respect to an issue such as diagnosis or causal relationship. All other factors being equal, the opinion of the Board-certified specialist would constitute the weight of medical evidence. The opinions of physicians who have training and experience in a specialized medical field have greater probative value concerning medical questions pertaining to that field than the opinions of other physicians.

(2) The opinions of two Board-certified specialists differ, but the opinion of one of the physicians is based upon an inaccurate or incomplete history. The opinion based on an incomplete or inaccurate history would be of lesser probative value than one based upon a complete and accurate history of injury.

(3) The opinions of the attending physician and the "second opinion" physician (both Board-certified specialists) differ on an issue such as causal relationship or the nature and extent of work limitations. However, the opinion of one physician is speculative, equivocal and/or unrationalized while the opinion of the other physician is supported by objective findings and is fully rationalized. The opinion of the first physician would be of diminished probative value and would be of lesser weight than that of the second physician.

2-0810-10 Obtaining Second Opinions for Surgery

10. Obtaining Second Opinions for Surgery. This paragraph describes the steps required when surgery is requested.

a. Emergency surgery may be defined as any procedure which needs to be performed promptly after the onset of a condition or injury in order to preserve life or

function of an organ or body part. Elective (or non-emergency) surgery may be defined as any procedure which is necessary for the adequate or normal function of an organ or body part, but which does not need to be performed promptly after the onset of the condition in order to achieve its purpose.

b. For emergency surgery, no prior authorization by the Office is required. However, prior authorization is required for all elective surgery. When requesting authorization, the following minimum documentation must be submitted from the attending physician: the name of the surgical procedure; diagnosis of the specific condition(s) which will be treated by the surgery; the type of surgery (emergency or elective); and the reason surgery is needed. Any ambiguity or omission in an attending physician's request for surgery should be resolved by telephone if possible, or by the RN if one is involved in the case. The individual making the call should prepare a detailed summary of any telephone conversation for the case record.

c. When authorization is requested for certain types of elective surgery, the CE must obtain a second medical opinion concerning the need for the procedure. The elective surgical procedures involved are: spinal surgery, organ transplants, and destructive procedures (i.e., chordotomy, rhizotomy, or amputation of a body part).

d. In cases involving spinal surgery the CE will obtain the minimum documentation described in paragraph 10b, and send the case file to the medical unit for referral to an Office consultant who will evaluate the request for surgery on the basis of the written record. The consultant will be advised that his or her report may be made available to the claimant and the attending doctor.

(1) The consultant should be asked to provide a rationalized opinion concerning the need for the surgical procedure, using the following guidelines (also see Exhibit 3):

(a) The surgical procedure must be related to the claimant's accepted condition.

(b) The medical reports must adequately describe the clinical history and severity of the condition, the results of the physical examination of the claimant, and the results of pertinent diagnostic tests. The presence or absence of complications should also be described.

(c) As appropriate, an adequate trial of conservative treatment should have been attempted prior to the decision to perform surgery.

(d) The history, physical examination, and/or results of pertinent diagnostic tests should support a specific diagnosis.

(e) The diagnosed condition warrants surgical intervention according to current medical concepts, and the proposed surgical procedure is within the realm of accepted medical practice.

(2) The file will be returned to the CE with the consultant's report. If the consultant agrees that surgery is warranted, the CE will authorize it. If the consultant's opinion is equivocal or negative, or if it indicates the need for clinical data not present in the file, the CE should prepare the file for a second opinion examination by formulating appropriate questions (see Exhibit 4).

(3) When the referral is arranged, the Medical Management Assistant (MMA) will provide the claimant and the attending doctor with a copy of the consultant's opinion which precipitated the need for the second opinion examination. The usual procedures for notifying the claimant of the second opinion examination will be followed, and the specialist should also be advised that a copy of the report will be furnished to the claimant and the attending doctor. The specialist should provide a report which contains a clinical history, results of a physical examination, results of any diagnostic tests performed, and a reasoned opinion regarding the appropriateness of the proposed surgery.

(4) If the specialist agrees that surgery is warranted, the CE will authorize it.

(5) If the specialist concludes that surgery is not warranted, the CE will issue a formal decision denying authorization for the surgery, explaining the basis for denial and providing a copy of the specialist's report. In the latter situation, it is anticipated that the weight of the medical evidence will rest with the Office consultant and the second opinion doctor, since both are specialists who have reviewed the medical records and one will have examined the claimant as well.

(6) Even if payment for surgery is denied, compensation for disability resulting from the surgery is payable in cases where the claimant was disabled for work prior to the surgery. Such payment may be made regardless of any indications that the period of disability would have been shorter without surgery. In addition, continuing medical care after discharge from the hospital should be authorized just as it would have been if surgery had not been at issue.

e. In cases involving destructive procedures or organ transplants, the MMA will arrange for a panel of physicians in the appropriate specialty to evaluate the request for surgery.

(1) After obtaining the minimum documentation required (as described in paragraph 10b above), the CE will refer the case file to the medical unit for referral to the panel. In some instances, evaluation of the case file alone may be preferable, and this is acceptable. When the claimant is to be examined, the usual

procedures for notifying him or her of the second opinion examination and forwarding a copy of the file to the panel will be followed. The panel will be advised that a copy of the report will be furnished to the claimant and the attending doctor.

(2) If the panel agrees that surgery is warranted, the CE will authorize it.

(3) If the panel concludes that surgery is not warranted, the CE will issue a formal decision denying authorization for the surgery, explaining the basis for denial and providing a copy of the panel's report. In the latter situation, it is anticipated that the weight of the medical evidence will rest with the panel physicians, since they are medical specialists who have reviewed the medical records and in most cases have also examined the claimant.

(4) Even if payment for surgery is denied, compensation for disability resulting from the surgery is payable in cases where the claimant was disabled for work during the period immediately prior to the surgery. Such payment may be made regardless of any indications that the period of disability would have been shorter without surgery. Additionally, continuing medical care after discharge from the hospital should be authorized just as it would have been if surgery had not been at issue.

f. Where the claimant fails to request prior authorization for surgery, the CE will instruct the claimant to submit the minimum documentation (described in paragraph 10b above) from the attending doctor, as well as a copy of the operative report. The CE will then refer the case file to the medical unit, which will arrange for evaluation of the written record by an Office consultant. Should the consultant conclude that surgery was unnecessary, a referee examination of the case file only will be arranged. (A second opinion examination should not be requested under these circumstances since "hands on" evaluation after the surgery was performed would have limited value).

Based on the results of this evaluation, the cost of surgery will be reimbursed or a formal decision will be issued denying payment for the surgery. Any such decision should address only the surgical bills, however, including hospitalization expenses, anesthesiologist's fees, etc. Payment of compensation for disability will not be affected by the decision to deny payment for surgery, and continuing medical care after discharge from the hospital should be authorized just as it would have been if surgery had not been at issue.

g. If the claim has not been adjudicated when authorization for surgery is requested, the CE will advise the claimant and the attending physician that the Office cannot consider a request for surgery before the case is adjudicated but that the request will be evaluated retroactively if the case is accepted. The procedure described in the preceding paragraph will be applied in making such determinations.

h. Where the claimant requests exemption from the requirement that he or she undergo a second opinion examination because of severe pain or inability to travel great distances, the CE should confer with the RN, if one is involved in the case, and permit the claimant to forego the second opinion examination if the objection is deemed reasonable. The discussion with the RN should be documented by memorandum to the file.

If no RN is involved, the CE should require the claimant to arrange for submission of a report from the attending doctor to substantiate such a claim. The CE should send this documentation to the DMA and ask him or her to give an opinion on the reasonableness of the request for exemption. If an exemption is granted, the CE will so advise the claimant and the attending doctor in writing.

2-0810-11 Referee Specialist Examinations

11. Referee Specialist Examinations. This paragraph describes how and when the CE should obtain an examination from a referee specialist.

a. Careful analysis of the medical evidence should allow for resolution of most issues without resorting to a referee or "impartial" specialist. However, where the analysis of the evidence demonstrates conflicting opinions or conclusions which are supported almost equally, the services of a referee specialist must be utilized.

b. The authority for referee medical examinations is found at 5 U.S.C. 8123(a), which states in pertinent part that "if there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination." Because this method of resolving conflicts is provided in the Act, the probative value of the referee specialist's report is great and will normally constitute the weight of the medical evidence of record. In Albert J. Scione, 36 ECAB 717, the Board held that a conflict in medical opinion under 5 U.S.C. 8123(a) cannot occur between two attending physicians.

c. The CE should consider the following points with respect to referee medical examinations:

(1) A conflict of medical opinion must actually exist as determined by weighing the medical evidence. The CE must decide the relative value of opposing opinions in the medical record, giving consideration to all factors of physician specialty and qualifications, completeness and comprehensiveness of evaluations and rationale and consistency of opinions.

It may be, as in the case of Jordan M. Carter, 32 ECAB 856, that no conflict in

medical opinion truly exists, and if so, merely declaring a conflict and referring the claimant and case record out for supposed impartial examination will not accord that physician's opinion any special weight. However, if a significantly greater weight cannot be assigned by the CE to one opinion, then it is proper to determine that a conflict in medical opinion exists and that a referee medical examination is appropriate.

(2) The referee specialist's report, once received, must actually fulfill the purpose for which it was intended, i.e., it must resolve the conflict in medical opinion. The ECAB has stated that "an impartial specialist's report is entitled to greater weight than other evidence of record as long as his conclusion is not vague, speculative or equivocal and is supported by substantial medical reasoning" (James P. Roberts, 31 ECAB 1010).

Therefore, the CE must ensure that the referee specialist's report is comprehensive, clear and definite, and that it is based on current information and supported by substantial medical reasoning, as well as a review of the entire case file (see Billie M. Gentry, 38 ECAB 498). If the report is vague, speculative, incomplete or unrationalized, it is the responsibility of the CE to secure a supplemental report from the referee specialist to correct the defect.

However, if the impartial specialist is unable or unwilling to give a supplemental report, or the supplemental report is also defective, i.e., it is still incomplete, vague, speculative or unrationalized, the OWCP should arrange for a second impartial evaluation (Charles Feldman, 28 ECAB 314 and April Ann Erickson, 28 ECAB 336). This measure should be undertaken with care; a premature or inappropriate second impartial examination would defeat the intent of 5 U.S.C. 8123(a) and could lead to the suspicion that OWCP is "doctor shopping."

d. The DMA, or the RN if involved in the case, should be consulted when the need for clarification arises over an issue such as explanation of medical terms or the developmental course of a disease. A memorandum to the file or a note written by the RN may be used to document such input. Cases returned from a referee medical examiner should not routinely be sent to the DMA for review unless a schedule award is at issue. Where a referee examination was arranged to resolve a conflict created by a DMA with respect to a schedule award issue, that DMA should not review the referee specialist's report. Rather, another DMA or consultant should review the file (John W. Slonaker, 35 ECAB 997.

2-0810-12 Weighing Medical Evidence in Memoranda and Decisions

12. Weighing Medical Evidence in Memoranda and Decisions. This paragraph describes how medical evidence should be addressed in formal decisions issued by the Office.

a. Section 8124 of the Act provides that a finding of fact shall be made in determining an award for or against payment of compensation. Since almost all terminations of compensation in accepted disability cases involve an analysis of medical evidence, it is important that memoranda and decisions terminating compensation in these cases contain an analysis of the relative merits of the medical evidence of record. This means that the CE must not only state that a particular piece of medical evidence constitutes the weight of that evidence, but also give the reasons for assigning that weight. For example:

(1) In a case when continuing benefits are denied on the basis of a report from a second opinion specialist, the CE may note that the independent specialist was Board-certified in the appropriate field of medicine, performed a full and complete evaluation, had a SOAF and provided a rationalized opinion. The CE would contrast the second opinion report with the report of an attending physician, finding that the attending physician's supportive opinion on continuing disability was of diminished probative value compared to the independent physician's opinion, since the attending physician was not a specialist and did not provide detailed reasoning in support of his or her opinion.

(2) In a case where referee medical evaluation was sought to resolve a true conflict in medical opinion, the explanation should identify the physicians whose reports are in conflict and the issue of disagreement, and may include reference to the provisions of 5 U.S.C. 8123(a) pursuant to which the referral to the impartial specialist was made; the finding that the report was thorough, unequivocal and rationalized and was prepared by an appropriate Board-certified specialist; and the conclusion that the specialist's report (in accordance with the ECAB's statement in James P. Roberts, 31 ECAB 1010) must be given special weight.

b. The CE must address all medical evidence of record as it relates to the issue at hand. If the issue is causal relationship, the memorandum or decision should note those physicians who did not comment on causal relationship and find that these reports had no evidentiary value on that issue. The memorandum or decision would note all other physicians' opinions and discuss their relative merits based on whether the opinions were vague or firm, reasoned or unreasoned, and well-founded or not, within the context of the physicians' respective training and qualifications.

2-0810-13 Exclusion of Medical Evidence

13. Exclusion of Medical Evidence. In its decisions in the cases of Carlton L. Owens, 36 ECAB 608; Aubrey Belnavis, 37 ECAB 206; and George W. Coast, 36 ECAB 600, the ECAB established new criteria for excluding improperly obtained medical reports from the case record. The purpose of this paragraph is to describe these criteria and the actions which must be taken

with respect to reports which must be excluded.

a. Improper Contact. The Board has required exclusion of medical reports if:

(1) The physician selected for referee examination is regularly involved in performing fitness for duty examinations for the claimant's employing agency. While such physicians may not be used as medical referees, they may be used as second opinion specialists. (See FECA PM 3-500.4.)

(2) A second referee specialist's report is requested before the Office has attempted to clarify the original referee specialist's report. Only if the selected physician fails to provide an adequate and clear response after a specific request for clarification may the Office seek a second referee specialist's opinion.

(3) A medical report is obtained through telephone contact or submitted as a result of such contact. CEs must refrain from verbal contact with physicians who are engaged to provide referee opinions to discuss any substantive issue in the case. All such communication must be in writing.

(4) A medical report is obtained as a result of "leading questions" to the physician in either a referee or second opinion context.

b. Annotating the File. A CE who identifies medical evidence which was obtained improperly should staple the pages of the report together and write "Excluded" and the date on the front of the report. It is not necessary to remove the report physically from the file, nor is it necessary to expunge all mention of the report from factual summaries, formal decisions, and other documents contained in the file. The CE should place a short memorandum in the file with an explanation for the action. Letters to any physician who is sent the entire case file should instruct him or her to disregard the excluded report, and such reports should be omitted from photocopies of medical evidence sent to second opinion specialists.

2-0810-14 Suspension of Benefits

14. Suspension of Benefits. This paragraph describes the circumstances under which benefits may be suspended for failure to undergo a medical examination as directed by the Office.

a. Legal Provisions. Section 5 U.S.C. 8123(d) states that "if an employee refuses to submit to or obstructs an examination, his right to compensation under this subchapter is suspended until the refusal or obstruction stops." To invoke this provision of the law, the CE must ensure that the claimant has been properly notified of his or her responsibilities with respect to the medical examination scheduled. In accordance with 20 C.F.R. 10.323,

the actions of an employee's representative will be considered the actions of the employee for the purpose of determining whether a claimant refused to submit to, or in any way obstructed, an examination required by OWCP.

b. Arrangements with the Physician. Either the CE or Medical Management Assistant (MMA) may contact the physician directly and make an appointment for examination. The claimant and representative, if any, must be notified in writing of the name and address of the physician to whom he or she is being referred as well as the date and time of the appointment. The notification of the appointment must contain a warning that benefits may be suspended under 5 U.S.C. 8123(d) for failure to report for examination. The claimant must have a chance to present any objections to the Office's choice of physician, or for failure to appear for the examination, before the CE acts to suspend compensation.

c. Follow-up Action. If no medical report is received within 30 to 60 days from the date of appointment arranged by the Office, the CE should telephone the physician's office. If the claimant reported for examination, the CE should ask when the report may be expected.

d. Failure to Appear. If the claimant does not report for a scheduled appointment, he or she should be asked in writing to provide an explanation within 14 days. If good cause is not established, entitlement to compensation should be suspended in accordance with 5 U.S.C. 8123(d) until the date on which claimant agrees to attend the examination.

Such agreement may be expressed in writing or by telephone (documented on Form CA-110). When the claimant actually reports for examination, payment retroactive to the date on which the claimant agreed to attend the examination may be made.

The claimant's statement that he or she will not appear for an examination is not sufficient to invoke the penalty (see

Leanna Garlington, 37 ECAB 849). Refusal to schedule an examination at the direction of the office is also insufficient to invoke section 8123(d) (see Herbert L. Dazey, 41 ECAB 271.

2-0810-15 Health Facility Membership and Special Equipment

15. Health Facility Membership and Special Equipment. This section describes procedures to be followed when a claimant requests authorization for membership in commercial health clubs/spas and/or purchase of commercial equipment/furnishings not commonly prescribed by physicians. OWCP will not approve an elaborate service or appliance where a more basic one is suitable.

a. Health Club/Spa Membership. Such memberships may be authorized if needed to treat the effects of an injury. If the case is under nurse intervention, any question regarding the use of health club or spa facilities should be discussed with the RN. In all cases where such memberships are at issue, the CE must determine that the membership is likely to be effective and cost-efficient, given that exercises performed at such facilities are generally done without supervision, the term of membership may be incompatible with the duration of the prescribed program, and membership dues often include charges for services not related to the treatment regimen.

Whenever a request for payment of health club/spa membership is received, the CE should obtain the following information:

(1) From the treating physician (see Exhibit 1):

(a) A description of the specific therapy and exercise routine needed to address effects of the work-related injury, including the frequency with which exercises should be performed;

(b) The anticipated duration of the recommended regimen (is it a trial period or an ongoing program);

(c) An opinion as to the actual/anticipated effectiveness of the regimen, treatment goals attained/sought, and frequency of examinations to determine the ongoing need for the program;

(d) A description of the specific equipment/ facilities needed to safely perform the prescribed regimen;

(e) The nature and extent of supervision, if any, required for safety while claimant is performing the exercises; and

(f) An opinion as to whether the exercise routine can be performed at home, or recommendation as to what kind of public or commercial facility can provide the exercise routine.

(2) From the claimant (see Exhibit 2):

(a) The full name and address, and distance from claimant's home or work location, of public facilities (where individual membership is not required) suited to the prescribed regimen;

(b) The full name, address, and distance from claimant's home or work location of commercial facilities (individual membership required) suited to the prescribed regimen;

(c) The specific reason(s) why membership in a commercial health club/spa is required where public facilities are available and/or where the doctor indicates the regimen can be performed at home;

(d) A signed statement from the health club/spa manager indicating that the club/spa is fully suitable for the exercise routine prescribed by the physician, and a breakdown of fees and charges for various membership options and terms (e.g., short-term vs. lifetime membership). The statement should describe all facilities, services, and special charges not included in the membership fee.

b. Special Equipment/Furnishings. Requests are sometimes received for purchase of equipment/furnishings not commonly obtainable from medical supply sources or prescribed for treatment (e.g., waterbeds, weight-lifting sets, saunas, tapedecks, vibrating chairs, exercise bicycles). In cases with current nurse intervention, the RN may at times initiate a request for special equipment.

Whatever the source of the request, the proposal must be discussed thoroughly with the RN if involved in the case.

In all instances, the CE must ensure that the equipment is necessary to treat the effects of the work-related injury and that its use will be consistent with the claimant's restrictions and safety. The CE must also consider the relative cost of purchase vs. rental, and whether the cost is commensurate with the basic (unadorned) item required for treatment. The CE should obtain the following information:

(1) From the treating physician:

(a) A full, specific description of the basic equipment/furnishing required to treat effects of the job-related condition;

(b) An explanation of how the item will address the effects of the job-related condition, and an opinion as to the anticipated effectiveness of the item in treatment;

(c) The anticipated duration of the need for the item (to determine whether rental or purchase is appropriate);

(d) A suggested supplier, if any.

(2) From the claimant:

(a) The full name and address of two or three suppliers:

(b) From each potential provider, a signed statement describing in detail the basic, unadorned item meeting the physician's specifications, and a breakdown of all costs, including delivery, installation, etc. If the claimant wants a more elaborate item (e.g., queen size bed vs. single needed for claimant), advise claimant to submit price quote for basic item only and of responsibility to pay for any enhancements.

c. Review of Request. Evaluate the information received from the physician, claimant, service/equipment provider, and (if appropriate) RN or Rehabilitation Counselor. The CE may approve requests for health club/spa memberships, special equipment, supplies and services (except as noted in (2) below), provided the cost does not exceed $500. Requests involving higher amounts will be referred to the Supervisory Claims Examiner with a written recommendation explaining the basis for approval. For vehicle and house modifications, see PM Chapter 2-1800.

(1) If the information received adequately supports the request, advise claimant by letter of the approval and any payment limitations or other restrictions or terms, e.g., rental vs. purchase, period of membership approved.

(a) Only individual (not family or group) health club or spa

memberships may be approved, and only for periods of six months at a time. The claimant should be advised of the period of approval, and if a further period of approval is requested, of the need for a medical report (approximately 45 days prior to expiration of current membership term) explaining the gains achieved to date and supporting an extension for a specified period.

(b) Nonpersonal equipment which costs more than $5000 and is not required as part of the approved vocational rehabilitation program is government property, and the claimant must be advised of this fact and informed that the item may not be resold, given away, traded, or otherwise disposed of without OWCP approval. The MMA should be advised of the purchase so that the required record can be established. See PM Chapter 3-400.4b.

(2) If the information received is incomplete or doubt exists about the suitability, appropriateness, and/or need for the membership, service, or equipment, request clarification from the attending physician or obtain a second opinion medical examination. If after weighing the medical evidence the purchase must be denied, advise the claimant by letter of the denial, the reasons for it, and the alternatives which can be considered. Provide a formal decision with appeal rights if requested. Copies of the letter approving or denying the request should be sent to the employing agency and treating physician.

2-0810-16 Physical Therapy

16. Physical Therapy. This paragraph describes how and when the CE may authorize physical therapy services.

a. In certain accepted claims, the CE should advise claimants that physical therapy (PT) is authorized if prescribed by the treating physician. Such notice should be sent in all claims with accepted orthopedic or neurologic conditions. (This notice may be deferred in cases involving brain and spinal cord injuries, extensive second and third degree burns, and other conditions which have rendered the claimant bedridden.) If there is any question regarding the appropriateness or duration of the physical therapy involved, the CE should confer with the RN if the case is under nurse intervention.

b. Notification may be accomplished via the acceptance letter (Form CA-1008). The CE should authorize PT for a period of 120 days from the date of injury. Authorization of therapy in excess of 120 days requires additional medical justification and formal approval by the CE. A sample paragraph for initial acceptance is shown in Exhibit 5.

c. If the accepted condition is severe brain and/or spinal cord injury or disease, widespread malignancies, severe second or third degree burns, etc., the CE should authorize PT as supported by medical documentation and should update Case Management screen 34 to show the period authorized.

d. If further authorization beyond the initial 120-day period is requested, the CE must request the following medical information, unless already present in file:

(1) Specific modalities, procedures and/or tests and measures to be administered, detailed by Physicians' Current Procedural Terminology (CPT-4) codes;

(2) Diagnosis for which the therapy is administered;

(3) Specific functional deficits which are to be treated, including a description of how these deficits affect the claimant's physical activities;

(4) Expected duration and frequency of treatment; and

(5) Specific functional goals of the additional therapy.

If this medical information is already present in the file, the CE should review it and evaluate the need for further treatment as detailed under paragraph 16e below. If the

information is not available in the treating physician's medical reports, the CE should request a narrative report from the treating physician and send copies of this letter to the physical therapist administering the treatment and to the claimant. A sample request letter is shown in Exhibit 6. Authorization for additional treatment may not be granted until this information is received and reviewed.

e. To evaluate the need for additional therapy, the CE weighs the medical evidence using the following criteria:

(1) The PT is directed to the accepted condition or to an accepted complication of this injury or condition, including surgery;

(2) The specific modalities, procedures and/or tests and measures include some form of active PT as evidenced by the use of any of the following CPT-4 procedure codes: 97110 through 97116 (therapeutic exercises); 97240 (pool therapy or Hubbard tank); 97241 (pool therapy or Hubbard tank, each additional body area); and 97500 through 97541 (orthotics, prosthetics and activities of daily living training); and

(3) A functional deficit exists and the additional therapy is expected to produce some functional improvement. Pain alone does not constitute a functional deficit. To authorize additional physical therapy for pain, the CE should ensure that the pain is associated with measurable objective findings such as muscle spasm, atrophy and/or radiologic changes in joints, muscles or bones, or that pain has placed measurable limitations upon the claimant's physical activities.

f. If these tests are met, the CE may authorize additional physical therapy for the period requested or 90 days, whichever is less. The newly authorized dates should be added to the Notes section of the Case Management File as described in paragraph c above, but the initial authorization should not be deleted or overwritten. The authorized dates should also be entered in the Physical Therapy portion of the FECS Case Management File (option 34). Failure to do so may result in denial of bills for PT services. Up to two periods of authorization may be entered. If necessary, the ending dates may be extended where additional periods of PT are authorized. The CE notifies the treating physician, claimant and physical therapy provider (if different from the treating physician) of the approval, indicating the specific period and CPT-4 procedure codes that are approved.

g. If a second opinion examination is required to establish the need for physical therapy, the CE will refer the claimant to a specialist conversant with physical therapy issues, such as an orthopedic surgeon, neurologist or physiatrist. Cases in which this action may be necessary include those where:

(1) The medical evidence is not in keeping with the three criteria described in paragraph 16e above;

(2) The therapy is for the accepted condition, but this condition is not orthopedic or neurologic in nature;

(3) The therapy extends beyond the initial and additional approval periods.

As appropriate, the CE should authorize therapy based on the results of the second opinion evaluation or refer the claimant for a referee examination for further resolution of the treatment issues. Charges for physical therapy rendered after the initial 120-day period or other authorized periods are not to be reimbursed until the process is completed and the CE has authorized the extension.

h. If the need for additional therapy is not established, the CE should issue pre-termination notice and prepare a formal denial as described in PM Chapter 2-1400.10.

2-0810-17 Authorization for Diagnostic Testing

17. Authorization for Diagnostic Testing. Diagnostic procedures are used to determine the exact nature and extent of the claimant's condition. Such assessments often clarify the medical status and may well save the claimant additional pain and time loss from work. This paragraph discusses when such tests may be authorized, and by whom.

a. Development. If a diagnostic procedure such as an MRI, CAT scan, or arthroscopy pertains to the accepted condition, or in unadjudicated cases to the part of the body which has been injured, the request should not routinely be developed. Even in the case of arthroscopy, the diagnostic nature of the test should take priority over its surgical nature when authorization is at issue, and the procedure should be authorized and paid for without further investigation in a case involving injury to the knee.

b. Sequence of Tests. For many conditions, a standard sequence for such tests exists--for instance, in cases of back injury, an initial x-ray is generally followed by a CAT scan or MRI if needed, with a myelogram performed if earlier procedures are inconclusive and the physical findings warrant it. If the CE is unaware of the usual sequence for a particular condition, or if the nature of the test is unfamiliar, a verbal consultation with the RN or DMA may be in order, but unless a specific reason exists to obtain further information, the test should be authorized.

c. Authorization. The CE may grant authorization for tests in accordance with the guidelines stated above. RNs may authorize non-invasive diagnostic procedure (CAT scans, MRIs, x-rays, laboratory work, EMGs, pulmonary function tests, nerve conduction

studies) without prior authorization from the CE. They may not, however, authorize invasive tests such as arthroscopy or myelogram.

2-0810-18 Transfer of Medical Care

18. Transfer of Medical Care. This paragraph addresses the circumstances under which the CE may consider transfer of care from one attending physician to another.

a. Section 5 U.S.C. 8103(a) states in part that:

> The employee may initially select a physician to provide medical services, appliances, and supplies, in accordance with such regulations and instructions as the Secretary considers necessary....

This initial choice must always be honored. Under limited circumstances, however, the Office may consider transfer of care.

b. Reasons based on OWCP's regulations necessarily include any situation where a provider is excluded from payment under the FECA because he or she:

(1) Failed, neglected or refused on three or more occasions during a twelve month period, to submit full and accurate medical reports, or to respond to requests by the Office for additional reports or information, as required by the Act at 10.410 of this part [20 C.F.R. 10.450 (f)].

(2) Knowingly furnished treatment, services or supplies which are substantially in excess of the claimant's needs, or of a quality which fails to meet professionally recognized standards [20 C.F.R. 10.450 (g)].

Well-documented instances of such occurrences should be brought to the attention of the District Director, who may at his or her discretion issue a warning letter to the physician (see Exhibit 7). A copy of this letter should be furnished to the Regional Director.

c. Other reasons include the physician's refusal to provide a treatment plan. Such a plan should be provided within 30 days of the request from the CE or the RN. Only the complete absence of a plan will justify an attempt to transfer care. A plan that is considered inadequate may still serve as the basis for further dialogue with the physician, or for referral for second opinion examination. However, making such a referral to obtain a treatment plan is not usually a viable option, since the original attending physician cannot be required to follow it.

If the physician refuses to provide a plan, or initially states that one will be forthcoming but then fails to provide it, the CE (or Staff RN, at the CE's direction) should advise the

physician that the Office will transfer the claimant's care absent submission of a plan within 30 days. The file must be documented to this effect before the CE or RN contacts the claimant to advise that care must be transferred. The claimant will be allowed to choose another physician without guidance from the Office, but at the claimant's request, the Office will prepare a list of three physicians specializing in the appropriate field of medicine so that the claimant may choose among them.

2-0810-19 Claimants in Prison

19. Claimants in Prison. Incarcerated persons do not lose entitlement to medical treatment for work-related injuries simply because they are imprisoned. Medical treatment and examinations should be arranged through prison officials. It may be sufficient to obtain routine medical services from the prison physician. If needed, with cooperation of prison authorities, the claimant may be taken to a specialist's office or arrangements may be made for the specialist to visit the prison to see the claimant. Such arrangements may be made not only for treatment and periodic examinations, but also to obtain physical work limitations for use in determining the estimated earning capacity. Copies of correspondence with prison officials regarding medical examination and treatment should be sent to the claimant to keep him or her informed.

2-0810-20 Functional Capacity Evaluations (FCEs)

20. Functional Capacity Evaluations (FCEs). These evaluations may be classified in two types according to their purpose, duration and content: a general-purpose FCE, and an FCE for placement into an Occupational Rehabilitation Program (ORP) such as Return to Work or Work Readiness (commonly called work-hardening, work conditioning, etc.)

a. A CE or SN may authorize a general-purpose FCE in cases where management of disability calls for clarification of job tolerance, job modifications, etc., and the treating physician, second opinion or referee specialist recommends or require this service. However, only a Rehabilitation Specialist can authorize an FCE in connection with an ORP (see PM 2-813).

b. Before authorizing the FCE, the CE or SN should review the case and verify that the injury occurred more than three months ago, the functional impairment is of moderate to high complexity, and the services recommended by the physician exceed routine physical performance tests and measurements (e.g. CPT 97750). More detailed guidelines appear in Chapter 1 of MEDGUIDE.

c. The CE or SN advises the recommending physician that the FCE is approved. Based on the severity of the case and whether or not any complicating factors are present, up to eight hours can be approved for a general-purpose FCE.

d. The CE or SN completes the authorization form and enters the authorization in the "Notes" section of the Case Management File (CMF). To ensure the accurate processing of bills for the FCE, the following information must be included: the approved service code, the number of hours approved, the name of the provider, and, as necessary, the use of modifiers.

The CE or SN also notifies the Field Nurse (FN) assigned to the case of the authorization of the FCE and provides the FN with a copy of the authorization.

2-0810 Exhibit 1: Information from Treating Physician Re Health Club/Spa Membership

Dear PHYSICIAN NAME:

CLAIMANT NAME has requested payment under the Federal Employees' Compensation Act for membership in a health club/spa and/or for special equipment for treatment of the accepted work-related condition.

We need your professional opinion and certain specific information as to the medical necessity for the program/equipment requested so that we can make a decision on this aspect of the claim. Please complete the form attached to this letter for this purpose.

Your cooperation is appreciated.

Sincerely,

CLAIMS EXAMINER

SAMPLE REQUEST FOR INFORMATION FROM TREATING PHYSICIAN RE HEALTH CLUB/SPA MEMBERSHIP, Continued

PHYSICIAN'S RECOMMENDATION FOR TREATMENT-RELATED HEALTH CLUB PROGRAMS OR PROCUREMENT OF SPECIAL EQUIPMENT FOR JOB-RELATED EXERCISE OR THERAPY

Name of Employee__________________________ OWCP File No.______________
Accepted Work-Related Condition(s)____

The Office of Workers' Compensation Programs requires the following information to determine whether health club/spa membership and/or special equipment is necessary and appropriate for effective treatment of the accepted work-related condition. The information will also be used to determine the best mode and source of treatment as well as the kind of payment arrangements which should be made according to the nature and duration of the program.

1. Description of Exercise/Therapy Program: Please describe each exercise/routine to be performed.

2. Frequency of Regimen: How many days per week is the routine to be performed?

3. Anticipated Duration of Program: Is this a trial, or an ongoing program? Approximately how long to you anticipate the program will be required?

4. Goals/Benefits: What are the specific goals of or benefits expected from the program for the work-related condition(s)?

5. Effectiveness: What is the relative effectiveness of this regimen compared to alternative modes?

6. Equipment Required: What specific basic equipment is needed to perform the exercise/therapy regime?

7. Supervision/Assistance Needed: Can the regimen be safely performed without help, or is supervision/assistance needed? Describe the nature and extent of assistance required, if any.

8. Home or Outside Facility: Can this regimen be performed at home? If not, or if special facilities or supervision are needed, please provide name and address of local facilities/ providers meeting regimen requirements. Include public/non-commercial facilities if available.

Signature of Physician___________________________ Date___________

Address _______________________________________ Phone____________

____

2-0810 Exhibit 2: Information from Claimant Re Health Club/Spa Membership

Dear CLAIMANT NAME:

We need the following information to make a decision on your request for payment of membership in a health club or spa.

1. Describe local public and commercial facilities which will allow you to fulfill the program described by your doctor, and the cost of each, using the form on the reverse of this letter.

2. Ask your doctor to describe the recommended exercise program, the equipment needed, and safety considerations, using the enclosed form. After the doctor completes the report, give a copy of it to the health club/spa manager so he or she is fully aware of the requirements of our program.

3. Submit a signed statement from the health club/spa manager indicating the extent to which the club is equipped and staffed to provide the program

described the doctor, and a detailed breakdown of fees and charges for various membership and equipment usage options and terms. The manager's statement should describe any special fees or charges not included in the membership fee, and any discounts available.

In evaluating the proposed program, we will consider such factors as equipment and supervision requirements, as well as cost and effectiveness of this mode versus other alternatives, including exercise at home or in public facilities.

OWCP policy limits payment for membership in commercial health clubs to no more than one year. At the end of that period, we can authorize an additional membership term if your doctor believes that the exercise program has been carefully followed and has been effective in achieving treatment goals.

Sincerely,

CLAIMS EXAMINER

SAMPLE REQUEST FOR INFORMATION FROM CLAIMANT RE HEALTH CLUB/SPA MEMBERSHIP, Continued

INJURED EMPLOYEE'S STATEMENT OF AVAILABLE
AND PREFERRED FACILITIES

Please provide the following information with respect to your request for payment of membership in a health club or spa. Use a separate sheet of paper if additional space is needed.

1. Contact and list local public or government facilities suitable for the exercise routine described by your doctor (include any available through your employing agency).

Name of Facility & Person Contacted	Full Address	Distance from Home	Charge or Fee
___________________	______________	__________	______
___________________	______________	__________	______
___________________	______________	__________	______

2. Contact and list local commercial (membership and/or usage fee required) facilities suitable for the exercise routine described by your doctor.

Name of Facility & Person Contacted	Full Address	Distance from Home	Charge or Fee
___________________	______________	__________	______
___________________	______________	__________	______
___________________	______________	__________	______

3. From the above lists, indicate your preference)(s) for use and/or membership if OWCP authorizes payment. If more than one is suitable, list in

order of your preference. If membership in a more costly facility is requested where a less costly local facility is also available, provide justification/explanation for use of the more costly facility.

I hereby certify that the above information is true to the best of my knowledge. I understand that any person who knowingly makes any false statement, misrepresentation, concealment of fact, or who commits any act of fraud to obtain benefits provided by the Federal Employees' Compensation Act is subject to felony criminal prosecution.

____ ___________

Signature of Employee Date

2-0810 Exhibit 3: General Guidelines for Review of Non-Emergency Back Surgery

1. The surgical procedure planned by the treating physician must be related to the claimant's accepted condition.

2. The medical reports available in the claim file should provide sufficient information to support a decision as to the appropriateness of surgery. In instances where you judge the information to be insufficient, please indicate so and return the file with your reasons.

3. The history, physical examination, and/or results of pertinent diagnostic procedures must support a specific diagnosis, and must support a finding that the disorder warrants the proposed surgical intervention according to current medical concepts. In addition, the proposed surgical procedure should be within the realm of accepted medical practice.

4. As appropriate, an adequate trial of conservative treatment has been attempted prior to the decision to perform surgery.

5. Your charges must be submitted on the HEALTH INSURANCE CLAIM FORM, HCFA-1500, one of which is enclosed with each medical record. It contains the proper code for use in our office, SURB1, which is entered in section 24c of the form. No other codes may be used.

2-0810 Exhibit 4: Instructions for Orthopedic Surgeons, Neurologic Surgeons, Neurologists Who Review Cases Where Authorization for Back Surgery Has Been Requested

1. The OWCP requires second opinions prior to approval to attending surgeons for the operations indicated above. The District Medical Advisor requests that you review the medical record accompanying these instructions, in accordance with the general guidelines prepared specifically for second

opinion evaluation (copy enclosed).

2. During your review, please give special attention to (1) the clinical history; (2) the severity of the condition for which the operation is proposed; (3) the presence or absence of complications; and (4) the presence or absence of confirmatory diagnostic clinical examination with sufficient support studies.

3. On these bases provide us with a rationalized orthopedic or neurological opinion concerning the need for the proposed operation. The first sentence of your report must state that you have reviewed the medical record and have read the Statement of Accepted Facts (SOAF). The SOAF provides an outline of the claim and contains the only diagnosis(es) accepted by the OWCP as related to the work injury. Do not discuss other diagnoses in the medical record unless those diagnoses contribute to your opinion.

4. To best serve the injured worker we have established a limit of 40 days, from the date of the receipt of the operative request, for complete evaluation and report. Please ensure that your review is completed within this time period.

2-0810 Exhibit 5: Sample Paragraph Authorizing Physical Therapy

If prescribed by your treating physician, physical therapy for your accepted condition is authorized for 120 days from the date of your injury. The prescription must describe the types of treatment to be rendered, and the objectives to be attained. Payment for services exceeding the 120 day period will require additional medical justification from your physician, including diagnosis, functional deficits, goals, duration and frequency of treatment, and treatment modalities.

2-0810 Exhibit 6: Letter to Physician Requiring Additional Medical Justification

Dear PHYSICIAN NAME:

The Office of Workers' Compensation Programs (OWCP) has authorized and reimbursed physical therapy services for CLAIMANT NAME for a period of 120 days. Please be aware that the following additional medical information is required before reimbursement for further therapy can be authorized:

(a) Diagnosis for which physical therapy will be administered.

(b) Specific functional deficits which are to be treated including a description of how these affect the patient's physical activities.

(c) Specific functional goals of the additional therapy.

(d) Expected duration and frequency of treatment.

(e) Modalities, procedures and/or tests and measures to be administered detailed by Physicians' Current Procedural Terminology (CPT-4) procedure codes.

If additional therapy is planned for this patient, please submit a report containing the above mentioned items to OWCP for consideration.

Sincerely,

CLAIMS EXAMINER

2-0810 Exhibit 7: Letter of Warning to Physician Failing to Supply Requested Information

Dear PHYSICIAN NAME:

This letter concerns your patient(s) who is/are claimants under the Federal Employees' Compensation Act (FECA).

The regulations of the Office of Workers' Compensation Programs state that medical providers who do not furnish information as requested by the Office, or who furnish inappropriate treatment to the claimants, may be excluded from payment and participation as a provider of medical services under the FECA.

The pertinent section of the regulations is found at 20 C.F.R. 10.450, as follows:

> A physician, hospital, or provider of medical support services or supplies shall be excluded from payment under the Act if such physician, hospital or provider has....EITHER: (f) Failed, neglected or refused on three or more occasions during a twelve month period, to submit full and accurate medical reports, or to respond to requests by the Office for additional reports or information, as required by the Act at 10.410 of this part [OR: (g) Knowingly furnished treatment, services or supplies which are substantially in excess of the claimant's needs, or of a quality which fails to meet professionally recognized standards.]

This Office has identified the following instances of non-compliance with this section of the regulations [concisely summarize the evidence and refer to supporting documentation, which should be attached to the letter].

The OWCP values its relationships with medical providers. However, it is vital that EITHER: we receive full and accurate medical reports OR: claimants receive appropriate medical treatment. Your future disregard of the regulatory provision cited above will lead to your exclusion from payment and participation as a provider of medical services under the FECA.

Please telephone me at (area code and number) if you have any questions.

Sincerely,

DISTRICT DIRECTOR

2-0811 EARLY MANAGEMENT OF DISABILITY CLAIMS

Paragraph	Subject	Date	Trans. No.
-	Table of Contents	02/02	02-05
1	Purpose and Scope	04/93	93-28
2	Introduction	04/93	93-28
3	Intervention	04/93	93-28
		07/97	97-17
4	Initial Case Actions	04/93	93-28
5	Medical Matrices	04/93	93-28
		09/95	95-35
6	Mandatory Intervention	04/93	93-28
7	Initial Payments	07/97	97-17
8	Daily Roll Payments	04/93	93-28
9	Periodic Roll Payments	07/97	97-17
10	Dependents	02/02	02-05
11	Second Opinion Examinations	04/93	93-28
12	Continuing Total Disability	04/93	93-28

Exhibits

1	Sample Letter to Claimant Describing Need for Referee Examination and Entitlement to Compensation	10/94	95-01

2-0811-1 Purpose and Scope

1. Purpose and Scope. This chapter discusses the early management of accepted disability claims where there is wage loss. It also touches upon nurse and rehabilitation interventions that are addressed in Chapter 2-600, Case Management, and the use of medical matrices that are found in Chapter 3-400.

2-0811-2 Introduction

2. Introduction. The effective management of a disability claim requires that a Claims Examiner (CE) make judgments about the probable course of the case. The CE must periodically assess the medical evidence to ensure that there is continuing compensable disability, that benefits are being paid consistent with the extent of compensable disability, that the claimant is receiving suitable medical care, and that the Office's nurse and rehabilitation services are being used to full advantage. Through periodic assessment, the CE can gain control of individual claims, and ultimately of an entire case load.

In addition, a primary goal of case management is to assist the claimant in returning to work within one year if possible. The one year period is significant because Section 8151(b) of the FECA requires the employing agency to offer the claimant his or her former position or its equivalent, "if the injury or disability has been overcome within one year" after compensation begins. If the disability is overcome after one year, the employer must make "all reasonable efforts" to rehire the claimant. In practice, this means that in most cases there is a one-year window of opportunity for return to work with the employing agency. It is therefore essential that a return-to-work agenda be emphasized early in the life of an accepted disability claim, to take advantage of this limited opportunity.

2-0811-3 Intervention

3. Intervention. This term refers to an action by the CE, OWCP Nurse, or Rehabilitation Specialist, as reasonable and appropriate to achieve the objectives in paragraph 2 above. An intervention may occur when the medical evidence is incomplete or contradictory, or at a specific time, such as a date of projected recovery, completion of a course of physical therapy, release from the hospital, or return to light duty. At these times the CE will need to assess the case and intervene as necessary to achieve the desired objectives.

The nature and extent of the intervention will be determined by what is necessary to resolve any medical shortcomings and to ensure that indicated nurse and/or rehabilitation referrals are proceeding as desired.

2-0811-4 Initial Case Actions

4. Initial Case Actions. Once a claim has been accepted, certain actions will follow, tailored to fit the circumstances of the particular case. The CE should:

a. Monitor medical care and evidence by considering any requests for diagnostic testing and procedures after approving the claim. The CE should also request an updated medical report if necessary. When an injury which is originally seen as minor results in disability exceeding early expectations or in additional or changed diagnoses, the CE should ensure that this is fully explained in the medical evidence and should request any clarification necessary, preferably via the OWCP RN.

If the attending physician's estimate of the length of disability seems excessive for the injury involved, or if it appears that the time frame of the medical matrix will be exceeded, the CE should confer with the OWCP RN if the case is open to such referral, and if indicated, the CE or the RN should ask the attending physician for an explanation or clarification of the estimate for the return to work.

b. Determine the appropriate intervention if disability exceeds the period shown in the medical matrix or the estimated recovery period stated by the attending physician. In some cases, a nurse should intervene as soon as continuation of pay (COP) expires or when Form CA-7 is received.

c. Review the medical evidence to see that the following information is on file from the attending physician:

(1) History of injury as given by the claimant.

(2) Objective findings from physical examination.

(3) Subjective complaints of the claimant.

(4) Results of any laboratory tests and/or X-rays.

(5) Identification of any pre-existing condition or underlying degenerative processes.

(6) Diagnosis.

(7) Prognosis.

(8) Reasoned opinion as to the causal relationship between the diagnosed condition(s) and the employment incident or factors.

(9) Course of treatment to be followed.

(10) Clinical estimate of the date of partial and/or full recovery.

(11) Any medically warranted work limitations (using the OWCP-5).

If any of this information is lacking or requires clarification, the CE should ask the attending physician to furnish it. Failure of the attending physician to respond completely (or at all) within 45 days indicates the need for a second opinion referral.

d. Take the following actions:

(1) Request additional medical evidence if necessary and establish the next intervention point. If the physician has not provided a comprehensive report as described above, a follow-up request should be made. If the physician has not yet given a clinical estimate of the date of partial or full recovery, the CE should request this information and set a 45-day call-up.

If complete and supportive medical evidence is received, establish the next intervention point and set a new call-up. This process should be repeated as necessary. If at any point a request for clarification does not result in receipt of the desired information within 45 days, consideration should be given to referral for a second opinion.

(2) Ask the employing agency to provide a copy of the claimant's position description, an assessment of the physical and any special emotional requirements of that position, and a statement as to the availability of limited or light duty. This information can be requested using Form CA-1656.

(3) Release Form CA-1008 and Pamphlet CA-1009 to the claimant. Form CA-1336 may be sent to the attending physician if desired. The information and instructions given in these letters will provide a framework to the recipients for understanding the basis of future actions taken in the claim.

e. Where permanent impairment is anticipated, a call-up should be set for the expected date of maximum medical improvement so the claimant's entitlement to a schedule award can be explored.

2-0811-5 Medical Matrices

5. Medical Matrices. For use in managing disability claims, OWCP has developed medical matrices showing the usual periods of disability for a number of commonly accepted conditions. The matrices appear in MEDGUIDE, which is contained in Folioviews.

a. The matrices may be applied only to the diagnoses indicated. Because the guidelines are organized by ICD-9 code, CEs should code accepted conditions as precisely as possible, using four or five digit codes whenever applicable. This practice will maximize the accuracy and usefulness of the matrices.

b. To allow for factors which may prolong the period of disability such as concurrent conditions, unusual severity and/or certain complications, an additional period of three months of disability may be authorized in individual cases, based on the medical information provided by the treating physician. It is anticipated that the conditions included in the matrices will not require additional time beyond the three months for

resolution, except in very rare instances.

c. The time limits stated in the matrices apply exclusively to the ICD-9-CM diagnosis codes listed in the guidelines. The matrices are not applicable to cases in which the treating physician changes the initial diagnosis (for which there is a matrix) to a more complex diagnosis not present in the matrices (e.g., an initial diagnosis of a simple back strain is changed to herniated intervertebral disc), nor are they applicable to cases where the initial diagnosis (present in the matrices) results in a complication best described by another ICD-9-CM diagnosis code.

d. The matrices include length of disability values for surgery associated with several conditions. In cases involving surgery, the CE should use the date of the procedure as the first day of disability, regardless of the time elapsed from the date of injury or the period of compensation already paid.
For example, a claimant suffers ruptured ligaments of the right knee and is being treated conservatively, so the CE assigns a length of disability of six weeks. Four weeks after the date of injury, the claimant undergoes surgical repair of the torn ligament. At this point, 12 additional weeks should be allowed, starting on the day of surgery. If the period of disability from surgery for a particular condition is not stated in the matrix, the CE should obtain it from the treating physician.

e. While the length of disability will often be shorter than the intervals stated, individual claims may fall outside the accepted limits for a number of medical reasons such as unusual severity, complications, concurrent conditions, and advanced age. The second matrix (also found in FECA PM Chapter 4-100) details some of the more common factors which may prolong recovery and the return to work. The list is not exhaustive, and other factors presented by the physician need to be weighed on a case by case basis.

f. When a complication is accepted, the CE should change the ICD-9-CM code to reflect the increased severity. Cases involving complications will likely result in longer periods of disability than those indicated in the matrices, and up to three months of additional disability may be allowed. Even where complicating factors are present, however, the conditions included in the matrices should resolve given appropriate treatment and time.

g. If a new condition is claimed (HNP, for instance, in a claim where only a low back strain had previously been accepted), the claimant will be required to submit medical evidence stating when the new condition became manifest. The dates of disability will then be determined in accordance with paragraphs 5a-f above. Similarly, if more than one condition has been accepted, the dates on which disability may reasonably be expected to end must be determined for each condition.

h. Claims accepted for recurrence may be assigned the same periods of disability as

were (or would have been) assigned to the original injury for the accepted condition involved.

i. The medical matrix should be used as an internal reference guide to evaluate the medical evidence and determine when an intervention should be undertaken. It may not be employed either to weigh the evidence or to create a conflict in the evidence, nor may it be used to justify termination or reduction of compensation. Once compensation payments have begun, they may not be terminated until the Office has met its burden of proof.

2-0811-6 Mandatory Intervention

6. Mandatory Intervention. The medical matrix must be used to establish the normally expected length of disability for the identified conditions, and interventions must be scheduled in cases where the claimant has not returned to work by the indicated date. Such interventions may take the form of obtaining treatment plans from attending physicians, making referrals to nurses, and/or arranging for examination by second opinion and referee specialists.

Referral to an OWCP Nurse may be undertaken simultaneously with either a further inquiry to the attending physician or a second opinion examination. The nurse will contact the claimant either by telephone or in person and work with him or her toward recovery and re-employment. In cases involving strains or sprains that do not appear to be resolving, the nurse referral should be made at the end of the COP period or upon receipt of the first claim for compensation.

Where the period of disability indicated by the matrix has ended or is about to end when the claim is received and processed, but the attending physician has certified continued disability, the CE should authorize additional payment of compensation and arrange immediate intervention.

2-0811-7 Initial Payments

7. Initial Payments. Before setting up payment, the CE should consider which method of payment is most appropriate, according to the following factors:

a. Where disability is present, the CE must decide whether to pay a claimant on the daily roll or the periodic roll.

(1) The daily roll should be used where the term of disability is not likely to exceed 60 days, unless return to work is imminent. It is best to avoid lengthy periods of payment on the basis of Forms CA-8.

(2) The periodic roll should be reserved for cases that involve clearly defined and well established long-term disability, early in the life of the case. Any uncertainty regarding the duration of long-term injury-related disability should be resolved before a case is placed on the periodic roll.

b. If the accepted condition is included in the medical matrix (see paragraph 5 above) the CE should consider both the period of disability indicated by the matrix and the period stated by the claimant's physician.

c. If the accepted condition is not included in the matrix the CE should use the projected date of return to light or full duty supplied by the attending physician as the intervention point. If no return to duty date is specified, the CE, or the RN at the CE's request, should call the attending physician immediately to obtain this information. A written confirmation must always be requested, and payment should continue for a reasonable period to allow for its receipt, but not beyond any return-to-work date estimated by the physician on the telephone.

2-0811-8 Daily Roll Payments

8. Daily Roll Payments. The following procedures apply specifically to payments made on the daily roll.

a. The claimant must submit Form CA-8 prior to payment, but no Form CA-20 is necessary if the condition involved is found in the matrix and the period claimed is shorter than the period specified in the matrix. Before setting up payment, the CE should telephone the employing agency or the claimant to verify that the claimant has not returned to work. If the claimant has not returned to work, payment may be set up through the current date.

b. When the first payment is made, the CE should advise both the claimant and the attending physician in writing of the following: the beginning and ending dates of compensation; the return to regular or light duty date provided by the attending physician or the matrix; the need to submit Form CA-8 to claim any additional compensation, whether during or after the period of disability specified by the matrix; and the likelihood that further intervention will be undertaken if the claimant does not return to work by the date specified. This notification may be made via Form CA-1650. Form CA-1655 should not be sent unless the claim is placed on the periodic roll.

c. Where payment will likely continue through the entire period specified by the matrix, the CE should set a call-up for five days prior to the ending date. At this time, the CE should query the agency or the claimant to determine whether the claimant has returned to duty (unless the nurse has already obtained this information).

If the claimant has not returned to duty, an intervention as described in paragraph 6 above must be initiated. The CE should advise the claimant in writing of the nature of the intervention and the need to claim additional compensation by submitting Forms CA-8 at regular intervals from the ending date of the matrix period until OWCP receives the evidence required by the intervention.

d. If the intervention is an inquiry to the attending physician and the medical report received is insufficient, a second opinion examination must be arranged (see paragraph 10 below). The CE should advise the claimant that additional compensation may be claimed for the period up to the date of examination plus a reasonable amount of time for receipt of the report by submitting Forms CA-8 at regular intervals.

e. If the report indicates that no disability is present, a decision concerning continuing entitlement should be made by weighing the medical evidence of record.

f. If a conflict in medical evidence occurs, a referee examination will be required. The claimant may continue to be paid on the daily roll with submission of Forms CA-8, or the claim may be transferred to the short-term roll until the report is received. Here again, no Form CA-20 or other medical report is required for continuing payment. A second letter advising the claimant of the action taken must be sent; see **Exhibit 1** for a sample letter.

2-0811-9 Periodic Roll Payments

a. Periodic roll payments may be made in both traumatic injury and occupational disease cases. The ending date of payment should correspond to the date of return to light or full duty specified by the attending physician or provided by the medical matrix. A medical, nurse or rehabilitation intervention should be undertaken on that date if the claimant has not returned to duty.

b. Form CA-25 should be used to set up periodic roll payments. If the expiration date does not correspond to the end of a periodic roll four-week cycle, it will be necessary to set up a supplemental payment.

c. When the claimant is placed on the roll, the CE should advise both the claimant and the attending physician in writing of the following: the period through which compensation will be paid; the expected date of return to regular or light duty provided by the attending physician or the matrix; and the likelihood that further medical investigation will be undertaken if the claimant does not return to work by the date specified. (However, the particular intervention need not be determined in advance or addressed in the letter.) This notification may be made using Form CA-1049.

d. <u>At the end of the specified period</u>, the CE should telephone the employing agency or claimant to determine if the claimant has returned to duty. If not, an intervention is required as described in paragraph 6 above. Once the date of the intervention is established, another period of compensation may be set up, to include a reasonable period for receipt of the evidence requested.

e. <u>If the intervention is an inquiry</u> to the attending physician and the medical report received is insufficient, a second opinion examination must be arranged. The CE should set up a payment for the period up to the date of examination plus a reasonable length of time for receipt of the report.

f. If the evidence obtained as a result of the intervention shows that no injury-related disability remains, the CE should weigh the medical evidence and reach a decision accordingly. If the report obtained creates a conflict in the medical evidence, a referee examination will be required. A second letter advising the claimant of the action taken must be sent. See **Exhibit 1** for a sample letter.

g Referrals for vocational rehabilitation services should be made according to the usual criteria (see PM 2-600 and PM 2-813).

2-0811-10 Dependents

10. Dependents. Augmented compensation is paid to a claimant with at least one dependent, including a spouse. Where only one dependent is claimed, and that person is a student, a child whose marriage has ended, a child incapable of self-support, or a parent, the CE must ensure that entitlement exists.

a. Student Status. Compensation paid on behalf of an unmarried child which would otherwise be terminated at age 18 may continue if the child is a student pursuing a full-time course of study or training at an accredited institution. Such benefits may be paid for four years of education beyond the high school level, or until the beneficiary reaches age 23, whichever comes first.

(1) A "year of education beyond the high school level" is defined as:

(a) The 12-month period beginning the month after the child graduates from high school, if the child has indicated an intention to continue in school during the next regular session, and each successive 12-month period, provided that school attendance continues.

(b) The 12-month period beginning on the date the child actually enters school to continue education, if the child has indicated that he or she will not attend during the next regular session, and each successive 12-month period, provided that attendance continues.

(2) A year of entitlement based on student status means any year during all or part of which compensation is paid based on school attendance. Therefore, if a beneficiary should decide for any reason not to attend school for part of a year during which benefits were paid on account of student status, that beneficiary would be charged with having used an entire year of eligibility out of the allotted four years, even though compensation terminates when the beneficiary leaves school. If a child has already completed one or two more years of college before turning 18, they would be deducted from the four years of entitlement.

(3) If the child does not begin post high school education immediately but later decides to enter school full-time, compensation would begin on the date school attendance began, as stated in (1)(b) above. In this situation, the individual would remain entitled to four years of compensation based on school attendance, provided he or she did not turn 23.

In either case, compensation is continued during any interval between school terms which does not exceed four months if the beneficiary demonstrates a bona fide intent to continue in school the following year. In the absence of specific contrary evidence, the CE may consider the student's decision to begin or continue full-time studies a bona fide statement of intent.

(4) Where a student is prevented by reasons beyond his or her control (such as brief but incapacitating illness) from continuing in school, compensation may be continued for a period of reasonable duration. However, any such period would be counted toward the four years of entitlement. The CE will determine what constitutes "reasons beyond the control" of the beneficiary and decide what may be considered a period of reasonable duration during which compensation may be continued. The CE will also place a memorandum in the file outlining the circumstances of the case and the reasons for the decision.

(5) The CE should periodically obtain proof of student status. See PM 2-812.5b concerning release of Forms CA-1615 and CA-1617. If the beneficiary is still receiving student benefits on turning 23, compensation should terminate at the end of that semester or enrollment period.

b. Marriage of Child. A dependent child's eligibility for benefits terminates on the date of the child's marriage. A child whose marriage ended prior to the beginning of disability will not be barred from receiving benefits if otherwise entitled. A child whose marriage is annulled after the employee's death is eligible for benefits from the effective date of the annulment or the date the claimant became eligible for disability benefits (see FECA Program Memorandum No. 4) if otherwise entitled, but a child who is divorced or widowed is not eligible for benefits.

c. Children Over 18 Who are Incapable of Self-Support. When claims are made by or for children over 18 who are physically or mentally incapable of self-support, the CE must investigate the extent and expected duration of the illness involved.

(1) Eligibility. To be entitled to benefits, a child over 18 must have been incapable of self-support by reason of a mental or physical disability at the time the claimant became eligible for disability benefits. A child over 18 is not entitled to benefits because of inability to obtain employment due to economic conditions, lack of job skills, etc.

(2) Definition. A claimant is incapable of self- support if his or her physical or mental condition renders him or her unable to obtain and retain a job, or engage in self-employment that would provide a sustained living wage. This determination must be based on medical evidence. When medical evidence demonstrates incapacity for self-support, this determination will stand unless refuted by the sustained work performance.

(3) Medical Evidence. A medical report covering the child's past and present condition must be submitted and referred to the DMA to determine whether it establishes incapacity for self-support. A physician's opinion must be based on sufficient findings and rationale to establish unemployability.

d. Compensation to Parents. Parents, stepparents, and parents by adoption may be entitled to benefits, but foster parents and in-laws are excluded. Proof of parentage is established by a birth certificate for the employee, or, in the case of adoption, copies of the legal documents. In the case of a stepparent, the file must contain proof of the stepparent's marriage to the natural or adoptive parent of the deceased, along with the birth certificate indicated above.

The parent must be wholly dependent on the employee for support when eligibility for benefits began. The test of dependency under the FECA is not whether the claimant is capable of self-support without the amount which was previously provided by the deceased. "It is only necessary to show that the person claiming as a dependent. . .looked to and relied upon the contributions. . .in whole or in part, as a means of maintaining or helping to maintain a customary standard of living" (Viola Davidson, 4 ECAB 263).

Compensation to a parent is payable until the parent dies, marries, or ceases to be dependent. A parent should be removed from the rolls when the current income received, less compensation, equals or exceeds the total income from all sources at the time of death. CPI adjustments should be included when making this determination. OWCP has the burden of proving under this formula that the parents are no longer dependent.

2-0811-11 Second Opinion Examinations

11. Second Opinion Examinations. Based on the medical evidence of record, the CE may request a second opinion examination at any time.

a. Conditions for Referral. Such referrals are recommended where:

(1) The attending physician has not provided reports which are complete and adequate, giving a clear picture of the claimant's present condition; or

(2) A specialist in the pertinent field of medicine has not previously examined the claimant and provided complete, supportive and well-reasoned reports; or

(3) The evidence indicates that the claimant will not return to duty within 30 days.

b. Content of Referral.

(1) The CE must prepare a Statement of Accepted Facts (SOAF) and draft questions to be posed to the examining physician (see PM Chapter 2-809). The SOAF should not include details regarding matters extraneous to the issue under consideration. If there is a question regarding the duration or degree of disability, the physical requirements of the job at injury should, of course, be included.

(2) Referrals should be made consistent with OWCP procedures for selection of and rotation among physicians (see PM Chapter 3-500). It is preferable but not required that physicians selected to perform second opinion evaluations be board-certified. Copies of all medical evidence in the file should be sent to the second opinion specialist.

(3) Where the opinion of the specialist is contrary to that of the attending physician, the CE must weigh the evidence of record. If the opinions are of nearly equal weight, an impartial medical examination is necessary. For a discussion of weighing medical evidence, see Chapter 2-810.

2-0811-12 Continuing Total Disability

12. Continuing Total Disability. If the medical evidence establishes continuing total disability, the CE should set a call-up for receipt of a medical progress report. If at that time updated medical evidence has not been received, the CE should ask the attending physician to provide a narrative report to include:

a. Objective findings from the most recent examination.

b. Subjective complaints of the claimant.

c. Current impairments and their relationship to the work injury.

d. Work limitations imposed (using Form OWCP-5).

e. Course of treatment followed, and a treatment plan.

f. Physician's estimate of the date of partial/full recovery.

If the attending physician does not adequately address these issues, the services of an independent specialist should be used even if one referral has already been made. The same physician may be employed for a subsequent opinion in the case, since the specialist was initially selected by rotation.

The process of obtaining current medical evidence, evaluating that evidence and establishing a new intervention point should be repeated until the claimant returns to work or is found to have no wage earning capacity. Procedures for re-employment and rehabilitation are described in Chapter 2-813.

2-0811 Exhibit 1: Sample Letter to Claimant Describing Need for Referee Examination and Entitlement to Compensation

Dear CLAIMANT NAME:

I am writing in reference to your claim for compensation due to injury on 01/01/01 while employed by the agency identified below.

Because a conflict in the medical evidence in your case has been identified, a referee examination at the expense of the Office of Workers' Compensation Programs will shortly be arranged. The conflict has occurred for the following reason: although your physician, Dr. X, states that you continue to be disabled for your regular duties because of your work-related injury, Dr. Y, who performed a second opinion evaluation on 02/02/02, states that no objective findings are present.

You have received compensation through 03/03/03. You are entitled to claim compensation through the date of receipt of the referee specialist's report. To claim compensation, you should submit the enclosed Form CA-8 [Or: Based on the claim you have already submitted, you will shortly begin receiving compensation benefits each 28 days] [Or: Based on the claim you have already submitted, you will receive compensation benefits from 04/04/04 to 05/05/05]. When the report of the referee specialist is received, we will determine whether you are entitled to any further compensation and advise you of the status of your claim.

If you have any questions, I can be reached at the address and telephone number noted above.

Sincerely,

CLAIMS EXAMINER

cc: Employing Agency

2-0812 PERIODIC REVIEW OF DISABILITY CASES

Paragraph	Subject	Date	Trans. No.
	Table of Contents	06/03	03-06
1	Purpose and Scope	07/93	93-38
2	Statutory Provisions	07/93	93-38
3	Burden of Proof in Continuing or Terminating Benefits	07/93	93-38
4	Placement and Monitoring of Claims on Periodic Roll	07/93	93-38
		06/03	03-06
5	PRMS Action Codes	06/03	03-06
6	Elements of Review	04/93	93-25
		06/92	92-26
		09/95	95-35
7	Definition and Frequency of Reviews	06/92	92-26
		07/97	97-17
		06/03	03-06
8	Medical Evidence	06/92	92-26
		07/93	93-38
		06/03	03-06
9	Attendant's Allowance	07/00	00-10
		06/03	03-06
10	Reports of Earnings	07/93	93-38
		06/03	03-06
11	Actions on Reports of Earnings and Dependents	07/93	93-38
		09/95	95-35
		07/97	97-17
		06/03	03-06

12	**Federal Employees' Group Life Insurance (FEGLI)**	**07/93**	**93-38**
		06/03	**03-06**

Exhibits

1	**Sample Questions**	**10/94**	**95-01**
2	**Sample Letter Where No Report of Earnings is Received**	**10/94**	**95-01**
3	**Sample Letter Where Report of Dependents is Not Received**	**10/94**	**95-01**
4	**Signature Authority (Approvals/ Denials/Certification)**	**06/03**	**03-06**
5	**PRMS Action Codes**	**06/03**	**03-06**

2-0812-1 Purpose and Scope

1. Purpose and Scope. This chapter discusses procedures for monitoring disability claims paid on the periodic roll and for developing evidence to determine the continuing entitlement to compensation as well as the nature of that entitlement. It also covers procedures for determining entitlement to an attendant's allowance. Monitoring of death claims is addressed in FECA PM 2-700.

Payment on the periodic roll is an efficient method of ensuring regular payments of compensation to those with long-term compensable disabilities. It remains the responsibility of the Claims Examiner (CE), in all periodic roll cases, to ensure that evidence remains current in the case, that all suitable medical care is provided, and that appropriate use is made of nursing and rehabilitation services. The goal is the best possible recovery, and a return to employment where at all feasible.

2-0812-2 Statutory Provisions

2. Statutory Provisions. When a case has been accepted, the claimant is entitled to full benefits of the FECA for the medical condition found to be related to the employment.

a. Sections 5 U.S.C. 8105-8106 provide that compensation is payable for wage loss caused by a medical condition found to be related to the employment. See FECA PM 5-304 and 5-305.

b. Section 5 U.S.C. 8107 provides that compensation is payable for the permanent loss or loss of use of certain anatomical members, functions or organs of the body.

Except for disfigurement, a schedule award entitlement is payable consecutively but not concurrently with an award for wage loss due to the same injury. See FECA PM 2-808 and 5-306.

c. Section 5 U.S.C. 8111 provides for additional compensation for the service of an attendant where required.

d. Section 5 U.S.C. 8133 provides that compensation is payable to eligible dependents of an employee whose death results from a physical condition found to be related to the employment. See FECA PM 2-700.

2-0812-3 Burden of Proof in Continuing or Terminating Benefits

3. Burden of Proof in Continuing or Terminating Benefits. Having accepted a claim and initiated payments, the Office may not terminate compensation without a positive demonstration, by the weight of evidence, that entitlement to benefits has ceased. Generally, this means that a claimant's failure to reply to a request for a medical report is insufficient grounds to terminate benefits unless the claimant was directed to report for examination and there is ground for suspension under section 8123 of the FECA. Furthermore, when a claimant is receiving benefits on the periodic roll, benefits may not be terminated or reduced without giving the claimant prior notice and an opportunity to provide evidence of continuing entitlement, except in a limited set of circumstances (see FECA PM 2-1400.6).

2-0812-4 Placement and Monitoring of Claims and Periodic Roll

4. Placement and Monitoring of Claims on Periodic Roll. Where either prolonged (over one year) or permanent disability is expected, compensation for wage loss will be paid on the periodic roll (see FECA PM 2-900 and 5-305). After payment has begun, the CE is responsible for obtaining medical and non-medical evidence to determine continued entitlement. The CE is responsible for periodic review of active cases to ensure that payments are correct and to document continuing entitlement in the file.

a. Placement. The CE should take the following actions when placing claimants on the periodic roll:

(1) Form CA-674. The CE will complete Form CA-674, Periodic Case Development/Management Checklist, and the certifier will sign it before the case is placed on the periodic roll.

(2) Notification to Claimant. When periodic roll payments are initiated, the CE should advise the claimant by Form CA-1049 or equivalent narrative letter. The letter should notify the claimant of the conditions for termination without

prior notice and the requirement that employment be reported. A copy of the notice should be sent to the employing agency regardless of the claimant's current employment status.

b. Monitoring. All cases on the periodic roll will be monitored closely to:

(1) Verify continuing entitlement to compensation and the appropriate level of payments.

(2) Ensure quality and appropriateness of medical care.

(3) Reduce or terminate compensation payments when a claimant recovers from the employment-related condition or returns to work.

(4) Initiate vocational rehabilitation and reemployment action as soon as it appears that permanent impairment may result or a change of job duties may be required due to the work-related injury.

c. Expiration Dates. All payment records for disability cases on the periodic roll contain expiration dates based on the claimant's date of birth.

(1) Where cessation of benefits is appropriate (e.g., disability has ceased), only a change in the pay status code will be needed.

(2) Where compensation should continue (e.g., a dependent is to turn 18 years of age, but will continue in school), the CE will need to set up another payment. The new payment setup must always include an expiration date. This date should be established to correspond with case management procedures and/or anticipated events in the life of the case (e.g., a child will attain four years of higher education). A date up to five years in the future may be entered.

2-0812-5 PRMS Action Codes

5. PRMS Action Codes. The PRMS action codes are separated into two categories regarding the specific uses for each code. The categories are Resolution Codes and Optional Codes.

a. PRMS Resolution Codes for Reduction of Compensation.

(1) R1 - - Constructed LWEC. Used when the CE issues a formal loss of wage earning decision based on a seclected position presented by the Rehabilitation Couonselor through the Rehabilitation Specialist after the claimant has undergone

Vocational Rehabilitation. See PM 2-0814.

(2) R2 - - RTW with LWEC. Used when the CE issues a formal loss of wage earning decision where an employee cannot return to the date of injury job because of disability due to work-related injury or disease, but does return to alternative employment with an actual wage loss. See PM-0814.

(3) R3 - - S/A expired with LWEC. Used when the CE issues a formal loss of wage earning decision (actual or constructed) before the S/A expires. Without a LWEC decision the claimant would have reverted back to a PR/PN pay status.

b. PRMS Resolution Codes for Suspension of Compensation.

(1) S2 - - Suspension 5 USC 8123. Used when the CE issues a suspension for obstruction of an office ordered medical examination (i.e. SECOP).

(2) S3 - - Suspension 5 USC 8113. Used when the CE issues a suspension for failure to cooperate with Vocational Rehabilitation efforts.

c. PRMS Resolution Codes for Termination of Compensation.

(1) T1 - - Terminated, no continuing IRD. Used when the CE issues a decision terminating medical and monetary benefits becuase the medical evidence in file demonstrates that the claimant no longer suffers from continuing residuals causally related to the accepted work-injury.

(2) T2 - - RTW, no LWEC. Used when the IW returned to work without incurring wage loss. This could be for either a return to full duty or to a modified full time position.

(3) T3 - - S/A expired, intervention, no LWEC. Used when the CE has initiated action, such as setting up a SECOP examination after the IW'S schedule award expired, but no formal decision on wage loss has been issued.

(4) T4 - - Refused suitable work. Used when the CE issues a formal decision under Section 8106(c) (2) of the Act if an IW refuses suitable employment as determined by the CE.

(5) T5 - - Death of Claimant. Used when an IW dies. The case should be taken out of PW/PR/PS/PN status and removed from the PRM universe.

(6) T6 - - Elected OPM with no periodic Schedule Award payments. Used when an IW elects OPM benefits instead of receiving OWCP compensation without receiving a Schedule Award from OWCP.

(7) T7 - - Terminated, Fraud Conviction. Used when an IW is convicted of fraud against OWCP and/or the United States Government.

d. PRMS code for Case Reviewed, no change.

(1) CR - - No Change in entitlement after review.

(a) Each case can be resolved only once using this code. It can be counted as a valid resolution only after 36 months from the date wage loss began. The CE must review the medical and factual evidence in the cae in order to determine whether or not any additional action should be taken to further resolve the case.

e. Necessary PRMS codes, not counted as resolution.

(1) S1 - - Suspension for no CA-1032. Used by the CE when the IW fails to complete and return the CA-1032 package.

(2) R4 - - Reduction 5 USC 8148(b). Used when the claimant is incarcerated due to a felony conviction that is not related to fraud against the United States Government. Benefits are reduced according to the status of the claimant's dependents.

(3) TO - - S/A expired, no intervention, no LWEC. Used when the schedule award expires and the CE does not take any action to further resolve the entitlement issues for the case.

(4) RO - - Recurrence - Case to QCM. Used when the claimant is receiving compensation in an LWEC status and suffers a work-related recurrence of disability resulting in temporary total disability. After the recurrence is accepted the case should be transferred to QCM. Once the case is opened for OCM tracking, the system will automatically code the case RO in PRMS. If a recurrence is accepted without a form CA-2a on file, the RO code should be added manually by the PRM claims examiner.

This will close the PRMS record and must be coded before the case is added to QCM tracking. Once QCM tracking is opened additional PRMS coding will not be permitted. The QCM claims examiner will be responsible for adding the case to QCM tracking.

If a situation arises and a PRMS case is added to QCM tracking in error, the QCM record should be zeroed out. The PRM claims examiner will then be able to delete the RO code and the case will automatically return to an active PRMS status.

f. PRMS codes for Optional use in tracking casework. The uses for these codes are self-explanatory.

(1) IR - - Initial Review Done.

(2) MN - - Narrative Requested.

(3) MR - - Narrative Received.

(4) SE - - SECOP scheduled.

(5) RF - - Referee scheduled.

(6) VR - - Referred for Rehab.

(7) JO - - Job Offer made.

(8) PR - - Pre-reduction sent.

(9) PT - - Preterm sent.

(10) EO-Elected OPM.

All non-QCM cases on the periodic roll will be part of the PRM universe. This includes any non-QCM periodic roll case transferred in to a district office. These cases will immediately become part of that district office's PRM universe. Any periodic roll case, which is closed, removed (zeroed out) or expired (more than 30 months old) from the QCM tracking will immediately become part of the PRM universe.

Cases can be removed from a district office's PRM universe only when the case is transferred to another district office, a recurrence is approved causing the case to drop into the QCM tracking system, or the case is deleted from the periodic roll (i.e. termination of compensation).

2-0812-6 Elements of Review

6. Elements of Review. The elements of periodic roll review are as follows:

a. Medical evidence should be obtained on a periodic basis as outlined in paragraph 6 below, to determine the progress of the employment-related condition and the extent of

physical impairment resulting from this condition. If in a total disability case it appears that permanent impairment will result from the employment-related condition, the CE should also obtain evidence as to the presence of physical impairments existing prior to the employment injury.

b. Factual evidence is obtained primarily from Form CA-1032, which is released to each claimant on a yearly basis.

(1) Earnings information is requested from each claimant on Form CA-1032. Other sources include:

(a) The Social Security Administration, which should be asked to complete Form CA-1036 each three years.

(b) A new employer, who may be asked to complete Form CA-1027 when information about a claimant's employment and earnings from a private employer will be helpful in determining the nature and extent of continuing entitlement to compensation.

(c) Sources developed by investigation as outlined in FECA PM 2-0402. Investigation may be considered when evidence concerning the extent of the claimant's disability, earnings or activity is in question and cannot be determined adequately by the written evidence.

The CE is responsible for noting the existence of earnings and their bearing, if any, on continuing compensation entitlement.

(2) Dependents' entitlement to compensation is usually determined from information supplied by the claimant on Form CA-1032, although it may come in narrative form. Other sources are as follows:

(a) Form CA-1615 will be released for completion by the claimant shortly before a child reaches the age of 18, if augmented compensation is being paid solely on the basis of a dependent whose dependency status rests on the "student" requirement.

(b) Form CA-1617 will be released for completion on a twice yearly basis thereafter, for the duration of the award or for the duration of entitlement to augmented compensation on the basis of status as a "student."

(c) Investigation as outlined in FECA PM 2-0402 should be considered when evidence concerning the existence of eligible dependents is in question and cannot be determined adequately by the written

evidence.

The CE is responsible for monitoring ACPS reports and making any changes in payments when necessary.

(3) Dual benefits situations may also be identified from information supplied on Form CA-1032, which inquires about receipt of specific Federal pensions and other benefits which may require offset (see FECA PM 2-1000).

(4) Third party settlements may also be identified from information provided on Form CA-1032. The CE should refer to the designated third party examiner any cases in which settlements have been newly made.

2-0812-7 Definition and Frequency of Reviews

7. Definition and Frequency of Reviews. All cases require completion of Form CA-1032 on a yearly basis and completion of Form CA-1036 each three years. Medical reviews should be accomplished in accordance with the case status as follows:

a PR. Cases in which temporary total disability payments are being paid must be reviewed once a year.

b. PS. No medical reports need be requested in a case where a schedule award is being paid. These cases require annual release of Form CA-1032 where payment extends beyond one year, to determine the status of dependents for which augmented compensation is being paid. If the dependent's status is at issue, a more frequent check may be made.

c. PW. Cases receiving payments for loss of wage-earning capacity require medical review each two years.

d. PN. Cases in which the CE has determined, and the SCE has verified, that no wage-earning capacity exists require medical review each three years.

The CE should record his or her actions on Form CA-674a, Checklist for Cases on the Periodic Roll. A review may be considered accomplished when any follow-up requests for required information have been made and the CE has initiated any action required on the basis that no reply to the requests has been received. For instance, after two requests for reports of earnings on Form CA-1032, the CE is expected to begin suspension proceedings. At this point, the review may be considered complete, even though further action must be taken in the claim.

2-0812-8 Medical Evidence

8. Medical Evidence. Procedures for obtaining medical evidence in the first months of disability are described in FECA PM 2-811, while general procedures for obtaining medical evidence are contained in FECA PM 2-810. Where adequate medical reports are not received at intervals reasonable to the particular case, it is the CE's responsibility to obtain them or to make an appropriate referral using the authority provided in 5 U.S.C. 8123.

The CE may contact the physician directly, with a copy to the claimant, to obtain medical evidence containing the information shown below. Alternatively, at district office option, the CE may write directly to the claimant and advise that current medical evidence must be submitted to support continuing payment of benefits. The claimant need not be examined if the physician can provide the requested information from his or her records and an examination has occurred since the last periodic roll review.

a. Content of Medical Reports. Regardless of whether the CE contacts the physician or the claimant, the medical report should include:

(1) The date of most recent examination.

(2) The physical findings.

(3) The diagnosis of any conditions present.

(4) The opinion, and rationale for it, as to whether the condition is related to the employment.

(5) The claimant's work restrictions (enclose OWCP-5).

(6) The type and frequency of medical treatment being provided.

(7) If appropriate, specific questions as to whether a temporary aggravation has resolved, or whether the claimant's physical condition permits a return to the job held at time of injury or to another available job, should also be addressed to the physician, and a copy of the job description may be enclosed.

If a medical report is not received within the specified time (30-60 days should be considered reasonable), or the report does not contain the requested information, the CE should direct the claimant to undergo examination by the attending physician or by a second opinion specialist as appropriate. The Office should make an appointment for the examination. The notification to the claimant should include the warning that under 5 U.S.C. 8123(d) benefits may be suspended for failure to report for examination. (Section 8123(d) may be invoked only in connection with a specific appointment.)

b. Actions Following Receipt of Report.

(1) If the medical report is not responsive to the questions asked, the CE should write to the physician asking for more information. If the reply is not satisfactory, the claimant should be referred to a second opinion specialist if appropriate. If the CE determines that a conflict of opinion exists between the claimant's attending physician and the second opinion specialist concerning the extent and work-relatedness of disability, the conflict must be resolved by a referee specialist.

(2) When sufficient medical evidence is in file, the CE should review the reports to determine whether disability for the job held at time of injury continues; whether disability is related to the employment injury; whether a schedule award is payable; and whether appropriate medical treatment is being given. If partial disability is indicated, the CE should determine whether the claimant's work limitations permit any employment. If so, the CE should consider referring the case for vocational rehabilitation services (see FECA PM 2-813).

c. Changes in Medical Status. The CE should take action based on the weight of the medical evidence as follows:

(1) Where injury-related disability has ceased, notify the claimant of proposed termination of benefits (see FECA PM 2-1400.6 and 7). The Office has the burden of proof to justify the termination of benefits by positive and specific evidence that injury-related disability has ceased. The inadequacy or absence of a report in support of continuing benefits is not sufficient to support termination, and benefits should not be suspended for that reason.

(2) Where total disability has ceased but permanent residuals of the employment-related injury remain, which prevent the employee from performing his/her regular duties, action should be taken to reemploy or train followed by consideration of an award of compensation for permanent disability or loss of wage-earning capacity as outlined in FECA PM 2-0808 and 2-0814, respectively.

(3) Where the claimant has no earning capacity, prepare a memorandum to file for certification by the Supervisory Claims Examiner to establish placement in PN status.

2-0812-9 Attendant's Allowance

9. Attendant's Allowance. 20 CFR 10.314 allows payment for services of an attendant

where it is medically documented that the claimant requires assistance to care for personal needs such as bathing, dressing, eating, etc. Such services are paid as a medical expense under 5 U.S.C. 8103; are limited to $1500 per month under 5 U.S.C. 8111; and are paid directly to the provider of services.

Prior to the January 1999 revision to the Regulations, an attendant allowance was paid directly to the claimant prior to January 1999 will continue to be paid to the claimant until the need for the attendant ceases. Any future period of attendant services for the claimant will be paid under the revised procedures.

a. Determining Entitlement. Where the evidence strongly suggests that the claimant may require the services of an attendant or where the claimant inquires about such entitlement, the CE must determine entitlement as follows:

(1) Release Form CA-1086, Request to Physician or Hospital for Report on Need for Attendant. When a reply is received, the CE should determine whether the employee requires the services of an attendant. In some cases, it may be beneficial to consult the DMA.

(2) Consider the following factors:

(a) the particular kinds of activities for which assistance is needed. (The assistance must be for personal needs such as bathing or dressing, not for such tasks as cooking or housekeeping.)

(b) the need for daily assistance in these activities;

(c) the nature of the disability;

(d) any other facts which may be relevant to the situation.

b. Authorization of an Attendant's Allowance.

(1) Where the services of an attendant are approved, the CE will prepare a memorandum for the file outlining the reasons for approving the attendant allowance, and stating the period for which it is approved.

(2) A CE may approve the services of an attendant up to one year if the medical evidence supports a long-term need. If the services of an attendant are required beyond that period, the CE will prepare a memorandum to the Supervisory Claims Examiner making recommendations and requesting approval for another year. Such approval must be obtained annualy unless the SCE determines that an annual review is unnecessary.

(3) Enter a note in the automated system stating the an attendant allowance is approved, the period for which it is approved, and that it is limited to the amount of $1500 per month.

(4) Advise the claimant of the approval; that the services should be provided by a home health aide, licensed practical nurse, or similarly trained individual; that the amount is limited to $1500 per month; and that the provider should submit their bill for services directly to OWCP using Form HCFA 1500 or OWCP 1500 as directed in 20 CFR 10.801.

c. Payment of an Attendant's Allowance.

(1) Process all approved charges for the services of an attendant for payment directly to the provider of the services, up to a maximum of $1500 per month, and subject to the fee schedule. Use provider type C when paying for attendant care. At the present time, there is no indicator in the system to limit the payments for attendant services to $1500 per month. This must be monitored as the bills are paid.

(2) Where charges over the allowed amount are received, return them to the provider with an explanation that the charges for attendant services exceed the allowed monthly limit.

(3) Where payments are currently being made directly to a claimant, continue such payments directly to the claimant. After the need for the attendant ends, consider any new claims for an attendant allowance under the new regulations

d. Physical Examinations. When the condition requiring the services of an attendant is not permanent, periodic physical examinations must be arranged to determine whether the services of an attendant continue to be necessary. When a claimant is asked to report for examination and is unable to travel alone, transportation and other reasonable and necessary expenses may be paid for the attendant.

e. Concurrent Receipt of Other Federal Payments. An attendant's allowance is payable even though the claimant is receiving salary or sick or annual leave pay. A claimant who has elected benefits under the Civil Service Retirement Act or the Federal Employees' Retirement System may not receive an attendant's allowance except for periods concurrent with payment of a schedule award by the Office.

f. Termination of Allowance. Where the evidence of record, including medical opinion evidence from the physician chosen by the claimant to provide treatment, establishes that an attendant allowance should be terminated, the claimant is to be given pre-termination notice and the opportunity to respond.

2-0812-10 Reports of Earnings

10. Reports of Earnings.

a. Report from Claimant. Form CA-1032 serves as a report of earnings which OWCP may require under 5 U.S.C. 8106(b) when a claimant is receiving compensation. The CA-1032 package should be sent to claimants on the periodic roll annually and includes the Form CA-935 and the Form SSA-581. The completed Form SSa-581 should be maintained in the case file as a matter of record until needed. In addition to salaried employment, the claimant is required to report self-employment and unremunerated employment (see William H. Higgins, 34 ECAB 833, and Howard M. Sprayberry, 36 ECAB 115). A claimant is required to report what it would have cost him or her to hire someone to do the work performed. The fact that business expenses outweigh income does not excuse the claimant from making a report.

b. Report from the Social Security Administration (SSA). The CE should release Form CA-1036 if there is reason to believe that the claimant may have unreported earnings in cases where compensation is being paid on teh periodic roll for total disability or for partial disability resulting in a loss of wage-earning capacity. The following steps should be taken to obtain wage information from the SSA:

(1) Form CA-1036 must be accompanied by a signed release from the claimant on Form SSA-581. The CE should use Form SSA-581 received from the claimant in the latest CA-1032 package completed and returned by the claimant. Because Form SSA-581 is valid for only 60 days from the date signed by the claimant, the CE should check the date which the SSA-581 was sigined before releasing the CA-1036. If the SSA-581 is older then 60 days, then re-issue a CA-935 with a new SSA-581 to the claimant for completion before sending a CA-1036 to SSA.

(2) Include the claimant's full name, Social Security number, and date of birth in the spaces provided. Also include at the bottom left corner the full mailing address of the district office.

(3) If the amount of earnings is needed, check the box labeled "Quarterly wages for the period" and indicate the period for which the information is requested. The wage data from SSA is recorded on a quarterly basis (i.e. January through March, April through June, July through September, and October through December). The information will not be subdivided into smaller units. Howerver, the SSA will reply to the "Yearly wage request on the CA-1036 as long as the SSA-581 signed by the claimant is provided.

(4) Because of the six month time lag in recording wage information, SSA is unable to supply information for the six or nine-month period immediately preceding the date of the request. Where the most current information available is desired, the request should show the end of the period as "to date."

(5) The costs to OWCP for supplying the information are related directly to the period of time covered by the request. Therefore, the CE should insure that the request does not cover a longer period than necessary for the proper handling of the claim. Particular care should be exercised where the request concerns a period in excess of five years. It should not include any period for which information has previously been requested from SSA.

(6) If the names and addresses of employers are needed, check the "Identify Reporting Employers" box and insert the dates for which the information is wanted. The names and addresses of the employers are obtained from a record other than that which reflects the earnings. Therefore, supplying the names and addresses of the employers will approximately double the cost. Because the Office must reimburse SSA for the cost of assembling this information and transcribing it onto the form letter, the names and addresses of the employers should be requested only when a clear need for this information exists.

(7) SSA does not retain copies of these requests. Therefore, only one copy of Form CA-1036 should be sent. It should contain the signature of the Supervisory Claims Examiner or higher authority. The title of the person signing the request should be typed below the signature. No other persons are authorized to sign these requests and those persons holding these positions may not delegate this authority to others.

(8) In some cases it may be determined that the names and addresses of the employers are required after Form CA-1036 is received from SSA with data on quarterly earnings only. On a copy of the form, check the appropriate box and obtain the signature of one of the authorized officials with the title and date indicated as well.

(9) If the claimant refuses to authorize the Office to obtain earnings and employment reports from SSA and evidence in file indicates the presence of earnings, the CE should arrange for an OWCP or Office of Inspector General (OIG) investigation to determine if the claimant has in fact earned wages for the period under consideration. If so, the CE may invoke forfeiture proceedings as described in paragraph 11c below. Benefits may not be suspended, however, as authorization to obtain reports from SSA is not a requirement for receipt of compensation.

c. Report of Self-Employment. When OWCP receives evidence that the claimant owns or is a partner in his/her own business, or is an officer in a corporation, the claims examiner should request additional information from the claimant concerning the specific nature of the business and his/her involvement therein. This request should be made by narrative letter and the questions should be as specific as possible to the known circumstance of the case. The letter should include a reference to the Secretary's authority to require such information and the penalties associated with false reporting (the references contained in Form CA-1032 may be used). The letter should ask the claimant to sign and date his response, certifying the accuracy of the information given. (Exhibit 1 provides sample questions which may be used as appropriate to obtain the information needed. The sample questions may also be forwarded to OIG investigators for use as a reference when interviewing claimants.)

2-0812-11 Actions on Reports of Earnings and Dependents

11. Actions on Reports of Earnings and Dependents. Information received in response to requests for information on earnings and dependents may require the CE to adjust the compensation rate, and the claimant's failure to supply requested information may result in suspension or forfeiture of compensation. Any overpayment in a case involving actual earnings should be declared only after the issue of injury-related disability is determined or an LWEC has been established and benefits reduced.

a. Changes in Entitlement.

(1) Information obtained in response to Form CA-1032 or CA-1036 or from an investigative report may show that the claimant worked during a period when compensation was paid. The nature and regularity of the work may be sufficient to demonstrate an earning capacity warranting adjustment of the compensation even if it did not result in earnings (see FECA PM 2-813). Likewise, a level of activity which is inconsistent with total disability may support adjustment of compensation even if the work is not sufficient to establish a rating on actual earnings.

(2) Information obtained from Form CA-1032, CA-1615, or CA-1618 should be compared to ACPS reports to ensure that benefits are being paid at the proper compensation rate; adjustments should be made as necessary.

b. Suspension of Compensation. The Office's regulations provide that if timely reports of earnings are not made, the right to compensation for wage loss is suspended until the report is received. Likewise, entitlement to augmented compensation may be suspended (i.e., compensation may be reduced from 3/4 to 2/3) if the Office does not receive a timely response to a request for information concerning eligible dependents.

(1) Determining if Benefits Should be Suspended. If the claimant fails to return Form CA-1032 within 30 days, the CE should first examine the file to determine whether extenuating circumstances exist (for example, the claimant is hospitalized or has just moved and had no time to notify the office) and, if necessary, attempt to contact the claimant (preferably by telephone) to obtain clarifying information.

(a) If extenuating circumstances are not present and benefits are being paid for other than a schedule award, the CE should act to suspend compensation entirely since no report of either earnings or dependents (if any) will have been received.

(b) If extenuating circumstances are not present and a schedule award is being paid, only the entitlement of dependents will be at issue. The CE need not act to suspend augmented compensation if some recent communication (a letter from the claimant, or a completed Form CA-1618, for example) appears in the file showing that the claimant has at least one eligible dependent.

(c) If extenuating circumstances apply or the form is received but not substantially completed, the CE should advise the claimant of the information which is still required and indicate that, unless a fully completed affidavit is received within 30 days, benefits will be suspended.

(2) Advising the Claimant. Before effecting the suspension (whether of all compensation or of augmented compensation) the CE should send a narrative letter which explains the basis of the action and notes the regulatory authority for it. The letter should state whether a report of earnings, a report of dependents, or both are lacking and cite the date of the previous request. It should also advise the claimant that benefits will be restored retroactively once the necessary information is received as long as it supports continuing payment, and the decision should include appeal rights (see **Exhibits** 2 and 3).

(3) Fiscal Action.

(a) Benefits should be suspended effective the beginning date of the next periodic roll cycle. No deductions for health benefits (HB) and/or optional life insurance (OLI) will be made during the period of suspension.

(b) When the requested information concerning earnings and/or dependents is received, the CE should act promptly to restore benefits. Compensation should be reinstated retroactive to the date of suspension where the evidence submitted supports the payment of benefits.

c. Forfeiture. Section 8106(b) of the FECA provides that compensation may be forfeited for failure to report earnings.

(1) Circumstances under which Forfeiture may be Applied.

(a) Although section 8106 refers to "partially disabled" claimants, the ECAB has held that the forfeiture provision also applies to claimants receiving compensation for total disability.

(b) If the employee knowingly omits or understates earnings, compensation will be declared forfeit for the period covered by the requested report. Also, forfeiture may be declared for failure to report self-employment if a value could be placed on the work performed in the open labor market and the evidence establishes that the claimant was aware or reasonably should have been aware of the requirement to report such employment.

(c) For an omission or understatement to be considered "knowingly" made, the file must contain positive evidence such as a statement from the claimant that he or she had no earnings or a statement indicating earnings less than the amount actually earned according to other sources. To determine whether the claimant reasonably should have known that the earnings or employment activity should have been reported to the Office, the circumstances of the case should be carefully evaluated with respect to the claimant's age, education level and familiarity with the reporting requirements, as well as the nature of the employment/earnings involved and any other relevant factors.

(d) If it is determined that the omission or failure was not knowingly made, the claimant's compensation entitlement during the period of the employment should be determined on the basis of his or her actual earnings in accordance with the procedures set forth in FECA PM 2-813. If the claimant simply fails to make a report, benefits are suspended as described in paragraph b above.

(e) Forfeiture may not be declared for failure to provide reports of dependents since this penalty applies only to reports of earnings.

Also, criminal prosecution may result if deliberate falsehood is employed in providing answers.

(2) Advising the Claimant. When the evidence shows that the claimant had earnings and knowingly did not show them on Form CA-1032, the CE should

prepare a formal decision declaring the compensation forfeit and an overpayment. The period of forfeiture is as follows:

(a) If Form CA-1032 was issued, the forfeiture applies to the entire period covered by the form (fifteen months, or the period since the last report of earnings, whichever is less). The entire period is forfeit even if the claimant had unreported earnings for only part of the period.

(b) If a CA-1032 was not issued for the period during which the claimant worked, but the claimant had earnings while receiving compensation, the period of forfeiture is limited to the period that the claimant actually worked and did not report earnings (see Jack Langley, 34 ECAB 1077).

Form CA-2201 should be released with the formal decision, since the claimant has failed to furnish information which he or she should have known to be material and is considered to be with fault.

(c) Prior to declaring the forfeiture, the CE must take action on the entitlement issue. If injury-related disability does not continue, a notice of proposed termination should be issued simultaneously with the forfeiture decision.

If injury-related disability is established, the CE should determine the claimant's wage-earning capacity, based on either actual earnings or a constructed LWEC rating, and reduce benefits accordingly. Under no circumstance should any forfeiture decision be released until the entitlement issue is fully resolved.

If for some reason the entitlement issue cannot be addressed in a timely manner (e.g., as a result of investigation and/or litigation) the CE should consult with the District Director (DD) as to how to proceed. Such cases should be tracked and monthly status reports should be provided to the DD until the entitlement issue is resolved. In these cases and any other which has been requested by the Branch of Hearings and Review or the ECAB, the Office should photocopy the file, refer the original to the appellate body, and proceed with the entitlement issue while the case is on appeal for the forfeiture issue.

(3) Fiscal Actions. Compensation should be terminated retroactive to the beginning of the pertinent reporting period. After due process requirements have been satisfied, the Office should recover the forfeited amount in the same manner as any other kind of overpayment.

(4) Later reports of Earnings. The CE should send Form CA-1032 to the claimant annually with a reminder that any compensation used to recover an established overpayment is itself subject to forfeiture should the claimant again knowingly fail to properly complete Form CA-1032.

2-0812-12 Federal Employees' Group Life Insurance (FEGLI)

12. Federal Employees' Group Life Insurance (FEGLI). Section 5 U.S.C. 8706(c) provides that a claimant's FEGLI coverage may continue if he or she is receiving compensation when the coverage would otherwise cease. However, once separated from the employing agency, the "Five Year/First Opportunity" rule must be met by the employee in order to have FEGLI coverage continued. Claimants also retain the right to elect continued life insurance coverage beyond age 65. The district office will only make deductions for coverage beyond age 65 upon notification by the Office of Personnel Management (OPM) that the claimant has elected to continue coverage. OPM sometimes requires OWCP to certify the periods that compensation is paid and the claimant's inability to return to duty.

a. Return to Duty. The term "return to duty" as used in 5 U.S.C. 8706(c) means return to the work performed at the time of injury. The back of Form RI 20-8 should be completed for all periods the claimant received compensation for total disability or loss of wage-earning capacity becuase the claimant must have been unable to "return to duty" to qualify for compensation on either of these bases. (Note: OPM completes the front of Form RE 20-8.) With schedule awards, however, inability to return to duty is not a condition of receiving compensation. Therefore, it must be determined whether the claimant is or was unable to "return to duty" during the period of the schedule award. The file should contain the following:

(1) Medical evidence showing the physical restrictions caused by the impairment in terms of standing, walking, bending, lifting, hours of duty, etc., and a competent opinion showing whether the impairment would bar the claimant from returning to the work performed at the time of the injury. If this information does not already appear, the CE should ask the attending physician to submit a report providing it.

(2) The position description and a statement from the employing agency showing the physical requirements of the job if they are not already in the record.

Once all needed information has been received, the CE should compare the requirements of the job to the medical evidence, asking the District Medical Adviser to supply an opinion if necessary. The CE should then prepare a recommendation to the SCE as to whether the claimant could perform the job held at the time of injury. The determination must be made by the SCE or higher authority; it may not be delegated to anyone subordinate to the SCE.

b. Completion of Form RI 20-8. If certification by OWCP is necessary, OPM will forward Form RI 20-8 with the front of the form already completed. The CE completes the back of the form beginning with item 1, the "OWCP claim number."

(1) Item 2 - - Is an application pending? Complete this item if the individual appllying for OPM benefits has filed a claim with the Office but it has not yet been adjudicated.

(2) Item 3 - - Receipt of OWCP Benefit. Complete this item if the claimant has received or is receiving compensation for disability within the last two years.

(3) Item 4a - - Health Benefits Premiums Withheld. If premiums were withheld then list the period of withholding.

(4) Items 4b & 4c - - Transfer of Health Benefits. If the answer to 4b is yes, then complete 4c by providing the name and address of the agency where the HBI information was transferred.

(5) Item 5 - - Basic and Optional Life Insurance. The CE should complete this item if the claimant had life insurance withheld from compensation payments.

(6) Item 6a - - Possible Third Party Settlement. If the answer is yes, then provide the "Commencing" and "Ending" dates of the third party credit. Item 6b should also be answered.

(7) Item 7 - - Last Known Address for Deceased Claimant. This item should be completed if OPM is inquiring about a deceased claimant.

(8) Item 9 - - Certification. The CE should print and sign his or her name. The CE should also provide a phone number for OPM and date the form.

2-0812 Exhibit 1: Sample Questions

SOLE PROPRIETORSHIP

1. Give the name and address of the business and state in whose name the business is operated. Who has been held out as the owner?

2. Who manages the business? In what way, if any, is this person related to you?

3. Did that person work in a similar business before this business was started? If not, how did that person acquire the necessary skills?

4. Describe the exact duties you performed since the business was established. At a minimum, describe activities in bookkeeping and accounting; advertising; purchasing merchandise, equipment and supplies; setting prices and hours of operation; sales; and personnel actions such as hiring, firing, rates of pay and promotions. For all areas where you indicate that you perform no duties, explain who performs these functions and give their names and addresses. If no one has assumed these duties, how are they being handled?

5. Who is billed by suppliers and who actually pays for the merchandise? To whom do other creditors presently look for payment of bills?

6. Provide the names and addresses of three suppliers and three clients.

7. What income have you secured from the business since its establishment?

8. Who has authority to write checks and draw from the business bank account? If you have the right to sign checks, explain. Provide the name and address of the financial institution, proof of current signature authority, and the date it became effective.

9. What tax permits, business licenses, etc., does the business hold? In what name or names were they issued? Provide copies of the certificates.

10. If the business had employees at any time, does it have an employer's identification number (EIN)? In whose name has application been made for an EIN? If this was not done, explain.

11. If the business premises were leased, who holds the lease and pays the rent? What is the name and address of the landlord?

12. Who paid the business insurance premiums? Whose name is on the policies? Provide evidence.

13. Provide tax returns for all years in which you have been entitled to or are claiming FECA benefits, and for one year prior.

PARTNERSHIP INTEREST

1. In whose name is the business operated? Who are the partners? Which individuals have been held out as active partners? What is the distributive share of the partnership of each partner? Provide the names and addresses of each partner.

2. Provide a copy of the partnership agreement.

3. What are the duties of each partner? List hours per month spent by each. Include references to bookkeeping and accounting; purchasing merchandise and supplies; setting prices and hours of operation; sales; and personnel actions such as hiring, firing, rates of pay and promotions.

4. How did the active partners gain the skills needed to perform these services? Are there other employees? Provide the names and addresses of three of these individuals.

5. What income have you received from the partnership?

6. Who is billed by suppliers and who actually pays for the merchandise? To whom do other creditors look for payment of bills?

7. Provide the names and addresses of three suppliers and three clients.

8. If there is a business bank account, in whose name is it held? Who can withdraw from the account? If you have the right to sign checks, is this on your own authority, or on the authority of the other partner(s)? Give the name address of the financial institution and provide proof of who has access to the account and on what date the access became effective.

9. What tax permits, business licenses, etc., does the business have? In whose name were these issued? Has an assumed name certificate been issued? If no, why not? Provide copies of documents currently in force.

10. If the business has had employees at any time, has it received an employer's identification number (EIN)? Which partner(s) applied for it?

11. If the business premises are leased, who signed the lease? Provide documentation.

12. If the business carries insurance, whose name is on the policies? Provide documentation. Who is liable for payment of premiums?

13. Provide partnership tax returns for all years in which you have either been entitled to or are claiming benefits under the Federal Employees' Compensation Act, and for one year prior.

CORPORATE OFFICERS

1. Provide the name, address and telephone number of the corporation and the date of incorporation.

2. Describe the type of business.

3. What was the business structure prior to incorporation?

4. Give the names, addresses, salaries and personal relationships to you (if any) of all corporate officers.

5. Who determined the salaries for the corporate officers? Explain fully.

6. Does the corporation have a board of directors? If so, give the names, addresses, directors' fees and personal relationship to you (if any) of all board members.

7. Who are the major stockholders?

8. Who is authorized at the company's financial institution to sign checks for the business? Provide the name and address of the institution and proof of who has signature authority for company checks.

9. How many people were hired to work in the business? Give the names and addressees of three of these individuals.

10. Were people hired to replace you in the business? If so, give their names and addresses and their relationship (if any) to you.

11. Explain in detail the nature of your services in the business. At a minimum, describe activities in bookkeeping and accounting; advertising; purchasing merchandise, equipment and supplies; setting prices and hours of operation; sales; and personnel actions such as hiring, firing, rates of pay and promotions. For all areas where you indicate that you have performed no duties, explain who performs these functions and give their names and addresses. If no one has assumed these duties, how are they being handed?

12. Provide the names and addresses of three suppliers and three clients.

13. How many hours per month do you now spend in any of the activities described above? How many hours per month did you previously work? On what date did this situation change?

14. If you were previously self-employed (as a sole proprietor), what were your gross and net earnings in the year prior to incorporation? Provide IRS Forms 1040, Schedule F or C and Schedule SE for that year.

15. If the business existed while you were waiting for benefits under the Federal Employees' Compensation Act (FECA) to begin, and you waived your salary, how did you meet your living expenses?

16. What monies do you derive from the corporation? List separately by amount and date received monies representing dividends, rents, loan repayments, wages, reimbursement of personal expenses, and use of a company vehicle.

17. What was your personal reason for incorporating?

18. If your spouse or child (as applicable) was not previously employed in this or a similar business, when, where, and how did he or she gain the expertise to run the corporation?

19. Has corporate profit been distributed in any year since the date of incorporation? If not, why not?

20. Submit Articles of Incorporation, copies of the minutes of the corporate officers, and corporate tax returns for all years in which the business was incorporated and you have been entitled to or are claiming benefits under the FECA, as well as copies of all W-2 forms attached to your personal return. Provide returns for those years, and for one year prior.

2-0812 Exhibit 2: Sample Letter Where No Report of Earnings Is Received

Dear CLAIMANT NAME:

I am writing in reference to the compensation benefits you receive from the Office of Workers' Compensation Programs (OWCP).

Section 10.125(a) of the OWCP's regulations requires the claimant to report earnings from any employment, whether full or part time. If timely response is not made, the right to compensation for wage loss is suspended until the report is received, at which time compensation will be restored retroactively. If the claimant omits or understates earnings, compensation will be declared forfeit for the period involved. Moreover, criminal prosecution may result if the claimant deliberately provides false information.

On DATE, Form CA-1032 was sent to you for completion. No reply has been received, and your benefits have therefore been suspended as of DATE. If you complete and return the enclosed copy of Form CA-1032, your compensation benefits will be restored retroactively to the date they were suspended as long as the information submitted supports continuing payment.

This is a formal decision, and your appeal rights are attached.

Sincerely,

SENIOR CLAIMS EXAMINER

2-0812 Exhibit 3: Sample Letter Where No Report of Dependents Is Received

Dear CLAIMANT NAME:

I am writing in reference to the compensation benefits you receive from the Office of Workers' Compensation Programs (OWCP).

You have been receiving augmented compensation (that is, the difference between 2/3 and 3/4 of the weekly pay which is payable to a claimant who has at least one dependent). Section 10.107(c) of OWCP's regulations state that entitlement to augmented compensation may be suspended if the OWCP does not receive a timely response to a request for information concerning eligible dependents. If the requested information is later received, the augmented compensation is reinstated retroactively to the date of suspension, as long as the evidence submitted supports the payment of augmented compensation.

On DATE, Form CA-1032 was sent to you for completion. No reply has been received, and augmented compensation has therefore been suspended as of DATE for [your wife, your husband and children, or name of child, as appropriate]. If you complete and return the enclosed copy of Form CA-1032, the augmented compensation will be restored retroactively to the date it was suspended, as long as the information provided shows that you are entitled to the payment.

This is a formal decision, and your appeal rights are attached.

Sincerely,

SENIOR CLAIMS EXAMINER

2-0812 Exhibit 4 Signature Authority (Approvals/Denials/Certification)

General GS-12 CEs

* Traumatic Injury Claims
* Occupational Disease Claims
* Most Complex Disability and Death Cases
* Medical Treatment, Equipment, Supplies
* Surgery Requests
* Recurrences
* Non-Rateable Hearing Loss
* COP
* Intermittent Wage Loss
* Payment Certification ($0-$14,000; including signature on CA-181 when certifying payment within prescribed limit) Note: Lump sum schedule award calculations must also be approved by a SCE.
* 0% LWECs

SENIOR CLAIMS EXAMINERS

* All items listed under General GS-12 CE
* All Complex Disability and Death Claims (approval/denial)
* Proposed Terminations & Final Terminations
* Proposed REductions & Final Reductions
* LWEC Modifications
* 8106c Decisions; Rehabilitation Sanction Decisions
* Disallowance of Disfigurement Awards
* Suspension or Forfeiture of Benefits
* Rescission of acceptance
* Housing or Vehicle Modifications
* Reconsiderations
* Certification of Placement on the PR for TTD, LWEC or survivor benefits. Certification of OPM/VA Election Letters
* Certification authority $0-$50,000

SUPERVISORY CLAIMS EXAMINER OR HIGHER LEVEL

* Payments in amounts greater than $50,000 must be verified/signed by a Supervisory Claims Examiner (SCE), GS-13 or higher level. This authority may be delegated to a SrCE in writing for a specific period of time, for example while serving as acting SCE. The SrCE should reflect such authorization in the case file by signing the payment as 'Acting SCE'.
* SCE - Attorney Fees ($0-$50,000)
* DD or ADD - Attorney Fees > $50,000

2-0812 Exhibit 5 PRMS Action Codes

PRMS ACTION CODES

Resolution Codes

Reduction of compensation:

R1	Constructed LWEC
R2	RTW with LWEC
R3	S/A expired with LWEC

Suspension of compensation:

S2	Suspension 5 USC 8123
S3	Suspension 5 USC 8113
PT	Pre-term sent
EO	Elected OPM

Termination of compensation:

T1	Terminated, no continuing IRD
T2	RTW, no LWEC
T3	S/A expired, intervention, no LWEC
T4	Refused suitable work
T5	Death of claimant
T6	Elected OPM with no periodic Schedule Award payments
T7	Terminated, fraud conviction

Case reviewed, no change:

CR	No change in entitlement after review

Necessary code, not counted as resolution:

S1	Suspension, no 1032
R4	Reduction, during incarceration

Optional Codes

IR	Initial Review Done
MN	Narrative Requested
MR	Narrative Received
SE	SECOP scheduled
RF	Referee scheduled
VR	Referred for rehab
JO	Job offer made
PR	Pre-reduction sent

due to a felony conviction
TO S/A expired, no intervention, no LWEC
RO Recurrence, Case to QCM

2-0813 REEMPLOYMENT: VOCATIONAL REHABILITATION SERVICES

Paragraph	Subject	Date	Trans. No.
	Table of Contents	11/96	97-03
1	Purpose and Scope	12/93	94-05
2	Introduction	12/93	94-05
3	Policy		
4	Restoration Rights with the Federal Government	08/95	95-31
5	Referrals for Vocational Rehabilitation Services	12/93	94-05
		11/96	97-03
6	Kinds of Services Provided	12/93	94-05
		11/96	97-03
7	Communication Among the CE, the RS, the RC, and the Claimant	12/93	94-05
8	Compensation Entitlement During Vocational Rehabilitation	12/93	94-05
		09/95	95-36
9	Assisted Reemployment	12/93	94-05
		02/96	96-11
10	Effects of Substance Abuse	12/93	94-05
11	Failure to Cooperate in Vocational Rehabilitation Efforts	12/93	94-05
		11/96	97-03
12	Sanction Decisions	12/93	94-05
		11/96	97-03
13	Occupational Rehabilitation Programs	11/96	97-03

Exhibits

1	Sample Letter to Claimant Who is Authorized Medical Care for Substance Abuse	12/93	94-05
2	Non-Cooperation with Vocational Rehabilitation Efforts (Link to Image)	12/93	94-05
3	Sample Letter to Claimant --Refusal to Participate in Training	12/93	94-05
4	Sample Letter to Claimant --Refusal to Participate in Placement	12/93	94-05

2-0813-1 Purpose and Scope

1. Purpose and Scope. This chapter explains the procedures for referring partially disabled claimants for vocational rehabilitation services and describes the services which may be provided. (A fuller discussion of services may be found in OWCP PM Part 3, Rehabilitation, Chapter 3-200). This chapter also addresses related topics such as restoration rights with the Federal government and the effects of substance abuse on the vocational rehabilitation effort. Finally, procedures for reducing monetary compensation for failure to apply for and undergo vocational rehabilitation are explained.

2-0813-2 Introduction

2. Introduction. The Office of Workers' Compensation Programs (OWCP) emphasizes returning partially disabled workers to suitable employment through vocational rehabilitation efforts, and determining the worker's wage-earning capacity on the basis of that employment (see PM Chapter 2-814).

When it appears that the claimant's work-related injury will prevent return to the job held at injury, vocational rehabilitation services are provided to assist the claimant in returning to suitable work. The Federal Employees' Compensation Act (FECA) provides for the imposition of certain penalties against workers who refuse vocational rehabilitation services.

2-0813-3 Policy

3. Policy. OWCP will make every reasonable effort to arrange for employment of a partially disabled claimant, taking into consideration not only the effects of the injury-related condition and any condition(s) pre-existing the injury, but also any medical condition(s) arising

after the compensable injury. Such efforts will be directed initially to the employing agency. Where reemployment with the employing agency is not possible, OWCP will help the claimant secure work with a new employer. OWCP will also sponsor vocational training if needed to furnish the claimant with necessary skills.

2-0813-4 Restoration Rights with the Federal Government

4. Restoration Rights with the Federal Government. Section 8151 of the FECA provides job retention rights to Federal employees who have recovered either fully or partially from an employment-related injury or illness, and who can perform the duties of the original job or its equivalent. The employing agency must restore a permanent employee (i.e., one with career or career-conditional status) who recovers within one year after beginning compensation to that position or its equivalent. This provision does not apply to temporary or term employees.

If recovery occurs after one year, the employee is entitled to priority consideration, provided the employee applies within 30 days of the date compensation ceases. Such claimants are assured that upon their return to Federal employment, they will incur no loss of benefits which they would have received but for the injury or disease. The Office of Personnel Management (OPM) is primarily responsible for enforcing this section.

a. OPM's regulations on retention rights are published at 5 C.F.R. 302, 330 and 353. They require agencies to grant leave without pay (LWOP) to disabled employees for at least the first year the employee is receiving compensation, with extensions in increments of six months or a year.

b. A claimant who has been terminated and who wishes to reclaim his or her job should be advised to contact the employing agency. If this effort fails, OWCP will contact the employing agency, citing 5 U.S.C. 8151 as the basis of the claimant's attempt to regain employment. If this course is also unsuccessful, the claimant may be advised to exercise his or her appeal rights as provided by OPM.

c. When an injured employee resumes employment with the Federal government, the employing agency is required to verify that the employee had been receiving compensation during the entire period of absence from work, whether in LWOP status or separated. The agency will ask OWCP to advise whether the employee was receiving compensation and, if so, the period compensation was paid, so that the employee may be credited with all rights and benefits based on length of service.

d. Other issues pertaining to retention rights should be referred to the employing agency or OPM.

2-0813-5 Referrals for Vocational Rehabilitation Services

5. Referrals for Vocational Rehabilitation Services. The probability of effective rehabilitation, resulting in the best return to work arrangement, is greatly increased when such efforts begin as early as possible in the recovery process.

a. The Claims Examiner (CE) will monitor cases for currency and adequacy of medical reports. If the medical evidence does not provide a return to work date, the CE will telephone the attending physician to obtain it, or will ask the Staff Nurse (SN) to do so. Where a return to work date cannot be given, but the medical evidence shows that the claimant is not totally disabled and the medical condition has stabilized, the CE or RN will obtain a completed Form OWCP-5 to show the work limitations. If the attending physician cannot furnish work limitations, or if they appear inconsistent with those expected, the CE should arrange a second opinion referral (see FECA PM 2-810).

b. The CE will ensure that the file contains the claimant's position description, including a report of the physical and any special psychological requirements of the job held at date of injury. This information would have been requested by Form CA-1656, released to the employing agency at the time of the first compensation payment.

c. The case will be referred to the Rehabilitation Specialist (RS) if the claimant has stable, well-defined work limitations which allow him or her to work eight hours per day, and the claimant has not been rated for loss of wage-earning capacity (LWEC). (A limited referral may be made for placement services with the previous employer when the claimant can work at least four hours per day and the previous employer may be able to offer a modified job. The CE should note on Form OWCP-14 that the referral is limited to placement with the previous employer.)

(1) The RN may recommend such referral at the end of RN services, and such a referral may be desirable if the claimant has declined nursing services or has not cooperated with the RN.

(2) For claimants who cannot work eight hours per day, the CE must attempt to establish the claimant's ability to work a full day by one or more of the following: referral for an Occupational Rehabilitation Program (ORP), monitoring the attending physician's reports until the physician can release the claimant to work an eight-hour day, or second opinion evaluation.

(3) An ORP is also appropriate when the specific work limitations are unknown. The CE may refer the claimant to the RS for an ORP when:

(a) Intervention by the FN has ended but the claimant has moderate to severe physical limitations or deconditioning, or has not had an assessment of physical limitations, and has not returned to work; or

(b) A health care provider has recommended rehabilitation or an ORP, unless the claimant has already returned to full-time regular duty.

(4) Only if the CE has taken these actions and documented them in a Memorandum to the File may he or she refer a claimant who can work less than eight hours per day for other vocational services.

(5) Cases in which rehabilitation services were previously terminated for reasons which are either unclear or no longer pertinent may be referred as long as the claimant is able to work eight hours, or the inability to do so is properly documented.

d. To identify cases for early intervention, the RS may use ADP reports which list unscreened cases on the periodic roll, or cases closed after nurse intervention with work tolerance limitations ("K" closures). The RS will use the OWCP-3 to notify the CE of cases which appear appropriate for rehabilitation services. The CE should concur absent a reason based on the medical evidence for not doing so, as long as a description of work limitations is in file.

e. To make the referral, the CE should use Form OWCP-14, noting which medical report contains the weight of the medical evidence and whether the RS or Rehabilitation Counselor (RC) may contact the attending physician (for instance, to obtain more complete work limitations. However, the CE should not authorize the RC to contact the attending physician when work tolerance limitations have been established by a second opinion or referee examiner.)

2-0813-6 Kinds of Services Provided

6. Kinds of Services Provided. While the RS provides some vocational rehabilitation services, he or she more usually directs the efforts of an RC assigned to the case. Following is an overview of the various stages and services in the vocational rehabilitation process. (For further information about services, see OWCP PM 3-300 and 3-200. For the relationship of these services to making LWEC determinations, see FECA PM 2-814; for review of vocational rehabilitation plans, see FECA PM 2-600.)

a. Initial Interview. Usually the RS or an RC-Screener will interview the claimant by telephone to discuss the services available and the claimant's attempts to return to work. Cases will be closed without an interview only if:

(1) The CE-accepted medical restrictions permanently limit the claimant to less than four hours of work;

(2) The claimant has returned to work or will apparently return to work without assistance; or

(3) The file shows that the claimant is not eligible for compensation.

The RS or RC-Screener will show the reason for closure on the OWCP-3 and route the case to the CE.

b. Placement with Previous Employer. Generally, following the initial interview, the case will be opened for placement with the previous employer, and an RC will be assigned. Unlike the RN, who attempts to identify light or limited duty for the claimant, the RC will work with the agency to modify the claimant's job or identify another position within the agency which the claimant can perform. If placement with the previous employer is not feasible, the RC will usually be asked to develop an alternative plan, based on vocational testing, which may include medical rehabilitation, training, and/or placement services.

c. Medical Rehabilitation. Services needed to correct, minimize or modify an impairment caused by injury or disease so that the claimant can return to an adequate level of function and employment are grouped under the term medical rehabilitation. They differ from medical services, which are provided to cure or give relief from the effects of an injury. Medical rehabilitation services include physical, occupational, and speech therapy; orthotics; prosthetics; and psychiatric counseling. While the RS may recommend such services, the CE must authorize them.

d. Guidance and Counseling. Guidance consists of providing information to claimants about such matters as looking for work; types of occupations; preparing applications and resumes; rehabilitation services and facilities; limitations and potential created by their physical conditions, interests and abilities. Counseling focuses on clarifying alternatives with respect to occupational, financial, social and emotional issues pertaining to the vocational rehabilitation effort.

e. Vocational Testing and Work Evaluations. The goal of these activities is to evaluate the claimant's physical, mental and emotional potential for various kinds of reemployment. Testing must be performed by qualified professionals. Specific requirements must be met for approval of college training, vocational-technical training, self-employment, and placement with a new employer.

f. Vocational Training. Training is considered whenever the previous employer cannot place the claimant, and the claimant's experience and aptitude make other placement with minimal loss of earnings unlikely. It includes pre-vocational training to upgrade basic academic skills; personal adjustment training to upgrade physical or behavioral skills; formal training courses; and on-the-job training.

g. Placement with New Employer. After any necessary testing and training has been

completed, the RC will attempt to match the claimant's experience, training, aptitudes, skills, and physical abilities with the physical and mental requirements of jobs with other government agencies or private concerns. The RC will work with the claimant to identify job openings, prepare applications, and undergo interviews.

h. Follow-up Services. The RC will follow a reemployed claimant for two months to ensure that the placement is viable and to identify any potential barriers to continued employment.

2-0813-7 Communication Among the CE, the RS, the RC and the Claimant

7. Communication Among the CE, the RS, the RC, and the Claimant.

a. The CE should receive periodic reports from the RS on Form OWCP-3 whenever the status of the case changes or a significant event occurs. While a vocational rehabilitation program may take several months or more than a year, counselors are required to report monthly or bimonthly, and the CE should request a status report by sending an OWCP-14 or short memo whenever the rehabilitation process requires an amount of time for completion that exceeds the time frames set forth in FECA PM Chapter 2-600 and OWCP PM Chapter 3-400.

b. The work tolerance limitations identified by the CE to the RS may change during the vocational rehabilitation effort, and if this happens the CE should advise the RS of the change as soon as possible. Under certain circumstances the RC may contact the claimant's physician and discuss the work limitations, a situation which may result in their modification by the physician. If the physician recommends more strict work limitations, the RC should submit these work limitations to the CE through the RS. It is the CE and not the RS or RC who establishes the accepted work limitations.

c. The CE should also notify the RS by short memo or OWCP-14 of any change in case status, such as the termination or suspension of compensation, or any information in the record which may directly affect the rehabilitation effort (e.g., a documented history of noncooperation).

d. Inquiries from Claimants. Claimants will sometimes query the RS or the RC about matters in the domain of the CE, such as compensation entitlement or medical authorization. Similarly, the CE may receive inquiries about vocational rehabilitation matters. Both rehabilitation and claims personnel are responsible for referring the claimant to the proper individual when issues arise which are not in the domain of the party addressed. No attempt should be made to address questions outside one's own area of expertise and responsibility.

2-0813-8 Compensation Entitlement During Vocational Rehabilitation

8. Compensation Entitlement During Vocational Rehabilitation.

a. Section 8104(b) of the FECA provides that an individual undergoing an OWCP-approved rehabilitation program is entitled to receive compensation at the rate for total disability, less any earnings received from employment which is not undertaken as a specific part of the rehabilitation program. The RS will advise the CE via Form OWCP-3 of the dates when the claimant is actually enrolled in a vocational rehabilitation program and thus entitled to compensation at the rate for total disability.

b. If the claimant is receiving a schedule award, such payments should continue unless the claimant is also receiving an annuity from the Office of Personnel Management (OPM), in which case the claimant should be advised that he or she cannot be provided with vocational rehabilitation services while receiving an annuity from OPM (see FECA PM 2-808.7a(5) and FECA PM 2-1000.6c). The claimant should be offered an election, and if he or she elects OWCP benefits, the schedule award payments should be converted to payments for temporary total wage loss until completion of the rehabilitation effort. If the claimant elects OPM benefits, the schedule award benefits should continue and medical and factual development should be undertaken to determine claimant's LWEC at the end of the schedule award, but vocational rehabilitation efforts should be terminated.

2-0813-9 Assisted Reemployment

9. Assisted Reemployment. Disabled Federal workers with skills transferable to jobs within the general labor market may prove difficult to place due to economic factors in both the Federal and private employment sectors. Assisted Reemployment is a project designed to increase the number of permanently disabled employees who successfully return to the labor force even though they could not be placed with their former employers.

a. General Provisions.

(1) Assisted Reemployment will allow for three years of partial reimbursement of salaries to employers, other than the original employer, who reemploy disabled FECA beneficiaries. The project allows reimbursement on a quarterly basis to the new employer of salary paid to the claimant up to 75% the first year, up to 50% the second year, and up to 25% the third and final year.

However, other rates of reimbursement may be applied, subject to approval by the National Office.

(2) These wage subsidies to the employer plus the LWEC payment to the claimant shall never exceed the amount of compensation which would be paid to the claimant in the absence of employment. Similarly, if basic compensation is being paid, i.e., the claimant has no dependents, the subsidy rate may not exceed 66 $^{2/3}$ percent.

(3) Should compensation be terminated (e.g., because work-related disability ceases), wage subsidies to the employer should also be discontinued.

b. Identifying Candidates. An Assisted Reemployment wage subsidy may be appropriate when the claimant has significant transferable skills but has not been placed because of the difficult job market in that specialty, or because of the severity of the disability even though the job is suitable.

(1) The RS and the RC will make most of the selections for this program.

(2) In evaluating cases for return to work potential, the CE may also identify claimants as candidates for Assisted Reemployment.

c. Action by RS and RC. The RS and the RC will consider jobs which correspond to the claimant's educational background and employment history. The RS will ensure that the employment under consideration conforms with the medical limitations imposed by the residuals of the work injury and any pre-existing conditions. Once this is accomplished, the RS will instruct the RC to propose a wage subsidy to a qualified employer as an incentive to make a bona fide job offer to the claimant.

d. Cooperative Agreement. The title of the job, the job duties, the salary to be paid, and the wage subsidy rate will all be specified in a cooperative agreement. The District Director must approve the cooperative agreement between the OWCP and the new employer. The employer's representative will also sign the cooperative agreement.

e. Concurrence of CE. The CE must concur, in the form of a memorandum, with the cooperative agreement. The CE should attach the memorandum of concurrence to the cooperative agreement and forward it to the District Director for approval after ensuring that the job offer:

(1) Is in writing;

(2) Conforms to the claimant's work limitations and is suitable within the meaning of Section 8106 (c); and

(3) Supports an LWEC rating, i.e., the earnings must fairly and reasonably represent the claimant's wage-earning capacity.

f. Payment of Compensation.

(1) To eliminate the possibility of an overpayment, the CE should remove the case from the periodic roll as soon as the beginning date of work is known.

(2) Any additional entitlement to compensation on the basis of temporary total disability (TTD) should be paid on the daily roll until the employment commences.

(3) The CE will be required to set the formal LWEC in place (including formal findings of no loss in wage-earning capacity) once the claimant has been working for 60 days. If the claimant is entitled to compensation on the basis of an LWEC after returning to employment, the CE should set up payment on the daily roll using the Shadrick formula until the claimant has worked in the job for 60 days.

g. Reimbursement. For Federal agencies which process payments through the U.S. Treasury, the GOALS/OPAC system will be used for reimbursement. Checks will be issued through the Bill Payment System (BPS) to the new employers of the private sector, state and local governments, and Federal agencies that do not process payments through the U.S. Treasury. See PM Chapter 5-202.30 for more information concerning reimbursement.

2-0813-10 Effects of Substance Abuse

10. Effects of Substance Abuse. Inappropriate use of drugs, whether legal or illegal, may complicate recovery from other medical conditions and hinder return to work. Substance abuse may come to light from medical reports, contacts with the RN, RS or RC, or through direct communication with the claimant. Actions to be taken when such use is identified are as follows, regardless of whether the Office has accepted it as work-related.

a. Treatment. Where substance abuse or addiction prevents a claimant from entering a vocational rehabilitation program, continuing with such a program once it has begun, or returning to work, the RC or RS may recommend participation in a drug treatment plan. The CE (not the RS or RC) is responsible for authorizing such care where necessary based on the medical evidence of record (that is, the recommendation of the attending physician).

(1) Ordinarily, inpatient care will be limited to a one-time 28-day stay at a reputable facility, though in unusual circumstances additional inpatient care may be authorized (see FECA PM 3-400.5). The facility selected should be within 25 miles of the claimant's residence wherever feasible, and where inpatient care is recommended, costs of at least two facilities should be compared before care is

authorized.

(2) Outpatient treatment may be recommended by itself or as a follow-up measure to inpatient care. Such treatment may be authorized when recommended by the attending physician, as may medications prescribed to alleviate the effects of addiction (e.g., Antabuse). Likewise, counseling in a group setting may be undertaken at OWCP expense.

b. Effect on Vocational Rehabilitation. The CE, or the SN on request of the CE, should advise the claimant of the terms of the referral before treatment begins. In particular, the claimant should be notified that non-completion of the program, or continued abuse of the substance after the treatment ends will result in suspension of compensation benefits under 5 U.S.C. 8113 at the salary level of the job which is the goal of the training. The suspension of benefits will continue until the claimant reenters a program and/or discontinues use of the substance. (See Exhibit 1 for a sample letter).

If the effort is not successful, the claimant's LWEC should be determined in accordance with paragraphs 11 and 12 of this chapter, according to the claimant's status in the vocational rehabilitation process.

2-0813-11 Failure to Cooperate in Vocational Rehabilitation Efforts

11. Failure to Cooperate in Vocational Rehabilitation Efforts. A claimant may fail to cooperate with vocational rehabilitation efforts in various ways. General examples of noncooperation include lack of response to letters or phone calls from the RS or RC and repeated failure to keep appointments or interviews arranged by the RC. Specific examples of noncooperation in the various stages of the vocational rehabilitation process are described below.

The RS will advise the CE of noncooperation which occurs during the initial interview, while the RC will document in progress reports submitted to the RS any instances where the claimant fails to communicate or cooperate with the RC or refuses to participate or make a good faith effort. The RS will then provide the CE with a Form OWCP-3 that details the claimant's non-cooperation or non-participation.

When a claimant refuses or impedes rehabilitation efforts, the CE must intervene. The intervention differs depending on whether the refusal or impedance occurs during the early stages of the vocational rehabilitation effort, during training, or during placement efforts. The CE should take the following actions according to the specific problem, as outlined below and in the flow chart shown as Exhibit 2 (Link to Image).

a. Refusing or Impeding Early Vocational Rehabilitation Efforts. Specific instances of non-cooperation include failure to appear for the initial interview, counseling sessions,

a functional capacity evaluation (FCE), other interviews conducted by the RC, vocational testing sessions, and work evaluations, as well as lack of response or inappropriate response to directions in a testing session after several attempts at instruction. They also include failure to begin or continue pre-vocational training such as English lessons for those who lack command of the language, or classes for a General Equivalency Diploma (GED) for those without a high school education.

(1) If the claimant refuses or impedes the early steps of vocational rehabilitation, the CE should release Form Letter CA-1657 (or equivalent) to the claimant, advising that failure to cooperate with the vocational rehabilitation effort will result in a reduction of monetary compensation benefits to zero, based on the assumption that the vocational rehabilitation effort would have resulted in a return to work with no LWEC (in the absence of any evidence to the contrary). The claimant should be instructed to begin or resume a good faith effort to cooperate with the RS, or show good cause for refusing within 30 days.

(2) Release of Form Letter CA-1657 (or equivalent) satisfies the requirement to provide a 30-day pre-reduction notice. If no response is received, or if the claimant does not begin or resume a good faith effort, compensation will be reduced to zero under 5 U.S.C. 8113(b) and 20 C.F.R. §10.124(f), which states in part that "It will be assumed...in the absence of evidence to the contrary, that the vocational rehabilitation effort would have resulted in a return to work with no loss of wage-earning capacity...."

In Linda M. McCormick, 44 ECAB 958, the Board addressed the claimant's failure to participate in the early stages of vocational rehabilitation. The Board held that in the absence of "probative, rationalized medical evidence which explains why with vocational rehabilitation appellant could not return [to] some work activities", the Office properly reduced the claimant's compensation to zero. This is the correct course of action unless the file contains convincing *prima facie* medical evidence establishing that the claimant cannot return to full-time work when the non-cooperation occurs.

(3) When compensation is reduced to zero, contributions for the claimant's health benefits (HB) and optional life insurance (OLI) premiums will stop. HB coverage should be terminated by completion of a Form SF-2810. The HB enrollment should be retained in the case file and not transferred to OPM or to the employing agency unless they request it.

(4) If the claimant later complies with the Office's direction to undergo vocational rehabilitation after a formal decision has been issued reducing compensation under Section 8113(b), compensation should be reinstated prospectively at the previous rate. HB/OLI coverage is to be reinstated

retroactively to the date of termination and the premiums due for the period of reduction should be deducted from the continuing compensation beginning with the date of reinstatement.

The effective date of reinstatement of the previous rate of compensation should be the date the claimant indicates in writing his or her intent to comply, as long as actual compliance is confirmed by the RS or RC. Compliance is shown by actions such as undergoing interviews or testing.

(5) If the claimant elects OPM benefits in lieu of cooperating with rehabilitation efforts, the CE, RS and RC should not delay or discourage this choice. If the claimant elects benefits from OPM in lieu of complying with the Office's instructions, the final decision reducing compensation to zero must still be issued.

b. Refusing or Impeding OWCP-Approved Training Program. Examples of such situations would include a claimant's failure to attend classes or to apply appropriate effort to succeed in such classes or failure to undergo training after a training program has been approved.

(1) The CE should release a letter advising the claimant of the provisions of 5 U.S.C. 8113(b) and direct the claimant to apply for, participate in, or resume participation in the program. The claimant should be directed to comply or provide a written explanation of failure to comply within 30 days or the provisions of Section 8113(b) will be applied (see Exhibit 3). Release of this letter satisfies the requirement to provide pre-reduction notice.

(2) To reduce compensation in this situation under the provisions of Section 8113(b), the Office must direct the claimant to apply for or undergo the training, find that the claimant's failure was without good cause, and find that cooperation with the training would probably have substantially increased the claimant's earnings.

If these criteria are met, the CE should act to reduce compensation prospectively to reflect the claimant's earning capacity (that is, the salary level of the job which was the goal of training, as specified in the vocational rehabilitation plan), and issue a formal decision.

(3) If the claimant later complies with the Office's direction to undergo vocational rehabilitation after a formal decision has been issued reducing compensation under Section 8113(b), compensation should be reinstated prospectively at the previous rate. The effective date of reinstatement of the previous rate of compensation should be the date the claimant indicates in writing his or her intent to comply, as long as actual compliance is confirmed by the RS

or RC. Compliance is shown by actions such as attending school on a regular basis.

(4) If the claimant elects OPM benefits in lieu of cooperating with rehabilitation efforts, the CE, RS and RC should not delay or discourage this choice. Because the claimant may subsequently elect FECA benefits retroactively, however, it is necessary to establish the level of compensation entitlement in accordance with 5 U.S.C. 8113 so that any future retroactive compensation will not be paid in error at the rate for total disability due to failure to follow through on the current sanction action.

c. Refusing or Impeding Placement Effort. When placement efforts with a new employer are to be made, the CE should advise the claimant that OWCP will provide 90 days of placement assistance and that his or her LWEC probably will be based on the job for which placement is being attempted. (The 90 days is calculated from the date of the OWCP-3 approving placement with new employer.)

(1) If the claimant does not participate or cooperate in placement activities, or ceases participation once they have begun, the CE may (but is not required to) issue a warning letter citing 5 U.S.C. 8113. (See Exhibit 4 for a sample letter). However, the CE should ascertain that the claimant has been advised of his or her wage-earning capacity (including the specific dollar amount) and the expectation that he or she would return to work in a job similar to the one identified (see Exhibit 2 in FECA PM Chapter 2-600). If such a letter has not been released, the claimant should be so notified.

(2) At the end of the 90-day period of entitlement to placement assistance (with a 30-day extension at the RS's discretion if the claimant is cooperating), the RC should be asked (through the RS) to submit a final report and list the jobs for which placement was being attempted which were found to be within the claimant's restrictions and abilities. This action should be taken whether or not the claimant resumes participation or cooperation in placement efforts.

The CE should then prepare a pre-reduction notice determining the claimant's wage-earning capacity prospectively under 5 U.S.C. 8115 based on one of these jobs. Such action should be taken within 30 days of receipt of the RC's final report or from the end of the 90-day period, whichever is later. After 30 days and considering any response to the pre-reduction notice, the CE should issue a final decision if appropriate.

(3) If the claimant elects OPM benefits in lieu of cooperating with rehabilitation efforts, the CE, RS and RC should not delay or discourage this choice. Because the claimant may later elect FECA benefits retroactively, however, it is necessary to establish any wage-earning capacity in accordance

with 5 U.S.C. 8115 so that any future retroactive compensation will not be paid in error at the rate for total disability.

It is improper to use the services of an RC when the claimant is receiving OPM benefits. Therefore, to confirm or identify two jobs which the claimant can perform and which are sufficiently available in the commuting area, the CE should refer the case to the RS. The jobs should be identified by number from the Dictionary of Occupational Titles (DOT), and the file should document the source of the information concerning availability. The CE should select one of these jobs on the basis of the claimant's previous education and vocational experience as reflected in the file and issue a 30-day pre-reduction notice based on the claimant's constructed LWEC.

2-0813-12 Sanction Decisions

12. Sanction Decisions. Any reduction or termination of benefits applies to compensation for wage loss, whether total or partial.

a. Evaluating Reasons for Lack of Cooperation. Given the variety of reasons which claimants may offer for non-cooperation, and the variety of circumstances in which these reasons may be offered, it is impossible to establish a definitive list of acceptable and unacceptable reasons for lack of cooperation. In general, however, the claimant is expected to treat the vocational rehabilitation effort as seriously as employment, and reasons for lack of cooperation should be considered in this light. A situation which would be considered a valid reason for absence from work (e.g., an illness) may be considered good cause for failure to cooperate with vocational rehabilitation for a reasonable period of time.

The specificity of the reasons offered and the claimant's diligence in advising the RC of the problem should also be considered in evaluating reasons offered. Moreover, the CE must consider how much the specific failure to cooperate will affect the overall success of the vocational rehabilitation effort. For example, an automobile breakdown is a less plausible excuse for missing an examination given only twice a year than for missing a testing session which can be scheduled for the following week.

b. Issuing the Decision. Application of sanctions under 5 U.S.C. 8113(b) will result in suspension or reduction of compensation unless and until the claimant demonstrates cooperation with vocational rehabilitation efforts. This is true even when the next opportunity for actual cooperation will not occur for several months and the claimant has stated that he or she will in fact comply with the Office's requirements.

The decision should be geared to the specific stage of the vocational rehabilitation process--initial, training, or placement. It should address the following:

(1) The nature of the specific failure or impedance;

(2) The contacts or dialogue among all parties, including the claimant, the RC, the RS, the CE, and the vocational entity in question (e. g., the testing facility or company where the claimant had an interview);

(3) The contents and date of the warning letter;

(4) Any reasons advanced by the claimant for failure to cooperate. Each reason should be evaluated according to the criteria discussed in paragraph 12a above;

(5) The conclusion that the claimant's failure was without good cause, and that either:

(a) The rehabilitation effort would have resulted in a return to work with no loss in wage-earning capacity (early stages); or

(b) Cooperation with the training would probably have substantially increased the claimant's earnings (training and placement phases).

The case status should remain PR, even if compensation is reduced, since no formal LWEC decision has been issued.

c. Multiple Instances of Failure to Cooperate. A claimant who fails to cooperate with the OWCP more than once during the course of vocational rehabilitation should not be rated for LWEC. Rather, he or she should be given progressively more serious sanctions for the second and subsequent instances of non-cooperation if he or she does not resume cooperation after issuance of a warning letter, and good reasons for failure to cooperate are not provided.

For example: early in January 1994 a claimant repeatedly and without explanation fails to appear for vocational testing, and after appropriate warning and assessment of the response, compensation is suspended at the end of February. In mid-March, the claimant states willingness to cooperate, and actually does undergo the testing as directed in April. Compensation is then reinstated retroactive to mid-March.

A plan is developed, and the claimant is placed in a one-year training program beginning in September. The claimant misses the deadline for registration, and again, after appropriate warning and assessment of the response, compensation is reduced (to the rate for partial disability, reflecting the job for which the training program is to prepare the claimant) in October. In mid-November, the claimant states willingness to resume cooperation, and compensation (at the rate for total disability) is reinstated retroactive to that date when the claimant registers for the next trimester in January 1995.

In February, the RC reports to the OWCP that the claimant has been absent from school for two weeks without explanation. A warning letter is issued, but the claimant does not reply to it, and compensation is once again reduced (to the partial disability rate) in March. The claimant immediately contacts the OWCP, promises to resume attendance at school, and promptly does so. Instead of accepting the return to school as a demonstration of cooperation, however, the OWCP determines that in light of previous instances of non-cooperation, the claimant must complete the trimester (which ends in April) before compensation payments are resumed (again at the rate for total disability).

2-0813-13 Occupational Rehabilitation Programs

13. Occupational Rehabilitation Programs. Services which help the injured worker return to work through the use of abbreviated workdays or altered job duties are known as Occupational Rehabilitation Programs (ORPs).

a. Kinds of ORPs. The two kinds of ORPs are as follows:

(1) Return to Work (RTW) ORPs are intended for claimants who were injured more than 60 days ago, have not worked for at least 30 days, and are returning to a particular job and employer with defined duties, including transitional duties. RTW ORPs are highly structured, job oriented, goal-directed, individualized, and interdisciplinary. They are intended to maximize the claimant's ability to return to work. Real or simulated work activities are used in conjunction with graded conditioning tasks to aid the transition between acute care and return to work.

(2) Work Readiness (WR) ORPs are used when no specific job is available with a known employer. Services provided have the potential to improve the claimant's work options. These programs are highly structured, individualized and interdisciplinary. They are designed to evaluate and treat the claimant's physical, behavioral, and vocational functions. These programs includes real or simulated job-specific work tasks with modifications. A job site visit and follow-up monitoring may be included.

The WR-ORP uses many of the tests, evaluations, and restorative services used in the RTW-ORP, but the job skill requirements under this category are less well defined. The goal in most cases is to maximize potential job options rather than prepare for a

specific job. Sometimes, however, the goal is to document the claimant's job potential, and/or measure ability to improve physical tolerance, productivity, and work behavior.

b. Referral for ORPs. CEs should refer cases meeting the criteria stated in paragraph 5c above to the RS for an ORP assessment. The RS may also initiate an ORP placement. Also, the RS will notify the responsible CE in any case already open for vocational rehabilitation which, in his or her opinion, may benefit from this type of service.

c. Initial RS Actions. The RS opens for rehabilitation those cases referred by the CE that meet the basic criteria. The RS refers the case to a RC for a screening interview and the scheduling of a Functional Capacity Evaluation (FCE) to determine the type and nature of the ORP most suited to the claimant's needs. (See FECA PM 2-0810 for a discussion of Functional Capacity Evaluations.)

d. Authorization of ORP. When the FCE is completed, the RS authorizes the kind of ORP most suitable for the claimant. The RS enters the authorization for the ORP in the "notes" section of the Case Management File (CMF). Once the claimant is enrolled in the ORP, the RS so notifies the treating physician, employer (when available), the RC and the CE that the program has been authorized.

e. Obstacles to Completion. Medical or other issues which could delay or terminate the ORP, such as the emergence of non-work related conditions, recurrences, complaints of high levels of pain, etc. must be reported immediately to the RS and CE. When the ORP is interrupted, the RC notifies the RS immediately, carefully detailing the reason(s) for the interruption. The RS communicates this fact to the CE and recommends an appropriate course of action based on the circumstances of the case.

f. Outcomes. The following outcomes are based on the results of a completed ORP:

(1) Where the claimant cannot perform the duties of the previous employment or the targeted jobs, the RS may place the case in rehabilitation status D, Plan Development, with the concurrence of the CE to consider other rehabilitation solutions.

(2) Where the claimant can perform the duties of the date of injury job, the RS should notify the CE immediately. Alternatively, the RS may select other options (e.g., recommend the application of sanctions or the performance of a second opinion) and forwards the case to the CE.

g. Reports. The ORP facility must submit at least two reports. The FCE Report is the basis for the ORP program plan. The final report should contain the following:

(1) The present and potential status of the claimant for each of the elements reported in the FCE or the ORP plan, including the positive or negative changes that have occurred during the program as well as information on the claimant's attendance, efforts, and general condition.

(2) Specific information on the vocational and functional status of the claimant and relationship to the targeted job(s), fitness for return to work, and behavioral and attitudinal status.

(3) Any issues related to work site safety, accommodations, ergonomics, transportation, etc.

(4) Any additional relevant information, such as recommendations for maintenance of work capacity, improvement in functional status, considerations for alternative occupations, and need for continued monitoring and support.

2-0813 Exhibit 1: Sample Letter to Claimant Who Is Authorized Medical Care for Substance Abuse

Dear CLAIMANT NAME:

I am writing in reference to your compensation claim with this office, and in particular to the substance abuse which has been addressed in reports (copies attached) from your attending physician, Dr.__________. This condition has been documented as hindering your [participation in rehabilitation services, ability to accept employment offered by your employing agency, etc.]

This Office has approved an [inpatient, outpatient] treatment program for substance abuse at [name of facility]. At the conclusion of the course of treatment, which is expected to end on [date], it is anticipated that you will be able to [resume your participation in rehabilitation services, accept the offered position, etc.]

If the expected improvement does not occur, or if substance abuse continues after the completion of the program, your compensation benefits will be partially suspended until you re-enter a program and discontinue abuse of the substance in question. Your benefits will be suspended at the rate of pay which reflects your wage-earning capacity, as represented by the salary level of the job which is the goal of training. This action will be taken under authority of section 5 U.S.C. 8113 of the Federal Employees' Compensation Act. [For claimants whose substance abuse has been accepted as work-related: Additional treatment for substance abuse will be authorized only under exceptional circumstances.] [For claimants whose substance abuse is not accepted as work-related: The cost of any further treatment will be your responsibility.]

If you have any questions, please contact this office at the address shown above.

Sincerely,

CLAIMS EXAMINER

2-0813 Exhibit 2: Non-Cooperation With Vocational Rehabilitation Effort (Link to Image)

2-0813 Exhibit 3: Sample Letter to Claimant--Refusal to Participate in Training

Dear CLAIMANT NAME:

We have been advised that you have refused to participate in an OWCP-approved training program in ____________________________________ as recommended by your rehabilitation counselor, NAME OF COUNSELOR.

The rehabilitation counselor has advised that you have not undertaken the training because you feel it is beyond your ability. However, the results of the tests and evaluations performed by ___________________________________ clearly show that you have the ability to successfully complete the training program.

The primary purpose of the rehabilitation effort is to assist you in returning to gainful employment, and participation in the training program will provide you with the knowledge and skills necessary for a placement effort in the field of ___________________________________.

Section 8113(b) of the Federal Employees' Compensation Act states that a claimant must undergo vocational rehabilitation when OWCP so directs, unless there is a good reason not to do so. If the claimant does not undergo vocational rehabilitation as directed, and the OWCP finds that the claimant's wage-earning capacity would likely have increased a great deal, OWCP may

reduce the claimant's compensation. The amount of the reduction will be based on what the claimant would probably have earned had he or she undergone vocational rehabilitation.

You are directed to undergo the training program in _________________________, which has been approved by the OWCP. You should contact me within 30 days from the date of this letter to make necessary arrangements to enter the training program.

If you believe you have good reason for not participating in this effort, you should so advise this Office within 30 days from the date of this letter. Give the reasons for this belief and submit any evidence in support of your position.

If you do not comply with the instructions contained in this letter within 30 days, we will end the rehabilitation effort and reduce your compensation under the provisions of Section 8113 (b) of the FECA to reflect your probable wage-earning capacity had you completed the training program in _________________________.

If you have any questions, please contact this Office using the address or telephone number shown above.

Sincerely,

CLAIMS EXAMINER

2-0813 Exhibit 4: Sample Letter to Claimant--Refusal to Participate in Placement

Dear CLAIMANT NAME:

The reports of your rehabilitation counselor, NAME OF COUNSELOR, indicate that you have refused to participate in [or: obstructed] efforts to place you as a NAME OF OCCUPATION.

This kind of work was identified in the vocational rehabilitation plan approved by this Office [and you have undergone training to prepare for it].

The rehabilitation counselor has advised that you have been poorly groomed for job interviews [or: have stressed your disability for work, rather than your skills and abilities, during job interviews] [or: have repeatedly failed to appear for job interviews], thus decreasing the likelihood that you will be offered employment. However, the results of the tests performed by ________________________ [as well as the training you have undergone] clearly show that you have the ability to pursue the line of work for which placement efforts are under way.

The primary purpose of the rehabilitation effort is to assist you in returning to gainful employment, and good-faith participation in placement efforts should lead to reemployment in the field identified during your participation in the OWCP-sponsored vocational rehabilitation program.

Section 8113(b) of the Federal Employees' Compensation Act states that a claimant must undergo vocational rehabilitation when OWCP so directs, unless

there is a good reason not to do so. If the claimant does not undergo vocational rehabilitation as directed, and the OWCP finds that the claimant's wage-earning capacity would likely have increased a great deal, OWCP may reduce the claimant's compensation. The amount of the reduction will be based on what the claimant would probably have earned had he or she undergone vocational rehabilitation, including placement.

You are directed to begin [or: resume] good-faith participation in placement efforts sponsored by the OWCP. You should contact me within 30 days from the date of this letter to make necessary arrangements to resume such participation. The period of your entitlement to receive placement assistance will not exceed a total of 90 days.

If you believe you have good reason for not participating in this effort, you should so advise this Office within 30 days from the date of this letter. Give the reasons for this belief and submit any evidence in support of your position.

If you do not comply with the instructions contained in this letter within 30 days, we will end the placement effort and reduce your compensation under the provisions of Section 8113 (b) of the FECA to reflect your probable wage-earning capacity had you participated [or: continued to participate] in placement efforts.

If you have any questions, please contact this Office using the address or telephone number shown above.

Sincerely,

CLAIMS EXAMINER

2-0814 REEMPLOYMENT: DETERMINING WAGE-EARNING CAPACITY

Paragraph	Subject	Date	Trans. No.
	Table of Contents	07/97	97-17
1	Purpose and Scope	12/93	94-05
2	Introduction	12/93	94-05
3	Policy	12/93	94-05
4	Offers of Employment	12/93	94-05
		06/96	96-20
		07/97	97-17
5	Refusal of Job Offer	07/96	96-23
		07/97	97-17
6	Relocation Expenses	12/93	94-05
		12/95	96-07

		07/97	97-17
7	Determining WEC Based on Actual Earnings	12/93	94-05
		12/95	96-07
		06/96	96-20
		07/97	97-17
8	Determining WEC Based on Constructed Position	12/93	94-05
		12/95	96-07
9	Claims Actions After Reemployment	12/95	96-07
10	Abandonment of Job	12/95	96-07
		07/96	96-23
		07/97	97-17
11	Modifying Formal LWEC Decision	12/95	96-07
		06/96	96-20
12	Termination of Employment	05/97	97-10
		07/97	97-17
13	Effect of Federal Reemployment on Retirement Status	06/96	96-20

Exhibits

1	Sample Letter to Claimant -- Refusal of Employment	12/93	94-05
2	Sample Letter to Claimant Advising That Compensation is Being Reduced Based on Actual Earnings	12/93	94-05
		12/95	96-07
3	Sample Letter to Employing Agency Authorizing Payment of Relocation Expenses	12/93	94-05
4	Certification Checklist		
	Page 1 (Link to Image)	12/95	96-07
	Page 2 (Link to Image)	12/95	96-07

2-0814-1 Purpose and Scope

1. Purpose and Scope. This chapter explains the procedures for determining entitlement to compensation after reemployment and for determining wage-earning capacity (WEC) where reemployment is not possible. Procedures are also explained for terminating compensation for failure to accept suitable work.

2-0814-2 Introduction

2. Introduction. Section 8106 of the Federal Employees' Compensation Act (FECA) provides for a reduction in compensation to reflect a loss of wage-earning capacity (LWEC) when the disability for work is partial. The employee's actual earnings may be used to calculate reduced compensation if these earnings are found to fairly and reasonably reflect his or her earning capacity. When they do not, the employee's WEC is determined on the basis of factors described at Section 8115 of the FECA.

The method of computing compensation for wage loss due to partial disability is set forth in the FECA at Section 8106(a):

> If the disability is partial, the United States shall pay the employee during the disability monthly monetary compensation equal to 66 $^{2/3}$ percent of the difference between his monthly pay and his monthly wage-earning capacity....
>
> In the case of Albert Shadrick, 5 ECAB 376, issued March 23, 1953, the Employees' Compensation Appeals Board established a principle to eliminate economic factors such as inflation or recession when computing the amount of monetary compensation due for partial disability. According to this rule, the injured worker would be paid compensation based on the difference between the pay which had been determined to be his or her post-injury WEC, and the contemporaneous pay of the date of injury job. OWCP established the "Shadrick Formula" (see FECA PM 2-900.16) as the method of computing compensation when determining an injured worker's WEC.
>
> Finally, the FECA at Section 8106 provides for the imposition of certain penalties against workers who refuse offers of suitable work, or who abandon suitable work without good cause.

2-0814-3 Policy

3. Policy. The Office of Workers' Compensation Programs (OWCP) emphasizes returning partially disabled workers to suitable employment through vocational rehabilitation efforts (see PM Chapter 2-813). OWCP will make every reasonable effort to arrange for employment of a partially disabled claimant, first with the employing agency and then with a new employer. This effort will take into account both medical conditions which pre-existed the injury, and those which arose afterwards.

As a last resort, benefits will be reduced on the basis of an estimated earning capacity, based upon a job not actually held by the claimant, but performed to a reasonable extent in the commuting area and suitable to the claimant's vocational background. Any medical condition(s)

arising after the compensable injury will not be considered in selecting a job for an estimated earning capacity determination.

2-0814-4 Offers of Employment

4. Offers of Employment.

a. Offer of Modified Duty by Agency. If the agency can provide alternative employment, it will make an offer of light duty to the claimant. A job offer may be solicited by the Rehabilitation Specialist (RS), Rehabilitation Counselor (RC), Staff Nurse (SN), Claims Examiner (CE), or by the claimant.

(1) Any such offer must be in writing and must include the following information:

(a) A description of the duties to be performed.

(b) The specific physical requirements of the position and any special demands of the workload or unusual working conditions.

(c) The organizational and geographical location of the job.

(d) The date on which the job will first be available.

(e) The date by which a response to the job offer is required.

(2) The agency should also provide pay rate information for the offered job. The agency should not include any information in the job offer regarding election of OPM benefits, since obtaining an election is solely the responsibility of OWCP. A copy of the job offer should be sent to OWCP when it is made and the claimant's response should be provided to OWCP by the agency when it is received.

If the job offer is made by a non-Federal employer, the RS/RC will provide the information listed in items (1)(a) to (e), as well as pay rate information.

b. Preliminary Assessment of Position. On receipt of a copy of the written job offer, the Claims Examiner (CE) should review it and consider the factors listed below in making a preliminary assessment of whether the offered job is suitable. If none of these factors applies to the case and the claimant has accepted the job, a formal finding of suitability need not be made.

(1) A job which involves less than four hours of work per day where the

claimant is capable of working four or more hours per day will be considered unsuitable.

(2) A job which represents permanent seasonal employment will generally be considered unsuitable unless the claimant was a career seasonal or temporary employee when injured. In locations where year-round jobs are scarce, however, a seasonal position may be considered suitable for an employee who previously held a year-round job. In either case, the job must reasonably represent the claimant's WEC.

(3) A temporary job will be considered unsuitable unless the claimant was a temporary employee when injured and the temporary job reasonably represents the claimant's WEC. Even if these conditions are met, a job which will terminate in less than 90 days will be considered unsuitable.

(4) If medical reports in file document a condition which has arisen since the compensable injury, and this condition disables the claimant from the offered job, the job will be considered unsuitable (even if the subsequently-acquired condition is not work-related).

c. Advising the Claimant. After assessing the position, the CE must telephone the agency, confirm that the job remains open to the claimant, document the file using Form CA-110, and then advise the claimant in writing that:

(1) The job is considered suitable.

(2) The job remains open for the claimant.

(3) The claimant will be paid compensation for the difference (if any) between the pay of the offered job and the pay of the claimant's date of injury job.

(4) The claimant can still accept the job with no penalty.

(5) The claimant has 30 days from the date of the CE's letter to either accept the job or provide a written explanation of the reason(s) for refusing it.

(6) A claimant who unreasonably refuses an offer of suitable employment is not entitled to any further compensation benefits (with the exception of medical expenses for treatment of the accepted condition). A sample letter is included as Exhibit 1.

All of the foregoing is the responsibility of OWCP and cannot be delegated to the employing agency.

d. Claimant's Response.

(1) If the claimant accepts the position offered, compensation should be promptly terminated or reduced, as appropriate. A letter explaining the basis for this action should be issued promptly to the claimant (Exhibit 2), with a formal decision to follow after 60 days of reemployment.

(2) If no reply is received from the claimant, the CE should prepare a formal decision which terminates any further compensation for wage loss (effective as of the end of the roll period), as well as compensation for permanent partial impairment to a schedule member, under Section 8106(c)(2) of the Act. The claimant's entitlement to payment of medical expenses for treatment of the accepted condition is not terminated.

2-0814-5 Refusal of Job Offer

5. Refusal of Job Offer. If the claimant submits evidence and/or reasons for refusing the offered position, the CE must carefully evaluate the claimant's response and determine whether the claimant's reasons for refusing the job are valid.

a. Acceptable Reasons for Refusal. Reasons which may be considered acceptable for refusing the offered job include (but are not limited to):

(1) The offered position was withdrawn.

(2) The claimant found other work which fairly and reasonably represents his or her earning capacity (in which case compensation would be adjusted or terminated based on actual earnings).

(3) The medical evidence establishes that the claimant's condition has worsened since the beginning of the reemployment effort and the claimant is now disabled for the job in question.

(4) The claimant provides evidence that his or her decision was based on the attending physician's advice and that such advice included medical reasoning in support of the opinion. If this occurs, the following actions should be taken:

(a) The CE should provide the attending physician with copies of medical reports supporting ability to perform light duty and a copy of the claimant's position description with a request for a reasoned medical opinion as to why the claimant would be at medical risk in performing the duties of the job.

(b) If the attending physician continues to state that the claimant should not perform the duties of the offered position, and a second opinion specialist states that claimant can in fact perform those duties, then a conflict in the medical evidence exists as to whether the position offered can be considered suitable.

(c) If, after a referral to an impartial medical specialist, the claimant is found to be medically able to perform the duties of the job in question, the claimant must be advised of this finding and told that the Office will apply the sanctions of Section 8106(c) for continued refusal to accept the job (see James F. Banks, Docket No. 90-1413, issued February 12, 1991).

(5) The medical evidence establishes that the claimant is unable to travel to the job because of residuals of the injury. (However, the expenditures of a claimant who is able to travel but requires special arrangements to do so may be reimbursed as a vocational rehabilitation expense.)

b. Acceptable Reasons for Refusal When Claimant is No Longer on Agency's Rolls. A claimant may be on both the agency's rolls as a matter of employment status and OWCP's rolls for purposes of compensation payment at the same time. For claimants no longer on the agency's rolls--that is, who have been separated by formal personnel action--the following are also considered acceptable reasons for refusing the offered job:

(1) The claimant will lose health insurance coverage by accepting the job. (If the offered job is not classified at the same grade level as the date of injury job, the employing agency should be asked to offer the job at a pay rate lower than the date of injury job, so that compensation will be payable and OWCP can retain the claimant's health insurance enrollment.)

(2) The claimant is already working, and the job fairly and reasonably represents his or her WEC, whether or not a formal rating is in place.

(3) The claimant has moved, and a medical condition (either pre-existing or subsequent to the injury) of the claimant or a family member contraindicates return to the area of residence at the time of injury.

c. Unacceptable Reasons for Refusal. Reasons which may not be considered acceptable for refusing the offered job include (but are not limited to): the claimant's preference for the area in which he or she currently resides; personal dislike of the position offered or the work hours scheduled; lack of potential for promotion; lack of job security; retirement; and previously-issued rating for LWEC based on a constructed position where the claimant is not already working at a job which fairly and reasonably represents his or her WEC.

d. Further Action. If it is not possible to determine whether a claimant's reason for refusal is justified without further investigation of the issues, the CE should contact the claimant for clarifying information and set another 30-day deadline. The employing agency should be contacted again and asked to keep the job open during this period. If the agency is unable or unwilling to do this, the CE must discontinue any further consideration of applying the sanction provided by Section 8106.

(1) If the claimant's refusal of the offered job is not deemed justified, the CE must so advise the claimant and allow 15 additional days for him or her to accept the job (see Maggie L. Moore, Docket No. 90-1291, issued March 8, 1991). The notice should state that no further reason for refusal will be considered, but it need not include the reason for finding the claimant's refusal unjustified.

If the claimant does not accept the job, the CE should prepare a formal decision which provides full findings of facts as to why claimant's reasons for refusing the job are deemed unacceptable and terminate compensation under Section 8106(c)(2) of the Act as of the end of the roll period. Such a decision should not be modified even if the claimant's medical condition later deteriorates and he or she claims a recurrence of total disability.

(2) If the refusal is deemed justified, the CE should so notify both the claimant and the employing agency. The claimant will be continued on temporary total disability (TTD) while the CE contacts the agency concerning further attempts at placement. If the agency is unable to make any further job offers, the CE should refer the case to the Rehabilitation Specialist (RS) for consideration of further vocational rehabilitation services.

2-0814-6 Relocation Expenses

6. Relocation Expenses. Section 10.123(f) of the Office's regulations provides that an injured employee who relocates to accept a suitable job offer after termination from the agency rolls may receive payment or reimbursement of moving expenses from the compensation fund. This provision further states that Federal travel regulations addressing permanent change of duty station (PCS) moves will be used to determine whether expenses claimed are reasonable and necessary.

a. Criteria for Payment. Relocation expenses are payable only to claimants who are no longer on the agency rolls. They are payable whether the claimant still resides in the locale where he or she last worked and is offered employment in another area, or whether the claimant has moved away from the locale where he or she was employed and is offered employment in either the original area or a different one. Expenses may be paid for relocation to a temporary job as long as it is expected to lead to a permanent assignment, but may not be paid for relocation to a temporary job which is not expected

to lead to a permanent assignment. The distance between the two locations must be at least 50 miles, but the claimant is not required to demonstrate financial need for relocation expenses to be paid.

b. Responsibilities.

(1) District Office staff will adjudicate all requests for relocation. (The employing agency, however, has an advisory role with respect to the amounts payable; see subparagraph (3) below.) Where relocation is approved, the district office will pay or reimburse authorized expenses to the claimant or the employing agency.

(2) National Office staff will handle all requests for advance payment from the compensation fund in cases where the employing agency cannot provide the money for the move from its own accounts, and the claimant has not already expended the funds.

(3) The employing agency will be asked to make all arrangements for the move (e.g., have a moving company transport the employee's household goods to the new duty station). It will also be asked to ensure that the types of expenses and the actual amounts are allowable according to GSA travel regulations and according to what the agency would authorize for any other employee making a PCS move. Claims Examiners are not expected to determine the kinds of expenses and the amounts payable.

c. Advising the Parties.

(1) The claimant may inquire whether relocation expenses will be paid if he or she accepts a job offer. Such a claimant may be advised that the expenses will be paid as long as the offered job is found suitable and the criteria listed in paragraph 6a are met.

(2) The employing agency may want to include a description of the claimant's entitlement to relocation expenses in the job offer. If so, the CE should ask the agency to send a copy of the job description to the district office before making the job offer so that suitability of the job and entitlement to payment of relocation expenses can be determined.

(3) The CE should notify claimants with suitable job offers who meet the criteria for payment of relocation expenses of the provisions of Section 10.123(f) of the regulations. This advice may be included in the letter notifying the claimant that the offered job has been found suitable.

d. Adjudication of Request. If the offered job is found suitable, medically and

otherwise, the CE may proceed to consider whether relocation expenses may be paid.

(1) Using the criteria listed in paragraph 6a, the CE should evaluate the request for payment of relocation expenses and make a recommendation to the Supervisory Claims Examiner (SCE) concerning their payment. Even though the SCE will advise the parties of this determination, the CE must still notify the claimant directly that the job has been found suitable.

(2) The Supervisory Claims Examiner should review the recommendation and advise the employing agency and the claimant of the decision. If the decision is favorable, the letter to the claimant should note that GSA regulations require employees whose moving expenses are paid by the Federal government to remain in Federal employment for one year after the move. Should the claimant cease working for a reason unacceptable to the Office (see paragraph 5 above), the relocation expenses will be declared an overpayment and handled according to the usual procedures (see PM Part 6).

(3) If the decision is favorable, the employing agency will include in the job offer a statement that the job has been found suitable and that relocation expenses are payable under Section 10.123(f) of the Office's regulations.

(4) OWCP is responsible for resolving any dispute between the claimant and the agency as to allowable costs in accordance with GSA regulations. Any denial will be accompanied by appeal rights.

e. Payment/Reimbursement of Relocation Expenses. Detailed information concerning processing of bills and receipts for relocation expenses may be found in FECA PM Chapter 5-604, Financial Reports (Relocation Expenses).

(1) An agency which can advance funds to the claimant may be authorized to do so on a transaction-by-transaction basis. For example, the amount required for temporary lodging should be forwarded first, followed by a separate advance for transportation of household goods (see Exhibit 3 for a sample letter).

(2) If the claimant or the agency requests reimbursement, the SCE should approve the relocation expenses (see Exhibit 3) and advise the parties of the procedures to obtain reimbursement.

Once the move is completed, the agency should examine the expenditures and certify that they are in accordance with GSA travel regulations. If so, the agency will send copies of the bills and travel vouchers to the district office for payment.

(3) A claimant who has paid for relocation expenses from his or her own funds will be directed to submit copies of the bills and travel vouchers to the

employing agency for examination to ensure that the amounts claimed are in accordance with GSA travel regulations. The bills and vouchers should then be forwarded to OWCP for reimbursement to the claimant.

(4) Where the agency cannot pay the costs of relocation from its own funds, and the claimant has not already paid for the move, the CE (or RS) should forward to the National Office a copy of the job offer and the claimant's acceptance of it. (The case file should remain in the district office.)

National Office staff will contact the employing agency to determine the best method of transferring funds and send a letter outlining the procedures to be followed to the agency, with a copy to the district office. The letter will ask the agency to sign a written agreement to abide by GSA regulations in approving expenditures.

The agency will be authorized to withdraw from the compensation fund the amount of estimated or actual expenses. The agency will be required to submit copies of bills and travel vouchers to support its payments and the withdrawals from the compensation fund. Any difference between the amount of the advance and actual expenses will be recovered by the agency from the employee and refunded to OWCP.

2-0814-7 Determining WEC Based on Actual Earnings

7. Determining WEC Based on Actual Earnings. When an employee cannot return to the date of injury job because of disability due to work-related injury or disease, but does return to alternative employment with an actual wage loss, the CE must determine whether the earnings in the alternative employment fairly and reasonably represent the employee's WEC. Following is an outline of actions to be taken by the CE when a partially disabled claimant returns to alternative work:

a. Factors Considered. To determine whether the claimant's work fairly and reasonably represents his or her WEC, the CE should consider whether the kind of appointment and tour of duty (see FECA PM 2-0900.3) are at least equivalent to those of the job held on date of injury. Unless they are, the CE may not consider the work suitable.

For instance, reemployment of a temporary or casual worker in another temporary or casual (USPS) position is proper, as long as it will last at least 90 days, and reemployment of a term or transitional (USPS) worker in another term or transitional position is likewise acceptable. However, the reemployment may not be considered suitable when:

(1) The job is part-time (unless the claimant was a part-time worker at the time of injury) or sporadic in nature;

(2) The job is seasonal in an area where year-round employment is available. If an employee obtains seasonal work voluntarily in an area where year-round work is generally performed, the CE should carefully determine whether such work is truly representative of the claimant's WEC; or

(3) The job is temporary where the claimant's previous job was permanent.

The CE should not consider the factors set forth in 5 U.S.C. 8115; they should be addressed only when reaching a constructed LWEC (see paragraph 8 below).

b. Initial Fiscal Actions.

(1) If the claimant has been receiving compensation on the periodic roll, the CE should delete the payment record from ACPS as soon as possible. If the deletion can be made effective with the current roll period, any additional compensation due should be paid on the daily roll. Any compensation paid for total wage loss subsequent to the date of return to work should be declared an overpayment.

(2) If the claimant is entitled to compensation for partial wage loss after return to work, the CE should compute entitlement using the Shadrick formula and authorize compensation on a 28-day payment cycle. The CE should make every effort to avoid interruption of income to the claimant.

The CE will advise the claimant (see Exhibit 2) that compensation will be paid based on actual earnings, and that the claimant remains entitled to payment of medical expenses for treatment of the accepted condition. This letter will not constitute a formal decision and will have no appeal rights attached.

c. Issuance of Decision.

(1) After the claimant has been working for 60 days, the CE will determine whether the claimant's actual earnings fairly and reasonably represent his or her WEC. If so, a formal decision should be issued no later than 90 days after the date of return to work. If not, the CE should proceed with a constructed LWEC by asking the RS to identify two suitable jobs and applying the factors set forth under 5 U.S.C. 8115(a) (see paragraph 8 below).

(2) The CE will determine the claimant's monetary entitlement using the Shadrick formula (see FECA PM 2-900.16). As necessary, the CE should confirm the respective pay rates for each job by telephone and document the file

accordingly. The pay rates of the date of injury job and the new job should be compared as of the time that the formal LWEC decision is being prepared, unless there are compelling reasons to use a different date. If the file shows that the claimant has an approved OPM annuity, a new election of benefits must be obtained and OPM advised of the election.

(3) Since the claimant was not provided with a formal decision concerning his or her entitlement to compensation based on actual earnings from the date of return to work until issuance of the formal LWEC decision, the LWEC decision should include language awarding compensation for this period (e.g., "It is hereby determined that the claimant is entitled to compensation from DATE to DATE based upon his actual earnings.")

If the claimant was overpaid compensation based on actual earnings from the date compensation was paid for partial wage loss to the effective date of the formal LWEC decision, the usual overpayment procedures should be followed.

(4) If the claimant returns to work at a retained pay rate, and therefore incurs no wage loss, the CE should still issue a formal LWEC decision. Wages lost because step increases and/or cost-of-living increases were not applied to the retained pay rate do not constitute a LWEC, and claims based on this premise should be denied (see Joseph D. Musolino, Docket No. 89-1765, issued March 12, 1991). Such claims may be denied even if no formal LWEC decision was made at the time of reemployment, but compensation should be terminated prospectively, not retroactively.

d. Computing Entitlement to Compensation. The following procedures address situations where the claimant returns to other than full-time year-round work.

(1) For part-time work, compensation should be computed using the Shadrick formula, which is more advantageous to the claimant than simple deduction of earnings would be. This rule has no exceptions.

(2) For seasonal and temporary employment, the annual salary of the job selected must be divided by 52 to obtain a weekly pay rate. The figure obtained should then be compared, using the Shadrick formula, to the weekly pay for the grade and step of the job held when injured, and the result should be applied to the pay rate for compensation purposes.

However, when a career seasonal employee is rated in a career seasonal job, the salary of the current job should be annualized before the Shadrick formula is applied, so that a true LWEC will be obtained.

(3) Earnings of a sporadic or intermittent nature which do not fairly and

reasonably represent the claimant's WEC should be deducted from continuing compensation payments using the Shadrick formula (past earnings must be declared an overpayment). Sporadic or intermittent earnings should not be used as the basis for an LWEC determination (see Barbara Hines, Docket No. 91-1803, issued February 17, 1993), but they should be used to help establish the kind of work the claimant can perform.

For example, a claimant who is being paid compensation for total wage loss reports sporadic earnings as a baby-sitter, but the CE determines that these earnings do not fairly and reasonably represent the claimant's WEC. The CE should use the Shadrick formula to deduct earnings only for the period in question, then refer the claimant to the RS for vocational rehabilitation services. Any worksheet used to calculate deduction of sporadic earnings should be marked clearly at the bottom with the words "ACTUAL EARNINGS CALCULATION--NOT AN LWEC DETERMINATION."

(4) Where the Office learns of actual earnings that span a lengthy period of time (e.g., several months or more), the compensation entitlement should be determined by averaging the earnings for the entire period, determining the average pay rate, and applying the Shadrick formula (comparing the average pay rate for the entire period to the pay rate of the date of injury job in effect at the end of the period of actual earnings).

For example, the Office learns on October 1, 1992 that the claimant, injured on June 5, 1987, returned to work on September 1, 1988 and worked intermittently through September 1, 1992 when he ceased work. On September 1, 1992 the pay rate for the claimant's date of injury job was $500 per week. The claimant grossed $40,000 during the four years (208 weeks) he worked from September 1, 1988 through September 1, 1992, or an average of $192.30 per week. When using the Shadrick formula, the pay rate of $192.30 would be compared to the pay rate of $500.

e. Retroactive Determinations. Where the Office learns that the claimant has returned to alternative work more than 60 days after the fact, the CE may consider a retroactive LWEC determination. Such a determination may be appropriate where an investigation reveals that a claimant held private employment and had earnings which were not reported to OWCP. (See paragraph 12 concerning reduction-in-force situations.) A retroactive decision may be made if:

(1) The claimant has worked in the position for at least 60 days;

(2) The CE has determined that the employment fairly and reasonably represents the WEC (an assessment of suitability need not be made); and

(3) The work stoppage did not occur because of any change in the claimant's injury-related condition affecting ability to work.

A retroactive rating may result in creation of an overpayment, which should be handled in accordance with the usual procedures.

f. Changes in CMF Coding. When the formal LWEC decision is made, the case status must be changed to PW. Where the claimant received periodic roll payments and returned to full-time employment, rehabilitation personnel enter appropriate codes in the Rehabilitation Tracking System, which then appear in the CMF under option #18 of the Case Management function. However, the CE should arrange for entry of Code 8, which is used when the claimant returned to work without assistance from the CE, the RS, or the RC. This code should be entered when the case status is changed because of the reemployment (e.g., from DR to MC, or from PR to PW). [The CE should ensure that all returns to work are entered on option #36 of the CMF].

g. Checklist. The CE and/or the certifier may use the LWEC Certification Checklist (Page 2 of Exhibit 4 (Link to Image), Form CA-817)) to ensure that all the required evidence is obtained for properly determining the claimant's WEC.

2-0814-8 Determining WEC Based on Constructed Position

8. Determining WEC Based on Constructed Position. In some situations, vocational rehabilitation efforts do not succeed, and the claimant's WEC must be determined on the basis of a position deemed suitable but not actually held. In making this determination, the test is whether the claimant's WEC based on the selected job appears reasonable giving due regard to the factors specified in 5 U.S.C. 8115. A Federal or other civil service position in which the claimant is not actually employed may not be used to make an LWEC decision (see Rudy Solovic, 28 ECAB 105, Charles Brown, 31 ECAB 435, and Ann Rich, 34 ECAB 277).

a. Factors Considered. The CE must consider the following aspects of the case in assessing suitability and availability:

(1) The nature of the injury.

(2) The degree of physical impairment (including impairments resulting from both injury-related and pre-existing conditions).

(3) The usual employment.

(4) The claimant's age.

(5) Qualifications for other employment, including education, previous

employment, and training as well as work limitations imposed by the injury-related and pre-existing impairments.

(6) The availability of suitable employment.

b. Vocational Suitability. In cases where the claimant has undergone vocational rehabilitation, the RC will submit a final report to the RS summarizing why vocational rehabilitation was unsuccessful and listing two or three jobs which are medically and vocationally suitable for the claimant. Where no vocational rehabilitation services were provided, the RS will have provided this report. Included will be the corresponding job numbers from the Dictionary of Occupational Titles (DOT) and pay ranges in the relevant geographical area. The report should describe how requirements for Specific Vocational Preparation (SVP) were achieved.

(1) The RC will also include the DOT's description of the duties and physical requirements of each job. The positions listed may be those in which placement was attempted.

(2) The RS will indicate to the CE, using the OWCP-3, that a rating may be based on this report. Because the RS is an expert in the field of vocational rehabilitation, the CE may rely on his or her opinion as to whether the job is reasonably available and vocationally suitable.

(3) The CE may need to choose between two or more identified positions. Factors or circumstances to consider may include the employee's other skills, aptitude for acquiring new skills, mental alertness, general appearance, personality factors, and ability to adjust to the handicap; the need for a license; and the industrial realities in the area where the employee is to be rated.

c. Availability. The statement from the RC or RS will also include a statement which addresses reasonable availability of the jobs in that area. (The RS should evaluate the WEC selections to ensure that the RC has adequately documented availability, etc., and counsel the RC if indicated.) Lack of current job openings does not equate to a finding that the position was not performed in sufficient numbers to be considered reasonably available. When necessary, the CE should consider the following factors:

(1) The availability of the employment is usually evaluated with respect to the area where the injured employee resides at the time the determination is made, rather than the area of residence at the time of injury. However, when the employee voluntarily moves to an isolated locality with few job opportunities, the question of availability should be applied to the area of residence at the time of the injury.

(2) If the employee is required to move to a certain area, isolated or

otherwise, because of health conditions which were caused by the injury or which predated it, the issue of availability must be considered with respect to the new area of residence. (For a discussion of isolated areas and other relevant issues, see Robert Campbell, 14 ECAB 113; Sidney Kawalick, 19 ECAB 272; and Lloyd Allen, 24 ECAB 112.)

(3) If the employee can work only part-time, the position must be reasonably available on a part-time basis. A general finding of reasonable availability is not sufficient because a position which can be obtained on a full-time basis may not be available on a part-time basis (see Lewis Jackson, 32 ECAB 1225).

(4) When suitable year-round employment is not available, a seasonal job may be selected for LWEC purposes. The file must support the finding that the job is performed on a seasonal basis in sufficient numbers so as to be reasonably available. A seasonal job in the private sector should not ordinarily be used to rate a claimant who is not working and who resides in an area where year-round work is generally performed. The reasons for using a seasonal job should be explained in a memorandum for the file.

d. Medical Suitability. The CE is responsible for determining whether the medical evidence establishes that the claimant is able to perform the job, taking into consideration medical conditions due to the accepted work-related injury or disease, and any pre-existing medical conditions. (Medical conditions arising subsequent to the work-related injury or disease will not be considered.) If the medical evidence is not clear and unequivocal, the CE will seek medical advice from the DMA, treating physician, or second opinion specialist as appropriate.

If the position selected is not eventually determined to be suitable, the CE should consider the other positions listed by the RC and proceed as outlined above. If the CE concludes that no position can be identified which is medically, vocationally and otherwise suitable, the claimant will be deemed to have no current WEC. In this situation, the CE should prepare a memo explaining the circumstances and recommending that efforts to establish a reduced earning capacity be suspended.

e. Issuance of Decision.

(1) After selecting a position from those listed by the RC, and after determining that the job is suitable and available, the CE should provide the claimant with a pre-reduction notice as described in FECA PM 2-1400.6 and 7. This action should be taken within 30 days of receipt of the RC's or RS's final report.

(a) If the claimant does not respond n within 30 days of the notification of proposed reduction, the CE should prepare a formal

decision (Form CA-1048) determining the claimant's WEC and reducing the compensation payments beginning with the next periodic roll payment cycle.

(b) If the claimant does respond to the notification of proposed reduction, the CE should consider the response and proceed with any further development necessary (see FECA PM 2-1400.7).

(2) Tentative constructed LWEC determinations will not be made under any circumstances. When a claimant is receiving compensation for total disability and evidence shows that he or she is partially disabled, benefits must be paid at the rate for total disability until a proper job selection can be made.

(3) If the CE recommends suspension of efforts to determine a WEC and the SCE concurs, case status PN will be entered into the CMF. Thereafter, medical evidence should be obtained each three years to monitor the claimant's physical condition, and earnings information should be requested yearly via Form CA-1032.

f. Retroactive Determinations. Retroactive constructed LWEC determinations should be considered only when the evidence clearly shows that partial rather than total disability existed prior to adjudication, and no compensation has been paid for the period of disability in question. Additionally, it may be considered when vocational rehabilitation services cannot be employed (e.g., because a subsequent, totally disabling non-work-related condition has arisen).

In cases meeting these criteria, the CE must first determine whether the claimant has had any actual earnings. If so, see paragraph 7b above. If not, the CE should refer the case to the RS for preparation of a list of suitable positions from the DOT, as described in paragraph 8b above, and pay compensation for LWEC for the entire period of partial disability. Retroactive constructed LWEC determinations are not to be made where compensation is being paid for temporary total disability. In such cases payments must continue until the LWEC decision is made.

g. Claimants in Prison. Incarcerated claimants do not lose entitlement to compensation payments simply because they are imprisoned. Such cases are handled according to the same criteria as any other case, insofar as possible. Work performed in prison, and training received there, should be considered in assessing the claimant's physical capability to perform a job and his or her job skills along with other factors in the claimant's background to determine a suitable job on which to base an estimated earning capacity. Prison authorities should be asked to provide information on the claimant's work activities and training. The RS should contact the claimant and prison officials to arrange any feasible training program. Since prison is not an open labor market and the claimant is considered to be confined as the result of a voluntary misdeed,

job selection should be based upon availability in the area which would apply if the claimant were not imprisoned.

h. The CE and/or the certifier may use the LWEC Certification Checklist (Page 1 of Exhibit 4 (Link to Image), Form CA-817) to ensure that all the required evidence is obtained for properly determining the claimant's WEC.

2-0814-9 Claims Actions After Reemployment

9. Claims Actions After Reemployment. Cases where a claimant stops work after reemployment may require further action, depending on whether the rating has been completed at the time the work stoppage occurs.

a. Formal LWEC Decision Issued. If a formal LWEC decision has been issued, the rating should be left in place unless the claimant requests resumption of compensation for total wage loss. In this instance the CE will need to evaluate the request according to the customary criteria for modifying a formal LWEC decision (see paragraph 11 below. If the claimant retires, the CE should offer an election between FECA and OPM benefits if appropriate. A penalty decision under 5 U.S.C. 8106(c) should not be issued.

b. No Formal LWEC Decision Issued. If no formal LWEC decision has been issued, the CE must ask the claimant to state his or her reasons for ceasing work and make a suitability determination on the job in question. If the job is considered suitable, the CE then advises the claimant that he or she has the burden of proving total disability (Cloteal Thomas, 43 ECAB 1093) after return to work and invite the claimant to submit a Form CA-2a.)

(1) If the reasons stated by the claimant amount to an argument for a recurrence, the CE should develop and evaluate the medical and factual evidence upon receipt of Form CA-2a. In Terry Hedman, 38 ECAB 222, the Board held that a partially disabled claimant who returns to a light-duty job has the burden of proving that he or she cannot perform the light duty, if a recurrence of total disability is claimed. The Board held that the claimant "must show a change in the nature and extent of the injury-related condition, or a change in the nature and extent of the light-duty job requirements."

(a) If the recurrence is approved, compensation for total wage loss should be paid until the claimant can return to work. If the claimant cannot return to work, the CE will refer the case for vocational rehabilitation services.

(b) If the claimant fails to meet his or her burden of proving a recurrence of total disability, a formal decision denying the recurrence is

necessary.

(2) If no claim for recurrence is filed, and a retroactive LWEC is not appropriate (see paragraph 7e), the CE should consider applying the penalty provision of Section 8106(c)(2). This section may be invoked if an employee is shown to have abandoned a suitable job without good reason and subsequently claims benefits, but the reasons for abandoning employment must be explored before the penalty provision is applied (see Mary A. Howard, Docket No. 92-886, issued May 19, 1994, and Tobey A. Rael, Docket No. 94-537, issued November 17, 1994). See paragraph 10 below.

2-0814-10 Abandonment of Job

10. Abandonment of Job. The CE must make a finding of suitability, advise the claimant that the job is suitable and that refusal of it may result in application of the penalty provision of 5 U.S.C. 8106(c)(2), and allow the claimant 30 days to submit his or her reasons for abandoning the job. If the claimant submits evidence and/or reasons for abandoning the job, the CE must carefully evaluate the claimant's response and determine whether the claimant's reasons for doing so are valid.

a. Examples. Situations where the Board held that the OWCP properly terminated compensation pursuant to Section 8106(c)(2) are described in:

(1) Roy Bankston, 38 ECAB 380, where the claimant voluntarily retired two and a half years after he returned to work, and there was no evidence to indicate that he retired because of disability or health reasons;

(2) Arquelio Pacheco, 40 ECAB 277, where the claimant resigned a modified light-duty position without good reason; and

(3) James E. Kale, Docket No. 88-2031, issued May 22, 1991, where the claimant resigned from his limited-duty position "because it was going nowhere," and he preferred to go back to college.

b. Claimant's Response.

(1) If the claimant returns to work, a formal decision determining LWEC should be made after 60 days of reemployment.

(2) If no reply is received from the claimant, the CE should prepare a formal decision which terminates any further compensation for wage loss (effective as of the end of the roll period), as well as compensation for permanent partial impairment to a schedule member, under Section 8106(c)(2) of the Act. The

claimant's entitlement to payment of medical expenses for treatment of the accepted condition is not terminated.

(3) If the claimant provides reasons for ceasing employment which do not constitute a claim for recurrence (see paragraph 9b(1) above), the CE must evaluate the reasons given.

c. Acceptable Reasons for Abandonment. Reasons which the CE may accept include (but are not limited to):

(1) The claimant found other work which fairly and reasonably represents his or her earning capacity (in which case compensation would be adjusted or terminated based on actual earnings).

(2) A subsequent medical condition prevents the claimant from continuing to perform the job.

d. Unacceptable Reasons for Abandonment. Reasons which the CE should not accept include (but are not limited to) personal dislike of the position or the work hours, lack of potential for promotion, lack of job security, and retirement.

e. Further Action. If it is not possible to determine whether a claimant's reason for abandonment is justified without further investigation of the issues, the CE should contact the claimant for clarifying information and set another 30-day deadline. The CE should also contact the employing agency to verify that the job remains available and to ask that the job remain open during this period. If the agency is unable or unwilling to honor this request, the CE must discontinue any further consideration of applying the sanction provided by Section 8106.

(1) If the abandonment of the job is not deemed justified, the CE must so advise the claimant, and allow him or her 15 additional days to return to work. If the claimant does not do so, the CE should prepare a formal decision which provides full findings as to why the abandonment is deemed unacceptable and terminates compensation under Section 8106(c)(2) as of the end of the roll period. Such a decision should not be modified even if the claimant's medical condition later worsens and he or she claims a recurrence of total disability.

(2) If the abandonment is deemed justified, the CE should so notify both the claimant and the employing agency. The claimant will receive compensation for temporary total disability (TTD) while the CE or Field Nurse contacts the agency concerning further attempts at placement. If the agency is unable to make any further job offers, the CE should refer the case to the Rehabilitation Specialist (RS) for consideration of further vocational rehabilitation services.

2-0814-11 Modifying Formal LWEC Decisions

11. Modifying Formal LWEC Decisions.

a. Customary Criteria. The Board established the following criteria for modifying a formal LWEC decision in Elmer Strong, 17 ECAB 226:

(1) The original rating was in error;

(2) The claimant's medical condition has changed;

(3) The claimant has been vocationally rehabilitated.

b. Burden of Proof. The party seeking modification of the LWEC decision has the burden to prove that one of these criteria has been met.

(1) If the claimant is seeking modification (usually on the basis of an increase in wage loss), he or she must establish that the original rating was in error or that the injury-related condition has worsened.

(2) If the OWCP is seeking modification (usually on the basis of a decrease in wage loss), the OWCP must establish that the original rating was in error, or that the injury-related condition has improved, or that the claimant has been vocationally rehabilitated.

c. Increased Earnings. It may be appropriate to modify the rating on the grounds that the claimant has been vocationally rehabilitated if one of the following two circumstances applies:

(1) The claimant is earning substantially more in the job for which he or she was rated. This situation may occur where a claimant returned to part-time duty with the employing agency and was rated on that basis, but later increased his or her hours to full-time work.

(2) The claimant is employed in a new job (i.e., a job different from the job for which he or she was rated) which pays at least 25% more than the current pay of the job for which the claimant was rated.

d. CE Actions. If these earnings have continued for at least 60 days, the CE should:

(1) Determine the duration, exact pay, duties and responsibilities of the current job.

(2) Determine whether the claimant underwent training or vocational preparation to earn the current salary.

(3) Assess whether the actual job differs significantly in duties, responsibilities, or technical expertise from the job at which the claimant was rated.

e. If the results of this investigation establish that the claimant is rehabilitated or self-rehabilitated, or if the evidence shows that the claimant was retrained for a different job, compensation may be redetermined using the Shadrick formula. Any modification of compensation should be preceded by a 30-day pre-reduction notice and then be made prospectively so that no overpayment results.

2-0814-12 Termination of Employment

12. Termination of Employment. A reemployed claimant may face removal from employment due to closure of an installation, cessation of special ("pipeline") funding, or termination of temporary employment, or reduction in force (RIF). (A true RIF affects full-duty and light-duty workers alike. If it is not clear whether the claimant's situation involves a RIF or the withdrawal of light duty, the CE should request the personnel document on which the removal was based.) Such occurrences are not considered recurrences of disability (see FECA PM 2-1500.3b), and the CE should take action according to whether a formal LWEC determination has been made.

a. LWEC Determination Made. When a formal loss of wage-earning capacity (LWEC) has been determined (by Form CA-1047, CA-1048 or narrative decision), the claimant has the burden, with respect to any subsequent loss of earnings, to show that one of the accepted reasons for modifying an LWEC applies. These reasons are: the original LWEC rating was in error; the employee's medical condition has changed; or the employee has been vocationally rehabilitated, either through vocational training or self-rehabilitation, and the wage-earning capacity has increased as a result.

Therefore, the status of an employee with an established wage-earning capacity who is removed because of a RIF or closure does not change with regard to receipt of FECA benefits. If a formal claim for recurrence is filed, it should be denied unless the claimant has shown a material change in his or her medical condition as defined in paragraph 11 above.

b. LWEC Determination Not Made. When no formal finding of wage-earning capacity has been made, and the claimant has worked in the position for at least 60 days, the CE should consider a retroactive LWEC determination (see FECA PM 2-814.7e). This is true even if the claimant is a Federal employee, since general availability of the job need not be considered for a position actually held.

If a retroactive LWEC determination cannot be made, the CE should take the following actions:

(1) Upon receipt of a properly completed Form CA-7, reinstate the claimant to temporary total disability (TTD) benefits on the daily roll. The claimant should not be placed on the periodic roll until additional medical evidence is developed.

(2) Obtain a current medical report from a specialist in the appropriate field and inquire about current injury-related disability.

(3) If no continuing injury-related disability is established and the claimant is being paid on the daily roll, prepare a formal decision terminating compensation effective the date of the decision. If the claimant is being paid on the periodic roll, issue a pre-termination notice.

(4) If injury-related disability is established, place the claimant on the periodic roll and follow the case management procedures found in PM Chapter 2-600, including referral for rehabilitation services in accordance with PM Chapter 2-813.

(5) Advise the employing agency in a detailed letter that the injury-related disability continues and that the claimant is receiving compensation on the basis of temporary total disability until his or her wage-earning capacity can be determined.

2-0814-13 Effect of Federal Reemployment of Retirement Status

13. Effect of Federal Reemployment on Retirement Status.

a. Public Law 98-21, the Social Security Amendments of 1983, provides full Social Security Act (SSA) benefits rather than Civil Service Retirement Act (CSRA) benefits to Federal employees hired on and after January 1, 1984.

b. While in receipt of compensation, a claimant is deemed to be in leave status or absent without pay for purposes of credit for total service under the Civil Service Retirement System. A claimant who is in such status is not considered separated from employment for the purposes of Section 3121(b)(5)(B) of the Internal Revenue Code, even though the claimant may in fact have been separated from the agency's employment rolls.

c. Therefore, a claimant who was covered by CSRA (or other retirement system established by a law of the United States) and who is reemployed by the United States after January 1, 1984, either in the date of injury job or in an alternative job, would still be covered by that retirement system. On the other hand, if the claimant had SSA coverage at the time of the injury, he or she would continue under that coverage if reemployed.

2-0814 Exhibit 1: Sample Letter To Claimant--Refusal Of Employment

Dear CLAIMANT NAME:

You were offered a position as a TITLE OF POSITION with NAME OF EMPLOYER, which is found by OWCP to be suitable to your work capabilities. This position is currently available to you. Upon acceptance of this position, you will be paid compensation based on the difference (if any) between the pay of the offered position and the pay of your position on the date of injury. You may still accept the position with no penalty.

You have 30 days from the date of this letter to either accept the position or provide an explanation of the reasons for refusing it. At the end of 30 days, a final decision on this issue will be made. If you fail to accept the position, any explanation or evidence which you provide will be considered prior to determining whether or not your reasons for refusing the job are justified.

Section 5 U.S.C. 8106(c)(2) of the Federal Employees' Compensation Act states that "A partially disabled employee who refuses or neglects to work after suitable work is offered to, procured by, or secured for him is not entitled to compensation." Therefore, any claimant who refuses an offer of suitable employment is not entitled to any further compensation for wage loss. Therefore, if you do not accept the offered position, and do not show that the failure is justified, your compensation will be terminated.

Sincerely,

NAME OF SIGNER
TITLE

cc: Employing Agency

2-0814 Exhibit 2: Sample Letter To Claimant Advising That Compensation Is Being Reduced Based on Actual Earnings

Dear CLAIMANT NAME:

You have recently been reemployed as a ______________________

with wages of $000.00 per week. This employment was effective on 01/01/01.

We are reducing [or terminating] your monetary compensation effective 01/01/01 based upon your actual earnings, as these fairly and reasonably represent your wage-earning capacity in accordance with 5 U.S.C. 8115 (a).

The enclosure explains the method of calculating your entitlement to monetary compensation. You are still entitled to payment of medical expenses for treatment of your work-related medical condition(s).

You should notify this Office immediately if you stop working. Your notice should include the date of termination and the reason you stopped working.

If you receive an increase in pay over the amount cited above, you should notify us of the increase immediately. Failure to do so could cause an overpayment of compensation.

Sincerely,

CLAIMS EXAMINER

SAMPLE LETTER TO CLAIMANT ADVISING THAT COMPENSATION IS BEING REDUCED BASED ON ACTUAL EARNINGS, Continued

Computation of Compensation

1. Weekly pay rate:

2. Adjusted earning capacity in new position:

3. Loss in earning capacity per week: (item 1 less item 2)

4. Compensation rate: (2/3 or 3/4 x item 3)

5. Increased by applicable cost-of-living adjustments to:

6. New compensation rate each four weeks:

7. Less Health Benefits Premium:

8. Less Basic Life Insurance Premium:

9. Less Post-Retirement Basic Life Insurance:

10. Less Optional Life Insurance Premium:

11. New compensation each four weeks:

12. Beginning date of new rate:

13. First check at new rate:

14. Period covered by first check:

2-0814 Exhibit 3: Sample Letter To Employing Agency Authorizing Payment

Dear EMPLOYING AGENCY OFFICIAL:

We understand that you are attempting to reemploy CLAIMANT NAME, who has requested payment of relocation expenses by the Office of Workers' Compensation Programs (OWCP).

Under the provisions of 20 C.F.R. 10.123(f), OWCP may pay the relocation expenses of a reemployed claimant as long as the expenses are authorized according to Federal travel regulations for permanent change of duty station. This Office has found that the position accepted by CLAIMANT NAME is suitable, and relocation expenses for [him/her] may therefore be paid.

We understand that CLAIMANT NAME has already moved. [Or: We understand that your agency is able to advance travel funds to the claimant. Please release such funds on a transaction-by-transaction basis. For example, the amount required for temporary lodging should be forwarded first, followed by a separate advance for transportation of household goods.]

CLAIMANT NAME should submit bills and receipts for each expense to your office for examination. For all approved expenses, copies of the travel authorization, bill of lading and travel voucher should be forwarded to this office as soon as possible. (Copies of hotel bills, transportation tickets, etc., need not be provided).

Any disagreement between CLAIMANT NAME and your agency with regard to payment of any relocation expense should be referred to OWCP for resolution. Also, please note that payment of relocation expenses for any other employee must be authorized in advance by OWCP.

Sincerely,

SUPERVISORY CLAIMS EXAMINER

2-0814 Exhibit 4: Certification Checklist Page 1 (Link to Image)

2-0814 Exhibit 4: Certification Checklist Page 2 (Link to Image)

2-0900 DETERMINING PAY RATES

Paragraph	Subject	Date	Trans. No.
	Table of Contents	04/02	02-07
1	Purpose and Scope	12/95	96-02
		04/02	02-07
2	Establishing a Pay Rate	12/95	96-02
		04/02	02-07
3	Kinds of Appointments and Tours of Duty	12/95	96-02
		04/02	02-07
4	Average Annual Earnings	12/95	96-02
		03/96	96-06
		04/02	02-07
5	Effective Date of Pay Rate	12/95	96-02
		03/96	96-06
		04/02	02-07
6	Elements Excluded from Pay Rate	12/95	96-02
		04/02	02-07
7	Elements Included in Pay Rate	12/95	96-02
		06/97	97-13
		04/02	02-07
8	Applying Increments of Pay	12/95	96-02
		04/02	02-07
9	Daily Pay Rate	12/95	96-02
		04/02	02-07
10	Weekly Pay Rate	12/95	96-02
		06/97	97-13
		04/01	01-04
		04/02	02-07
11	Monthly Pay Rate	12/95	96-02
		04/02	02-07
12	Special Determinations	12/95	96-02
		07/96	96/17
		06/97	97-12
		04/02	02-07

2-0900-1 Purpose and Scope

1. Purpose and Scope. This chapter addresses determination of pay rates. It describes the steps in establishing pay rates, including the statutory basis of payment; the effective date of the pay rate; the elements of pay which are included in the pay rate, and those which are excluded; and how to establish daily, weekly, and monthly pay rates. The chapter also includes a section

on special determinations (which are also addressed in the FECA Program Memoranda).

2-0900-2 Establishing a Pay Rate

2. Establishing a Pay Rate. This paragraph describes in general how to determine a pay rate and where to find relevant information. While Forms CA-1, CA-2, CA-7, CA-8, CA-2a, and CA-6 contain much useful information, the Claims Examiner (CE) must also consider any narrative evidence in file. To set a pay rate, the CE should take the following steps:

a. Determine the Basis of Payment Under 5 U.S.C. 8114. If the claimant worked the whole year prior to injury (Form CA-7, section 9b., or Form CA-6, item 19) or would have done so but for the injury (Form CA-7, Section 9b., or Form CA-6, item 20), this determination is straightforward. However, if not, the CE must investigate all sources of income to determine the claimant's "average annual earnings" before proceeding further. See paragraphs 3 and 4 below.

b. Determine the Effective Date of Pay Rate. The CE must next decide whether to set the pay rate as of the date of injury (or death), the date disability began, or the date of recurrence. The pay rates on the date of injury and date disability began should be noted on Form CA-7, section 8, or Form CA-6, item 18. Pay rates for newly reported recurrences should be shown on Form CA-2a, while pay rates for previously accepted recurrences should be noted in screen 14 of the Case Management File in the Sequent system. Form CA-1003 can be used to request verification of the claimant's pay rate. See paragraph 5 below.

c. Consider Inclusions and Exclusions from Pay Rate. The nature of the increment must be considered first. Commonly encountered increments are reported on Form CA-7, section 8, and Form CA-6, item 18. If the increment can be included, the CE must determine how long it has been received and the amount of money that has been paid. Form CA-1003 can be used to ask the employing agency about commonly encountered increments of pay, such as Sunday pay and night differential. See paragraphs 6-8 below.

d. Clarify Any Discrepancies. The employing agency or claimant may challenge, correct, or expand on the evidence in the original reports with respect to terms of employment, amount of pay, or types and amounts of increments.

(1) The CE must clarify any material discrepancies in the record before establishing a pay rate for compensation purposes. This can be done by letter or by telephone call followed by written confirmation.

(2) Evidence submitted by an employing agency that is supported by records will usually prevail over statements from the claimant, unless such statements are

supported by documentary evidence.

(3) When a discrepancy in the reported pay rates is identified, compensation should be paid based on the lower figure until the CE resolves the discrepancy. A provisional rate of GS-2, step 1, or the amount reached by multiplying the daily wage by 150 may be used if necessary. Any adjustment should be included in a later payment. The CE should note use of a provisional or temporary rate in the pay rate history (screen 14 of the Case Management File) in the Sequent system.

e. Decide on Daily, Weekly, or Monthly Basis. While disability claims may be paid on a daily basis under limited circumstances, most are paid on a weekly basis. All death claims are paid on a monthly basis. See paragraphs 9-11 below.

2-0900-3 Kinds of Appointments and Tours of Duty

3. Kinds of Appointments and Tours of Duty. This paragraph describes the most common kinds of appointments in both regular Federal employment and in the Postal Service, and the most usual tours of duty.

a. Civil Service.

(1) Kinds of Appointments. The Office of Personnel Management (OPM) recognizes four kinds of appointments: career; career conditional (essentially a probationary period); term (not to exceed four years, and with no career status); and temporary (not to exceed one year, with a one-year extension possible, and with no career status).

(2) Tours of Duty. The OPM recognizes five kinds of tours of duty:

(a) Full time (40 hours per week);

(b) Part time (16-32 hours per week);

(c) Intermittent (no regularly scheduled hours);

(d) Seasonal (less than 12 months per year, with either a full-time, part-time or intermittent schedule); and

(e) On call (usually at least six months per year on an as-needed basis, with either a full-time or part-time schedule).

Items 20 and 21 on Form CA-1 and items 21 and 22 on Form CA-2 should show the employee's work schedule.

b. Postal Service.

(1) Kinds of Appointments. The Postal Service recognizes four kinds of appointments for craft employees: permanent; permanent without career status; transitional (up to one year, with no career status, similar to term employment for other Federal employees); and casual (up to 89 days, with no career status, similar to term employment for other Federal employees).

(2) Tours of Duty. The Postal Service recognizes several kinds of tours of duty, depending on the kind of work performed. An employee may work many more hours than indicated by the tour of duty. In such cases the pattern established by the actual number of hours worked or actual amounts of money earned takes precedence over the stated schedule or tour of duty in deciding which part of 5 U.S.C. 8114 to use in determining the pay rate. The tours are as follows:

(a) Craft employees, such as Letter Carriers and Mail Clerks, are paid under the Postal Service (PS) salary structure. They include: full-time regular employees, who work 40 hours per week;

Part-time regular employees, who have a fixed schedule of less than 40 hours per week; and part-time flexible employees, who are usually scheduled for 25 or more hours per week and who may in fact work a full time schedule.

Part-time flexible employees are not paid extra for holidays, as their basic pay rate includes an increment for holidays.

(b) Full time rural carriers are assigned to specific routes, each of which is evaluated at 36 to 48 hours per week depending on the size of the route.

Leave replacement workers, who include associates, reliefs and substitutes, can work any schedule.

(c) Postal inspectors have scheduled workweeks of six days per week and are not paid overtime for the sixth day. These employees are included in the Executive and Administrative Salary (EAS) pay structure, which also covers executives, professionals, supervisors, postmasters, and technical, administrative and clerical employees.

(d) Postmasters (A-E) may work 40 hours per week over six days. Pay for the sixth day does not constitute overtime.

(e) Postal Career Executive Service (PCES) employees are paid an annual salary and may work any schedule with no overtime payable.

2-0900-4 Average Annual Earnings

4. Average Annual Earnings. This paragraph describes how to determine average annual earnings. Such determinations depend on the nature and duration of the employment. They must be made before establishing weekly and monthly pay rates.

The four methods provided by the FECA for making these determinations are set forth in Section 5 U.S.C. 8114(d)(1) through (d)(4). They should be considered in the order given, so that only if the method prescribed in subsection (d)(1) cannot be reasonably and fairly applied should the CE consider using the method stated in subsection (d)(2), and so forth.

a. Whole-Year Employment--Section 5 U.S.C. 8114 (d)(1). If the employee worked at least 11 months ("substantially the whole year") before the injury in the job held at the time of injury (see section 9b. on Form CA-7 or item 19 on Form CA-6), the CE may accept the basic pay rate reported without further inquiry.

(1) Career seasonal employment is an arrangement where the employee regularly works just part of a calendar year, usually for the same general period each year and at the same type of job. Such workers often perform highly specialized duties (e.g., forest firefighters).

(a) An employee who has worked in such a position during more than one calendar year by prior written agreement with the employer is considered to be a career seasonal employee. Such an employee is entitled to receive compensation on the same basis as an employee with the same grade and step who has worked the whole year.

(b) In contrast, an employee who has worked in a position with no prior written agreement is not considered to be a career seasonal employee. For example, a holiday casual postal clerk may be rehired on new appointments several years in a row, but since the employer and the employee have not explicitly agreed that the employment will continue from year to year, it is not considered career seasonal work.

(c) Information as to the status of the employee may appear on Form CA-7. If not, the CE must contact the employing agency. The kind of appointment (career, career-conditional, term or temporary) is shown on the SF-50, Notification of Personnel Action. The form should show

clearly that the appointment is seasonal, either in the "remarks" section or in Item 32, "Work Schedule" (code G for full-time seasonal or code Q for part- time seasonal). An employee should not be considered "career seasonal" without explicit documentation of his or her status.

(d) Employment during the year before the injury is not a factor. For example, compensation for a career seasonal firefighter paid at a GS-7 level, who had worked full-time in such a position by mutual agreement during more than one calendar year, would be computed at the full-time year-round GS-7 salary, regardless of how much or how little the employee worked during the year prior to the injury.

(2) Teachers are not considered to fall under the provisions of career seasonal employment as set forth above in (1). The FECA provides for different methods of computation of average annual earnings depending on whether the employee worked in the employment in which he or she was injured for substantially a whole year. Substantially the whole year is normally defined as at least 11 months. However, substantially the whole year, in the teaching profession, would not be 11 months. In interpreting Section 5 U.S.C. 8114, the objective is to arrive at as fair an estimate as possible of a claimant’s future earning capacity. Therefore, consideration must be given to whether the claimant worked substantially the whole school year, i.e., 11/12ths of the school year.

(3) Concurrent employment can be included in determinations made under subsection 8114(d)(1) to the extent that it establishes the ability to work full-time. Either similar or dissimilar employment can be used to demonstrate this ability.

(a) A pay rate based on full-time Federal employment for at least 11 months prior to the injury may not be expanded to include the pay earned in concurrent employment, even if that employment is similar to the Federal duties. Likewise, a pay rate based on career seasonal employment may not be expanded to include the pay earned "off season".

(b) Sometimes an employee who has worked the whole year with a part-time or intermittent schedule has worked at another job concurrently with the Federal employment. If the duties of the concurrent job are similar to those of the Federal work, the pay rate must be determined according to Section 5 U.S.C. 8114(d)(3) rather than Section 5 U.S.C. 8114(d)(1). See paragraph 4c below and Program Memorandum No. 147. (Dissimilar employment may not be used to determine a pay rate.)

b. Anticipated Whole-Year Employment--Section 5 U.S.C. 8114(d)(2). An affirmative answer to section 9b. on Form CA-7 or item 20 on Form CA-6 is sufficient to show that the employee's position would have afforded employment for substantially a

whole year had it not been for the injury. A negative, absent, or ambiguous answer to this question should prompt the CE to release Form CA-1030 to the Federal employer.

Although the FECA calls for determination of the average annual earnings of an employee working the preceding year in the same or similar employment in the same or neighboring place, this step is not necessary in practice, since the earnings of an employee of the same grade and step will equal those of the injured employee. The average annual earnings are determined as described in paragraph 4.a. above. The discussion of concurrent employment in paragraph 4.a.(3) above also applies to these cases.

c. Part-Year Employment--Section 5 U.S.C. 8114(d)(3). To determine earnings under this section of the FECA, the CE will usually need to explore the claimant's employment history for the year before the injury. This may be accomplished by sending Form CA-1029 to the employee and sending Form CA-1027 to each private employer identified.

(1) Where a part-time or short-term employee has demonstrated the ability to work full time, the pay rate of an employee working full time in the job held by the injured employee should be used to compute compensation. In Irwin E. Goldman, 23 ECAB 6, the ECAB found that full-time work performed in another job during the year prior to an injury demonstrated an ability to perform full-time work in the job in which the injury occurred.

Therefore, a claimant who can establish that he or she worked for substantially the entire year prior to the injury is entitled to receive compensation on the same basis as a regular employee working in the same type of job. It does not matter what type of work the claimant performed during that year (though attending school is not considered employment). The fact that he or she had been employed demonstrates the ability to perform the job held at the time of injury for the entire year.

(2) Any situation not involving regular employment, a demonstrated ability to work full-time, or career seasonal employment is considered irregular employment. This category includes intermittent, seasonal, on-call, and discontinuous work, as well as employment where average annual earnings cannot be established under Section 5 U.S.C. 8114(d)(1) or (2).

Section 5 U.S.C. 8114(d)(3) is to be used only where sections 8114(d)(1) and (2) cannot be applied. For instance, the pay rate of a part-time flexible employee of the Postal Service who works substantially the entire year prior to injury would be computed under section 8114(d)(1)(B), not section 8114(d)(3), even if the earnings fluctuated considerably from week to week, because an annual rate of pay can be established.

Among other situations, irregular employment may include:

(a) Postal Service employees hired for the holiday season;

(b) Census enumerators;

(c) Casual firefighters hired by the Forest Service;

(d) Bin site workers, county and precinct committee workers, and a variety of other inspection personnel, food technologists, veterinary medical officers, and agriculture commodity workers personnel employed on an occasional basis by the Department of Agriculture.

(3) The factors to be considered and the sources of evidence are as follows:

(a) The injured employee's earnings in Federal employment, as obtained from the employing agency or other Federal agency where the employee worked;

(b) The earnings of another Federal employee working the greatest number of hours during the year prior to the injury in the same or most similar class, in the same or neighboring locality, as obtained from the employing agency or another Federal agency in the same or neighboring locality.

"Same or most similar class" refers both to the kind of work performed and the kind of appointment held. If the injured employee's term of employment is less than a year, the earnings of the similarly-situated employee should be pro-rated to represent the same term of employment.

If the "same or most similar class" contains more than one employee, the employing agency should be asked to state the earnings of the employee who worked the "greatest number of hours", and therefore had the highest earnings.

(c) The injured employee's occupation and earnings in non-Federal employment, as obtained from the claimant. Only earnings in employment which is the same as, or similar to, the work the employee was doing when injured may be considered. For this reason the CE must determine the nature of the employment.

The CE may release Form SSA-581 to the Social Security Administration or Form CA-1027 to the employers to verify the earnings, but if the

earnings appear reasonable, they may be used without verification; and

(d) Any other relevant factors--this is the "catch-all" provision set forth in Section 5 U.S.C. 8114(d)(3), and it is intended to encompass any factor which may pertain to the employee's "average annual earnings" in the employment in which he or she was working at the time of the injury. These factors are too various to enumerate.

(4) The last part of Section 5 U.S.C. 8114(d)(3) states that the average annual earnings shall not be less than 150 times the employee's average daily wage earned in the particular employment during the year just before the injury. In most cases this means 150 times the daily wage on the date of injury. See paragraph (5) directly below concerning application of this formula.

(5) To determine the employee's "average annual earnings" on the basis of this evidence, the CE should take the highest of:

(a) The earnings of the employee in the year prior to the injury, including any similar non-Federal employment;

(b) The earnings of a similarly-situated employee (see subparagraph (3)(b) above); or

(c) The pay rate determined by the "150 times" formula.

(6) The CE should prepare a memorandum setting forth this determination and explaining the basis for it. This memorandum, which is subject to the certifier's concurrence, should be made part of the record. Unless conflicting evidence is present or a protest occurs, approval at a level higher than the certifier is not required.

(7) Absent evidence of varying pay rates, the CE need not investigate whether the pay rate changed during the year just before the injury. However, if such evidence is received, the CE should determine the employee's various pay rates during the year just before the injury and the number of days during such period the employee was paid at each rate. The average daily wage will be determined based on this evidence according to the number of days employed at each rate.

d. Employment without Pay--Section 5 U.S.C. 8114(d)(4).

(1) Persons serving under Section 5 U.S.C. 8101(1)(B) -- that is, without pay or at nominal pay--come within the meaning of Section 5 U.S.C. 8114(d)(4). These persons usually have work schedules that are irregular as to hours worked per day and days worked per week, or the duration of the assignment is limited in

some way.

The CE should consider these factors when determining a pay rate, using narrative letters to request the evidence. The CE should allow a pay rate based upon full-time employment only if the evidence clearly shows that the person had served on a full-time basis for substantially the whole year immediately preceding the injury, or that the assignment would have afforded employment for substantially the whole year.

(2) The employing agency should be asked to furnish the following evidence:

(a) A description of the duties performed by the injured person;

(b) Full details about the person's work schedule, including the hours worked per day, the days worked per week, the date when the person began the assignment, and the date when the assignment was to be completed; and

(c) The title, grade, and pay rate of a full-time position at the employing agency in which the service performed is the same or most similar to that performed by the injured person.

(3) The injured person should be asked to submit a signed statement showing all of his or her employment during the year immediately preceding the injury, including the names and addresses of employers, the type of work performed for each, and gross earnings exclusive of overtime from each employer.

(4) The CE should prepare a memorandum setting forth the pertinent facts and recommending a determination of the average annual earnings. The pay rate may not exceed the minimum rate of pay of an employee at the GS-15, step 10 level. A Senior CE or higher-level employee must concur with the determination.

2-0900-5 Effective Date of Pay Rate

5. Effective Date of Pay Rate. This paragraph describes how to determine the date on which the pay rate should be based.

a. Disability Cases.

(1) In keeping with Section 5 U.S.C. 8101(4), compensation in disability cases is computed using the pay rates in effect on:

(a) The date of injury;

(b) The date disability began; or

(c) The date disability recurred, if the recurrence began more than six months after the employee resumed regular full-time employment with the U.S.

The dates when "disability began" or "compensable disability recurred" are the dates the employee stopped work, not the dates pay stopped. An increase of pay during the continuation of pay (COP) period does not change the pay rate for compensation purposes.

(2) The CE must first decide which date to use in establishing the pay rate. To do this the CE should determine whether:

(a) The employee was absent from work due to injury-related disability on or immediately after the date of injury; and

(b) The disability began at that time or is continuous from that time. If so, there is no choice and the date of injury will be used.

(3) If the employee did not stop work on the date of injury (or immediately afterwards, defined as the next day), and the disability began at a later date, the file should show the pay rate for the date of injury and the date when disability began. The greater of the two will be used in computing compensation. If they are the same, the pay rate should be effective on the date disability began.

(4) Recurrences of disability are defined in FECA PM 2-1500.3b. A recurrent pay rate applies only if the work stoppage began more than six months after return to regular full-time employment with the U.S.

(a) "Regular" means work that is established, rather than fictitious, odd-lot or sheltered.

(b) For employees who worked regular part-time schedules when injured, the term "full-time" should be construed as "full-schedule".

(c) Entitlement to a recurrent pay rate based on return to private employment is discussed in FECA Program Memoranda Nos. 164 and 268.

(5) If the recurrence is established, the CE should compare the pay rates on the date of injury, the date disability began (if delayed), and the date compensable disability recurred. The greatest of these pay rates will be used to compute

compensation.

(6) Payment of a schedule award does not entitle the claimant to a recurrent pay rate. The pay rate for compensation purposes is the greatest of the pay rates set forth in paragraph 5.a.(1) above (not the pay rate in effect on the date of maximum medical improvement). (See Program Memorandum No. 247.)

(7) A recurrent pay rate may be lower than the pay rate in effect on the date of injury or date disability began. This can happen when the claimant is originally injured in full-time employment, and the recurrence occurs when the claimant is working part time or has been rated for loss of wage-earning capacity. Even if the hourly rate is the same, the recurrent pay rate should be considered the actual weekly amount the claimant earned. In such cases, the pay rate on date of injury or date disability began would be used because it was the higher of the two.

(8) Due to application of cost-of-living increases, compensation based on the date of injury pay rate may exceed the amount payable using the recurrent pay rate. However, if the recurrent pay rate was higher than the date of injury pay rate, the recurrent pay rate should be used, even if a lower payment of compensation will result. (See Ralph W. Moody, 42 ECAB 364.)

b. Death Cases. The pay rate in death cases is determined by the date of injury, unless a different pay rate has been reached in a disability claim due to delayed or recurrent disability leading to the death, or because the decedent was a minor or learner whose pay rate was redetermined according to Section 5 U.S.C. 8113(a). [See paragraph 12.a. below.]

2-0900-6 Elements Excluded from Pay Rate

6. Elements Excluded from Pay Rate. This paragraph lists the increments of pay which may not be included in the pay rate, as determined either by statute or administrative decision.

a. Statutory Exclusions. Section 5 U.S.C. 8114(e) excludes the following elements from an employee's pay rate:

(1) Overtime pay. [The extra pay required by the Fair Labor Standards Act for hours worked in excess of the standard prescribed under that Act is not to be included in computing pay for the purposes of continuation of pay or compensation. Such extra pay is earned only if the actual hours are worked and is considered to be overtime pay for the purposes of Section 5 U.S.C. 8114(e)].

(2) Additional pay or allowance authorized outside the United States and its

possessions because of differential in cost of living or other special circumstances. The separate maintenance allowance authorized in Section 5 U.S.C. 5924(3) is also excluded since it is a cost-of-living allowance paid to an employee in a foreign area;

(3) Bonus or premium pay for extraordinary service, including amounts paid as a bonus for particularly hazardous services in time of war.

b. Administrative Exclusions. Per diem received by an employee while in a travel status and extra allowance paid for an employee's use of his or her private motor vehicle are excluded in determining the pay rate. Also, amounts received for unemployment compensation may not be included.

2-0900-7 Elements Included in Pay Rate

7. Elements Included in Pay Rate. This paragraph lists the increments of pay which may be included in the pay rate, either by statute or administrative determination.

a. Statutory Inclusions.

(1) Section 5 U.S.C. 8114(e) includes the following elements for determining an employee's pay rate:

(a) The employee's full salary or full cash wage;

(1) Section 5 U.S.C. 8114(e) includes the following elements for determining an employee's pay rate:

(a) The employee's full salary or full cash wage;

(b) The value of any subsistence and quarters received for services in addition to the cash wage (not including subsistence and quarters furnished by the employer and paid for directly by the employee or by deduction from the employee's salary); and

(c) Premium pay for scheduled standby duty as provided by Section 5 U.S.C. 5545(c)(1).

(2) The employer does not usually provide subsistence and quarters to employees unless the conditions and place of employment render it impossible or impractical for an employee to obtain food and lodging from another source. Therefore, the CE need be concerned with subsistence and quarters only where:

(a) The industry or the employer customarily provides such services (e.g., as with crew members employed by the Military Sealift Command, employees aboard boats, dredges, barges, and floating plant vessels, or temporary firefighters working for the Forest Service), or

(b) Item 18 on Form CA-6, section 8 on Form CA-7, or some other written evidence from the claimant or employing agency shows that the employer provided food and lodging.

b. Administrative Inclusions. It has been determined administratively that the following elements will be included in computing an employee's pay rate:

(1) Night or shift differential, including amounts paid to health professionals working for the Veterans' Administration. Night differential is paid for work between 6 p.m. and 6 a.m.;

(2) Extra compensation for Sunday or holiday work paid to regular employees of the Postal Service;

(3) Premium pay for work on Sundays under Section 5 U.S.C. 5546(a), which provides for extra pay when an employee's regular work schedule includes an eight-hour period, any part of which falls on a Sunday. This premium pay is similar to the premium pay for Sunday work paid by the Postal Service (see also Program Memorandum No. 106), and it is payable to health professionals working for the Veterans' Administration;

(4) Premium pay for work on holidays under Section 5 U.S.C. 5546(b), which provides for extra pay when an employee's regular schedule includes work on a holiday. This increment may not be paid for work which exceeds eight hours or which represents overtime;

(5) Premium pay for administratively uncontrollable overtime (AUO), including holiday pay under Section 5 U.S.C. 5545(c)(2) (see also FECA Program Memoranda Nos. 106 and 280);

(6) Extra pay received by immigration inspectors for work performed between 5:00 p.m. and 8:00 a.m. and for all work performed on Sundays and holidays (see FECA Program Memorandum No. 68;

(7) Extra pay received by customs inspectors for work performed between 5 p.m. and 8 a.m. and for all work performed on Sundays and holidays, until January 1, 1994 (see FECA Program Memoranda Nos. 278 and 281);

(8) Availability pay for criminal investigators pursuant to Pub. Law 103-329. This increment (25% of basic pay) is paid to ensure the availability of investigators for unscheduled duty, and replaces AUO [see (5) above] for these employees;

(9) "Heavy duty" pay pursuant to 39 U.S.C. 3543 for rural mail carriers serving heavily patronized routes;

(10) Quarters allowances for personnel serving overseas, paid pursuant to Section 901(1) of the Foreign Service Act of 1946 and Executive Order No. 10011, dated October 22, 1948;

(11) "Arctic bonus" pay received by personnel working at Foreign Arctic Weather Stations of the National Oceanic and Atmospheric Administration, Department of Commerce;

(12) Extra pay received by employees of the U.S. Public Health Service, Carville, Louisiana, because of the intimate contact with patients who have Hansen's disease and paid pursuant to the provisions of Section 209(g) of the Public Health Service Act (58 Stat. 687, 42 U.S.C. 210(f) and Executive Order No. 10354, dated May 26, 1952);

(13) Wages paid for National Guard service when membership in the National Guard is a condition of the employee's civilian employment with the Guard. The wages paid for National Guard service during the year prior to injury should be obtained. The annual wage paid for these services will be divided by 52 and added to the basic pay rate. Travel allowances and per diem pay are excluded, as are the items noted in Section 5 U.S.C. 8114(e)(1), (2) and (3) (see paragraph 6 above).

In addition to wages paid for attending drills or field training, the following are included in the pay rate for compensation purposes:

(a) Earnings received for active Federal service under a Presidential "call";

(b) All inactive military training pay regardless of the frequency or type of training;

(c) Subsistence and quarters authorized by 37 U.S.C. 402 and 403;

(d) Additional pay given to commanders of units for performing administrative duties under 37 U.S.C. 309;

(e) Dependents Assistance Act payments made to enlisted members in grades 4 and below;

(f) Incentive pay authorized by 37 U.S.C. 301; and

(g) Payments in accordance with 32 U.S.C. 319 or 37 U.S.C. 204(h) during periods of disability sustained by a National Guard member who has contracted a disease or incurred an injury in line of duty.

(14) "Dirty-work pay" extended to employees who work under conditions which soil the body or clothing more than normally expected in performing the duties of the job;

(15) "Hazard pay" when it is included for work which is recurrent in nature and part of the employee's normal duties;

(16) Locality pay and "COLA" (cost-of-living allowance) paid to certain employees as part of their normal pay and in addition to their salary, because of differences in cost of living within the U.S. and its possessions (e.g., Puerto Rico);

(17) "Remote worksite allowance" under the provisions of Section 5 U.S.C. 5942 paid to certain employees assigned to regular duty at designated locations so remote from the nearest established communities or suitable places of residence as to require an appreciable degree of expense, hardship, and inconvenience beyond that normally encountered in metropolitan commuting;

(18) "Post differential" paid under Title II, Part D of the Overseas Differential and Allowances Act (Pub. Law 86-707). This is regarded as a special recruitment and retention allowance granted because of the overall environmental conditions or rigors of the particular post. It is not a cost-of-living differential or economic equalization factor, which would be excluded from the pay rate for compensation purposes;

(19) "Nonwatchstanding allowance" paid to day-working crew members by the Military Sealift Command, to compensate for overtime they are not eligible to earn. This allowance is a means of maintaining wage differentials among the crew. It may be included in the base pay as reported by the official superior or may be shown separately;

(20) "Leave supplement" paid to all unlicensed crew members or watchstanding officers by the Military Sealift Command, to compensate for overtime, penalty or premium pay that is not earned while on authorized leave. This supplement is a means of maintaining wage differentials among the crew,

and is not among the categories of pay excluded by Section 5 U.S.C. 8114(e);

21) Extra pay authorized under the Fair Labor Standards Act (FLSA), 29 U.S.C. 207(k), for emergency medical technicians and other employees who earn and use leave on the basis of their entire tour of duty, and who are required to work more than 106 hours per pay period.

GS-081 firefighters with pay rate effective dates prior to October 11, 1998 would also be included in this section.

Such pay may be included retroactive to July 21, 1987, when the Office of Personnel Management made similar changes in its regulations. To be entitled to an adjustment in the pay rate, the claimant must have been in pay status on or after that date. If retroactive payment is authorized in a long-term disability case, the pay rate must be adjusted so that CPIs will be included;

(22) The Federal Firefighters Overtime Pay Reform Act of 1998 (Public Law No. 105-277) amended Title 5 of the U.S. Code to define hours worked by firefighters in excess of 106 bi-weekly, or 53 weekly, as "overtime". Public Law 106-554, which was enacted in December 2000, contained language establishing that those hours in excess of 106 bi-weekly or 53 weekly should not be considered "overtime" pay for the purpose of computing pay under Section 5 U.S.C. 5545b. These changes became effective the first day of the first pay period after October 1, 1998. (This date is presumed to be October 11, 1998.) This change applies only to GS-081 firefighters who are covered by Section 5 U.S.C. 5545b.

The Federal Firefighters Overtime Pay Reform Act of 1998 provides "overtime" for hours in the regular tour of duty to both FLSA nonexempt and exempt firefighters. The weekly pay rates are computed in the same manner for both types of firefighters *except* there is a cap on the "overtime" hourly rates for FLSA exempt firefighters. The cap is set at 1.5 times the GS 10, step 1 hourly rate (computed using the 2087 divisor and including any applicable locality pay) but the capped rate may not fall below the individual firefighter's hourly rate of basic pay. (See PM 2-0900.8.d.); and

(23) Dive pay is authorized for wage system employees for those hours when they are actually performing diving duties. The pay rate is 175 percent of the WG-10, step 2 rate, adjusted for locality.

2-0900-8 Applying Increments of Pay

8. Applying Increments of Pay. This paragraph discusses when the CE may accept the amounts of differential pay increments as reported, and when to seek clarification. The CE should normally not delay a payment to obtain such clarification, which can often be obtained by using Form CA-1003.

a. Receipt on Regular Basis. If an additional amount or percentage was paid for premium, Sunday, night differential, shift pay, FLSA extra pay (see paragraph 7.b.(21) above), or firefighters extra pay (see paragraph 7.b.(22) above) and the file contains no evidence showing that this amount or percentage was paid irregularly, or that it varied, the CE may add the indicated amount or percentage to the base pay reported without further inquiry. For wage grade employees, night differential pay is considered part of basic pay, and the CE need not obtain night differential earnings for an employee who worked the same shift all year.

b. Varying Amounts. If the evidence shows that the amount or percentage paid for premium, Sunday, night differential, shift pay, FLSA extra pay or firefighters extra pay actually or may have varied during the year prior to the injury, the CE should determine the amount of additional pay received during that year and add it to the reported base pay. (See subparagraph 8.c. below concerning FLSA pay and subparagraph 8.d. below concerning firefighters' pay.)

c. FLSA Pay. The pay rates of individuals entitled to this increment of pay are based on annual pay rate and percentage of premium pay, which is 25% if the employee works on Sundays and 22% if not. Their pay is based on 144 hours of work each 14 day pay period, of which 106 are regular hours and 38 are FLSA overtime hours. The formula is as follows:

(1) Yearly pay/26 = basic bi-weekly pay

(2) Basic bi-weekly pay x premium pay percentage = standby premium pay

(3) Basic bi-weekly pay + standby premium pay = total pay without FLSA OT

(4) Total pay without FLSA OT/144 = hourly regular rate

(5) Hourly regular rate x .5 x 38 = FLSA overtime

(6) Total pay without FLSA OT + FLSA overtime = total pay

d. GS-081 Firefighters Pay. Under the Federal Firefighters Overtime Pay Reform Act of 1998, there are two categories of firefighters based on the type of work schedule. Different pay computation rules apply to each category.

(1) Firefighters with regular tours of duty generally consisting of 24-hour shifts (which is the most common situation).

(a) Annual salary / 2756 (53 hours of regular pay per week X 52 weeks) = firefighter hourly rate

(b) Firefighter hourly rate X 106 hours = bi-weekly base pay

(c) Firefighter hourly rate X 1.5 = "firefighter overtime" rate (subject to GS-10, step 1 cap as described in PM 2-0900.7.b.(22)

(d) "Firefighter overtime" rate X number of hours in regular tour in excess of 106 hours = bi-weekly "firefighter overtime"

(e) (Bi-weekly base pay + bi-weekly "firefighter overtime") / 2 = weekly pay rate

(Note: most 24-hour shift firefighters have a regular bi-weekly tour of 144 hours (six 24-hours shifts) consisting of 106 regular hours and 38 "firefighter overtime" hours; thus, 38 hours (144-106) would be used in step (d) above.)

(2) Firefighters with an extended regular tour built on top of a 40-hour basic workweek.

(a) (Annual salary / 2087) X 80 hours = bi-weekly base pay

(b) Annual salary/ 2756 = firefighter hourly rate

(c) Firefighter hourly rate X 26 hours = additional bi-weekly base pay

(d) Firefighter hourly rate X 1.5 = "firefighter overtime" rate (subject to GS-10, step 1 cap as described in PM 2-0900.7.b.(22)

(e) "Firefighter overtime" rate X hours in regular tour in excess of 106 hours = bi-weekly "firefighter overtime"

(f) (Bi-weekly base pay + additional bi-weekly base pay + bi-weekly "firefighter overtime") / 2 = weekly pay rate

(Note: a common schedule would be a 40+16 weekly tour, which translates into a bi-weekly tour of 112 hours, including 6 "firefighter overtime" hours to be used in step (e) above.)

2-0900-9 Computing Daily Pay Rate

9. Computing Daily Pay Rate. This paragraph provides guidance on how to compute daily pay rates, which may be used under the circumstances noted below. However, in practice, payments in disability claims are almost always based on the weekly rate.

a. Criteria. A daily pay rate may be used only when the following three tests are met:

(1) The injury caused only temporary total disability.

(2) The period of compensable disability (the period for which compensation is paid) does not, or is not expected to, exceed 90 calendar days and no increments of pay (e.g., Sunday pay) are involved.

(3) The "average annual earnings" of the employee are not readily determinable.

b. Length and Permanency of Disability. In deciding whether the injury will likely cause permanent disability or a period of temporary total disability exceeding 90 calendar days, the CE must consider the nature and severity of the injury; the medical prognosis; the age of the employee; and the nature of the employment. When it is unclear whether permanent effects will result from the injury, or whether the temporary total disability will exceed 90 calendar days, and the "average annual earnings" cannot be readily determined, the CE should set up payment based on the daily pay rate and make appropriate inquiries to develop the weekly pay rate.

c. Fixed Schedule. Where the evidence on Form CA-1 or CA-2 shows that the employee is a regular worker with fixed hours and days of duty, the CE will determine the actual daily wage according to how it is reported:

(1) If on a daily basis, the amount shown will be used as the actual daily wage;

(2) If on an hourly basis, the actual daily wage will be computed by multiplying the hourly pay by the hours worked per day shown in item 20 on Form CA-1 or item 21 on Form CA-2; or

(3) If on a yearly basis, the actual daily wage will be computed by dividing the annual salary rate by 260 when the regular workweek is five days. For shorter or longer workweeks, it will be necessary to compute the number of work days per year, and divide the annual salary by that number.

d. Intermittent Schedule. Where Form CA-1 or CA-2 shows that the employee did not have fixed hours and days of duty, the CE should determine the actual dates worked during the month immediately preceding the injury to determine whether the employee worked a reasonably regular schedule of 5, 5 1/2 or 6 days per week.

(1) If so, the actual daily wage will be computed by dividing the employee's gross earnings during the month just before the injury by the actual number of days the employee worked during such period; or

(2) If not, the CE should not try to compute an actual daily wage when the employee did not work a reasonably regular schedule each week. In this situation, computing compensation on a daily basis is not feasible and the pay rate should be computed on a weekly basis.

2-0900-10 Computing Weekly Pay Rate

10. Computing Weekly Pay Pate. This paragraph provides guidance on how to compute a basic weekly pay rate, depending on the form in which pay is reported:

a. Annual Basis. An annual salary, which may be reached either by report from the employing agency or determination of average annual earnings, is divided by 52.

b. Daily Basis. The amount shown is multiplied by 5 for a five-day work week, 5½ for a five-and-a-half day workweek, and so on.

c. Hourly Basis.

(1) For Postal Service employees, the amount shown is multiplied by 2080, then divided by 52.

For USPS employees who work less than a full schedule, the figure of 2080 hours should be prorated (e.g. 1040 hours when the employee works four hours per day), then multiplied by the amount shown; or

(2) For regular Federal employees, the amount shown is multiplied by 2087 (by administrative determination, the number of hours in a full work year based on a 40 hour work week). This figure is then divided by 52.

For employees who work less than a full schedule, the figure of 2087 hours should be prorated (e.g., to 1043.5 hours when the employee works four hours per day), then multiplied by the amount shown.

The figure of 2087 hours equals 52 weeks plus .875 of one workday. To calculate

increments of pay (night, Sunday, etc.), first multiply the hourly increment by 2087, then divide the sum by 52 to obtain the amount of the weekly increment.

2-0900-11 Computing Monthly Pay Rate

11. Computing Monthly Pay Rate. This paragraph describes how to compute a monthly pay rate, which is used in death cases. To do so, the CE must first determine the employee's "average annual earnings" in the manner provided by Section 5 U.S.C. 8114(d) and the instructions appearing in paragraph 4 above. This figure is then divided by 12.

2-0900-12 Special Determinations

12. Special Determinations. This paragraph defines the rules for determining pay rates based on unusual terms of employment, pay scales, or increments of pay.

a. Minors. Section 5 U.S.C. 8113(a) states that:

> If an individual (1) was a minor or employed in a learner's capacity at the time of injury; and (2) was not physically or mentally handicapped before the injury; the Secretary of Labor...after the time the wage-earning capacity of the individual would probably have increased but for the injury, shall recompute prospectively the monetary compensation payable for disability on the basis of an assumed monthly pay corresponding to the probable increased wage-earning capacity.

The FECA does not define the term "minor", and whether a person has attained his or her majority must be determined under state law of the claimant's domicile. Since the interpretation of state laws and judicial decisions is involved, any case where this issue arises should be referred to the National Office for a determination.

b. Cadets at Federal and State Maritime Academies. Cadets at Federal and State Maritime Academies do not receive wages while in training, but they are provided with a monthly allowance for subsistence, quarters, etc. This sum will serve as the basis for computing compensation. However, cadets are working in learners' capacities and the pay rate may be recomputed according to the provisions of Section 8113(a) where appropriate.

c. Peace Corps Volunteers, Volunteers in Service to America (VISTA) and Job Corps Enrollees. (See also FECA PM 2-1700.4 through 6.) Entitlement to compensation for these groups of employees does not begin until the volunteers or enrollees are separated from their employment. The pay rate to be used is the one in effect at the time of separation.

(1) For Peace Corps Volunteers, the pay rate is set at the GS-7, step 1 level, and for Peace Corps Leaders, it is set at the GS-11, step 1 level. For injuries on or after September 7, 1974, the pay rate of Peace Corps Volunteers designated as "heads of households" is set at the GS-11 rate. Locality pay is not included.

(2) For VISTA Volunteers injured on or after October 1, 1993, the pay rate is set at the GS-5, step 1 level. (Before that time, the pay rate was set at the GS-7, step 1 level.); or

(3) For Job Corps enrollees, the pay rate is set at the GS-2, step 1 level.

d. Department of Agriculture--Cooperative Employees. For a person working with the Department of Agriculture under a cooperative agreement with a non-Federal public or private organization, the CE should compute the pay rate based on the total salary received from the Department of Agriculture and the cooperating organizations. Form CA-7 or some other report from the employing agency should show the gross salary received by the employee from all entities involved. The CE should request this information from the employing agency if it is not received with the original reports. Any compensation payable should be reduced by the amount which the non-Federal organization paid to the claimant.

e. Census Enumerators and Crew Leaders--1990 Census. (For injuries occurring during previous censuses, consult the National Office.) Information about computing compensation for these employees may be found in FECA PM 2-0901.9.

(1) For the 1990 count, the Bureau of the Census employed approximately 446,000 individuals in 449 district offices throughout the U.S. Another group of about 12,000 employees worked in processing offices located in Albany, NY; Baltimore, MD; Jacksonville, FL; Jeffersonville, IN; Kansas City, MO; Austin TX; and San Diego, CA. Most employees in district offices were enumerators and crew leaders on temporary not-to-exceed 180 day appointments, while most employees in the processing offices were clerks, lead clerks, data entry clerks, and lead data entry clerks.

(2) All employees were paid on an hourly basis. Wages in the district offices varied by geographical area, and pay types were assigned accordingly. Any questions regarding pay rates may be referred to the Bureau of the Census, Demographic and Decennial Staff.

(3) Following are the hourly wage rates for enumerators and crew leaders:

Pay Type	Enumerator	Crew Leader

Level A	$5.50	$6.50
Level B	6.00	7.00
Level C	6.50	7.50
Level D	7.00	8.00
Level E	7.50	8.50
Level F	8.00	9.00
Level G	5.00	6.00
Level H	8.50	9.50
Level I	9.00	10.00
Level J	10.00	11.00

(4) Entry level hourly wage rates for positions in the processing offices were as follows:

Clerk: $5.50
Lead Clerk: $6.90
Data Entry Clerk: $6.92
Lead Data Entry Clerk: $7.72

f. Special Census Employees. The Census Bureau sometimes enters into contracts with state, county and city governments to conduct various types of surveys. Most of the workers are hired for very short periods of time, and they are paid directly by the local entity conducting the study. It has been determined that they are not eligible for COP. The CE should follow the guidance given in paragraph 4.c.(3) above to establish the pay rate.

g. Rural Carriers/Rural Carrier Leave Replacements. The salaries for these employees are based on the evaluation of their routes. The Postal Service uses a formula to determine the evaluated salary which may be based on an evaluation of between 36 and 48 hours per week. Salaries derived from routes which are evaluated at more than 40 hours per week are not considered to include overtime. Rural carriers are not in an overtime status unless they actually work more than the number of hours stipulated in their contract for their route evaluation. The evaluated pay, therefore, is the pay rate for compensation purposes.

The salary for these employees may vary over the life of the claim due to reevaluations of the employee's route. These changes will only affect the pay rate for compensation purposes on the date disability begins, or if the employee is performing full duty at the time of a recurrence that qualifies for a recurrent pay rate. If the pay rate on the date disability begins or at the time of a qualifying recurrence is lower than the date of injury pay rate, then the date of injury pay rate is used to compute compensation.

If a change occurs during a period of disability, compensation continues to be based on

the original pay rate. For rural carrier leave replacements, who are hired on a part-time basis to substitute for rural carriers and may work from 1-6 days in a given week, the pay rate should be established in accordance with Section 5 U.S.C. 8114(d).

2-0901 COMPUTING COMPENSATION

Paragraph	Subject	Date	Trans. No.
	Table of Contents	04/02	02-08
1	Purpose and Scope	07/96	96-17
2	Related Topics	12/95	96-02
3	Responsibilities	01/01	01/03
4	Factors in Computing Compensation	12/95	96-02
5	Compensation Rate	12/95	96-02
6	Period of Entitlement	05/04	05-04
7	Work Days/Calendar Days	12/95	96-02
8	Basic Computations	12/95	96-02
9	Special Determinations	12/95	96-02
10	Minimum Compensation	12/95	96-02
11	Maximum Compensation	07/00	00-09
12	Consumer Price Index (CPI) Increases	12/95	96-02
13	Reserved	07/00	00-09
14	Schedule Awards	12/95	96-02
15	Loss of Wage-Earning Capacity	12/95	96-02
16	WL for Medical Examination or Treatment	12/95	96-02
17	Additional Death Benefits	12/95	96-02
18	Other Payees	12/95	96-02
19	Reinstatement of Leave	07/00	00-09

Exhibits

1	Minimum Compensation Rates	01/01	01-03
2	Maximum Compensation Rates	01/01	01-03
3	Consumer Price Index (CPI) Adjustments	01/01	01-03
4	Reserved	07/00	00-09
5	Percentage Table of Schedule Awards	07/96	96-17
6	Activity Codes	07/96	96-17

2-0901-1 Purpose and Scope

1. Purpose and Scope. This chapter defines the elements of a compensation payment and shows how they are combined to compute benefit payments for disability, death, and schedule award benefits. Formulas for computing basic entitlements are given. Also described are minimum and maximum limits to compensation, leave repurchase, loss of wage-earning capacity (LWEC) determinations, Consumer Price Index (CPI) increases, and payments made for wages lost while obtaining medical treatment.

The material in this chapter applies to computation of compensation for injuries occurring after September 12, 1960. For injuries prior to that date, consult the National Office.

2-0901-2 Related Topics

2. Related Topics. This paragraph indicates where more information on a variety of topics related to compensation payments may be found. This information is contained in other chapters of the FECA PM and in other resources.

a. Kinds of Payments.

(1) Initial payments of compensation are addressed in FECA PM 2-0807, which also discusses continuation of pay (COP), and in FECA PM 2-0811. These references describe the Claims Examiner's (CE's) responsibility to:

(a) Make timely payments of compensation, including the CE's authority to make a 15-day payment without Form CA-7;

(b) Establish a provisional pay rate if all elements of the pay rate cannot be determined immediately, and adjusting it later if necessary; and

(c) Call the employing agency if information is needed to make a payment.

(2) Placement on the periodic roll is addressed in FECA PM 2-0812, which also discusses monitoring claims on the periodic roll.

(3) Schedule awards are addressed in FECA PM 2-0808.

(4) Loss of wage-earning capacity determinations are addressed in FECA PM 2-0814.

(5) Death cases are addressed in FECA PM 2-0700.

b. Mechanics of Making Payments.

(1) Codes required to make payments, including adjudication codes, case status codes, and TPCUP (timely payment of compensation) codes, are described in FECA PM 2-0401.

(2) Set-up and keying of payments are addressed in FECA PM Part 5, Benefit Payments, as follows:

(a) Daily roll payments, FECA PM 5-304.

(b) Periodic roll payments, FECA PM 5-305.

(c) Schedule awards, FECA PM 5-306.

(d) Death benefits, FECA PM 5-307.

(3) Further information on keying payments can be found in the Compensation Payment Users' Guide.

c. Specialized Topics.

(1) Dual benefits and elections between various entitlements are discussed in FECA PM 2-1000.

(2) Lump sum payments, which are not made except in schedule award cases, are discussed in FECA PM 2-1300.

(3) Deductions for health benefits and life insurance are addressed in FECA PM 5-400.

(4) Garnishment of compensation payments is discussed in FECA Program Memorandums Nos. 235 and 248 (also see paragraph 18 below).

2-0901-3 Responsibilities

3. Responsibilities. This paragraph describes the major responsibilities in computing and paying compensation. In most offices, CEs and fiscal personnel share these duties, though the division of responsibilities may vary.

a. Computation. The CE is responsible for determining all factors involved in computing payments. The CE may also be responsible for the actual computations in some cases where the automated system cannot perform the calculations, but should refer complex cases to the claims or fiscal staff member designated to handle complicated calculations.

b. Certification. By initialing a payment setup, the certifier verifies that the adjudication or calculation of a schedule award is correct, and also that the setup is correct. Payments must be certified before the payment is issued. All payments must be verified after keying as well. The verifier must initial and date the CP040 output before the payment cut-off date. Where correction or deletion is necessary, this must be done before the cut-off date.

(1) All initial payments in death and schedule award cases must be certified by a GS-12 CE or above. No delegation is authorized.

(2) All other initial payments must be certified by a GS-12 CE or above, or by a GS-11 CE designated by the Supervisory CE to certify payments. The certifier of a first payment assumes responsibility for the adjudication of all issues in the case and the eligibility of the case for payment, as well as the correctness of the payment itself. Subsequent routine payments on the daily roll do not require certification.

(3) All subsequent payments for periodic, schedule award and death benefits must be certified by a GS-12 CE or above, or by a GS-11 CE designated by the Supervisory CE to certify payments. Likewise, overpayment calculations, adjustments to correct the pay rate, and payments for loss of wage-earning capacity must be certified. However, payments for disfigurement do not require certification.

(4) A GS-12 CE or designated CE may approve payments up to and including $50,000. All payments over $50,000 must be certified by a Supervisory CE, GS-13 or above, or by a designated GS-12 CE.

(5) When a decision concerning entitlement is made at a level above that of the CE and certifier, these individuals may still be required to authorize payment. In doing so they function in a dual capacity:

(a) With respect to the decision of this superior they are merely carrying out orders; and

(b) With respect to other decisions essential for making payment, they are solely responsible for the accuracy of such decisions.

(6) For claimants being paid on the periodic roll, no certification is required to change the compensation rate (from 66 to 75 percent, or vice versa) based upon marriage, death, divorce, student status, etc. Likewise, a change of payee address to reflect direct deposit need not be certified. The file must contain clear evidence supporting the change, however.

c. Data Entry. The CE is often responsible for entering payments directly into the Automated Compensation Payment System (ACPS). In some instances, the Benefits Payroll Assistant (BPA) or the Workers' Compensation Assistant (WCA) is responsible for this action.

(1) Depending on the kind of payment, the CE should complete the following:

(a) For initial daily roll payments, and later daily roll payments in offices where the BPA or WCA keys the payments, Daily Roll Payment Worksheet (Form CA-25A);

(b) For placement on the periodic roll, Disability Benefits Payment Worksheet (Form CA-25);

(c) For schedule award payments, Schedule Award Worksheet (Form CA-203);

(d) For death benefits, Fatal Benefits Payment Worksheets (Forms CA-24 and CA-24A).

(2) The CE is responsible for noting the pay rate, as well as information about health benefits enrollment and optional life insurance into the pay rate history, which is part of the Case Management function on the Sequent system.

d. Other Responsibilities of the CE.

(1) The need to make payments on a timely basis is addressed in FECA PM

2-0807.17. Entries to the Timely Payment of Compensation Program (TPCUP) are discussed in FECA PM 2-0401.10.

(2) The adjudication and case status codes must be entered correctly before keying the payment. A list of these codes is given in FECA PM 2-0401.7 and 8.

(3) The claimant's mailing and check addresses must be kept current in the Case Management File (CMF). When the CE notes a written request for change of address, the request must be referred to the person designated for changing addresses.

(4) In a doubled case, the CE must determine which file number should be used (i.e., the file number for the injury in question, which is not necessarily the master number).

2-0901-4 Factors in Computing Compensation

4. Factors in Computing Compensation. This paragraph defines the factors which enter into the computation of a payment for disability or death, and are established by statute. They are: the pay rate by day, week, month or year, including any increments such as night differential or Sunday pay; the compensation rate; the work or calendar day determination; the period of entitlement; and various adjustments to compensation reflecting health benefits, life insurance deductions, cost-of-living increases, wage-earning capacity, actual earnings, and minimum and maximum payments.

a. All Cases (Disability and Death. The CE must consider the following factors:

(1) The pay rate on which to base compensation. See FECA PM 2-0900 and FECA Program Memorandums.

(2) The period of entitlement. See paragraph 6 below.

(3) Whether the claimant is enrolled in a health benefits plan and, if so, under what plan and for what period premiums should be deducted. Form CA-1003 may be used to obtain this information. See FECA PM 5-400.

(4) Who shall receive the compensation payable for a claimant who is incompetent. See paragraph 18 below.

b. Disability Cases. The CE must also decide:

(1) The compensation rate (percentage of pay). See paragraph 5 below.

(2) Whether the three-day waiting period is applicable and, if so, the dates covered. See paragraph 6 below.

(3) Whether premiums for optional life insurance should be deducted, and if so, the date on which OWCP should begin deductions (see FECA PM 5-0400). Form CA-1003 may be used to obtain this information.

(4) Whether an attendant's allowance is payable, and if so, in what amount (see FECA PM 2-0812.8).

c. Death Cases. The CE must also decide:

(1) The persons entitled to receive compensation because of death and the rates at which compensation is payable to each, as well as payments for beneficiaries who are minors, students, or incompetent. See paragraph 5 below.

(2) The amounts payable for funeral and burial expenses, administrative costs, and transportation of remains, and who shall receive such payments. See FECA PM 2-0700.14 and 15 and paragraph 17 below.

2-0901-5 Compensation Rate

5. Compensation Rate. This paragraph addresses the percentage of the pay rate to which a beneficiary is entitled. This percentage is known as the compensation rate.

a. Disability Cases. The basic compensation rate is 66 $^{2/3}$ percent, which is increased to 75 percent if there is at least one eligible dependent as defined in Section 5 U.S.C. 8110. Basic compensation for disability is obtained by multiplying the pay rate times the compensation rate.

A discussion of dependents is found in FECA PM 2-0811.10.

b. Death Cases. The compensation rate for each beneficiary is established according to Section 5 U.S.C. 8133. Basic compensation for a beneficiary in a death case is obtained by multiplying his or her compensation rate by the deceased employee's monthly salary. The total of the rates for all survivors of one employee may not exceed 75 percent.

A discussion of dependents and determining the percentages of their entitlements is found in FECA PM 2-0700.7-10.

2-0901-6 Period of Entitlement

6. Period of Entitlement. This paragraph discusses the length of time for which compensation may be paid. The period of entitlement can be a segment of time in the past, or it can extend indefinitely into the future.

a. Waiting Days. Under Section 5 U.S.C. 8117, the waiting days are the first three calendar days of injury-related disability following the termination of any continuation of pay (COP), or any sick or annual leave used, if the employee is in a non-pay status for all or part of those days.

This provision applies regardless of whether the three days are regularly scheduled non-work days (e.g., Saturday and Sunday) or holidays. Non-work days occurring prior to or during any period of COP or leave use should not be considered as waiting days.

b. Dates of Payment. The CE is responsible for specifying these dates, as follows:

(1) For daily roll payments, the CE will provide a beginning date and an ending date; the number of days in the period, if an intermittent period is involved; and whether work days or calendar days were counted.

If the claim is for intermittent hours, then the total number of hours missed should be calculated and portions of an hour should be keyed as a decimal. For example, when entering a payment for 4 ¼ hours, it should be keyed as 4.25 hours.

(2) For periodic roll payments, only beginning and ending dates must be supplied.

(3) For schedule award payments, the CE provides the number of days of the award, which often includes a fraction of a day expressed as a decimal, and the beginning date.

(4) For death cases, a beginning date is supplied for all beneficiaries, and an expiration date is provided for each individual beneficiary in accordance with the person's eighteenth birthday, student status, etc.

2-0901-7 Work Days/Calendar Days

7. Work Days/Calendar Days. This paragraph discusses the difference between work days and calendar days. A "workweek" includes only the regularly scheduled workdays, while a "calendar week" includes all seven days, including off-duty days. The CE should note on the form used to set up payment, or in data entry, whether the payment is based on work days or calendar days. If the payment is for an intermittent period, the CE should also note how many days are to be paid. The employee's regular schedule can be determined from Form CA-7, item 22; Form CA-8, item 16; Form CA-2a, item 28; or narrative evidence.

a. Work Days. If compensation is paid for a short period in a disability case, the claimant is paid for each actual work day lost. The CE determines the number of days lost during the period of disability. If the claimant's normal work week is five days, OWCP pays one-fifth of the weekly compensation for each lost work day. This is the "work day" basis of payment. Computation is as follows:

Weekly pay rate x compensation rate =amount rounded to the nearest $.01) xno. days lost/no. workdays in work week

b. Calendar Days. If the employee had an irregular work schedule, or if the claimant is placed on the periodic roll, payment is made on a "calendar day" basis. Schedule awards and death benefits are also paid in this way. The claimant receives pay for every day of the week during the period of disability, at the rate of one-seventh of the compensation rate for each day.

(1) Computation is as follows: Weekly pay rate x compensation rate x no. days of entitlement/7

(2) The expiration date for payments other than schedule awards and death benefits should be set to coincide with the end of a roll period wherever possible, for administrative ease.

2-0901-8 Basic Computations

8. Basic Computations. This paragraph discusses how to compute various kinds of payments. Compensation for disability is almost always computed on a weekly basis, though payments are sometimes made on a daily basis. Compensation in death cases is computed on a monthly basis.

a. Daily Basis. Using the daily pay rate, compensation is paid for the regularly scheduled work days on which the employee was disabled due to the injury. The CE will need to determine the employee's basic workweek and regular days off as outlined in FECA PM 2-0900.9 to pay compensation on this basis.

b. Weekly Basis. Most temporary total disability cases, and all cases where the injury causes permanent total or partial disability and temporary partial disability, are paid on a weekly basis.

(1) Compensation for a full workweek is computed according to the following formula when the period of compensable disability, i.e., the number of calendar days, is divisible by seven, or when a schedule award is paid:

Weekly pay rate x compensation rate = amount rounded to the nearest $.01 x no. calendar days/7

(2) Compensation for less than a full workweek is paid for the regularly scheduled workdays on which the employee was disabled due to the injury, rather than the calendar week. (See Cecil W. Wood, 22 ECAB 257.)

(a) Compensation should be paid on the basis that the employee's regular days off are Saturday and Sunday unless the file shows otherwise. In the latter case, the CE will need to determine the employee's regularly scheduled workweek.

(b) For any period less than a full workweek, or any individual workdays not comprising a full workweek, the formula for computing compensation is:
Weekly pay rate x compensation rate =amount rounded to the nearest $.01 x no. workdays lost/no. workdays in workweek

(c) When compensation ends, any indication that the workweek has

changed from the one previously reported should prompt a determination of the new workweek. Compensation should be paid only for the regularly scheduled workdays during the week in which the employee returned to work.

(3) Either formula may be used in continuing payments of compensation for full scheduled workweeks in that five-fifths, six-sixths, and seven-sevenths all make a whole.

For example: An employee has a basic workweek of Friday through Tuesday, with Wednesday and Thursday off, and pay loss starts on Saturday. Compensation will be computed according to the formula outlined in subparagraph (2) just above for pay loss from Saturday through Thursday. Compensation for the week in which the employee returns to work should also be computed using the formula outlined in subparagraph (2).

(4) Compensation payable for less than a full workday is computed as follows:

Weekly pay rate x compensation rate =amount rounded to the nearest $.01 x no. hours lost, rounded to nearest whole hour / no. hours in work week

For example: Compensation for three hours of pay loss at $400 for 40 hours at the basic rate would be computed as follows:

$400 X 2/3 = 266.666...
($266.67 X 3)/40 = $20.00

(5) Some employees work their usual number of hours per week or pay period on alternative schedules (known as "flextime"). The arrangement may be informal, allowing the employee to work less or more than eight hours each day, within certain limitations, as long as a biweekly total of 80 hours (for a full-time employee) is met. Or, the schedule may be formally structured, such that (for example) a full-time employee works eight nine-hour days and one eight-hour day during a two week pay period, with the remaining day off.

(a) For either a formal or informal compressed schedule, compensation may be paid using a weekly pay rate if disability extends beyond the length of one full scheduling cycle (usually a pay period). Where a formal schedule exists and disability is less than a scheduling cycle, the CE should use the hourly pay rate, compute the total number of hours for which compensation is payable, and key or set up the payment accordingly.

(b) If the compressed schedule is not formal and/or the disability extends for at least a full scheduling cycle, the CE should treat a compressed workweek as the number of days which would correspond with the usual number of hours worked per week, with the number of hours worked per week evenly distributed throughout the week.

For instance, an employee who works 40 hours per week would be considered to have a workweek of five days, eight hours per day, whereas an employee who works 32 hours per week would be considered to have a workweek of four days, eight hours per day.

c. Conversion from Daily to Weekly Basis. If compensation is paid on a daily basis and the injury later results in permanent disability or a compensable period of temporary total disability longer than 90 calendar days, the CE should convert the pay rate from a daily to a weekly basis. This action should be taken by the 91st calendar day of compensable temporary total disability or when the evidence shows that permanent disability will result.

When converting to a weekly basis, no adjustment should be made for any prior period paid at the daily rate if the conversion would reduce the pay rate on which the compensation is computed. However, such an adjustment for the prior period should be made whenever the conversion increases the pay rate used.

d. Compensation for Death. These payments are computed on a monthly (calendar day) basis. When there is more than one beneficiary, the gross compensation is computed for all beneficiaries and then prorated to determine each individual's compensation.

(1) Periodic (28-day) payments are computed as follows:

Monthly pay rate x compensation rate =amount rounded to the nearest $.01 x 12/13

(2) Supplemental payments (any period of calendar days not evenly divisible by 28) are computed using calendar days:

Monthly pay rate x compensation rate =amount rounded to the nearest $.01 x no. calendar days/30

2-0901-9 Special Determinations

9. Special Determinations. This paragraph describes the rules for computing compensation to certain groups of employees.

a. Census Workers. Pay rates for these employees are addressed in FECA PM 2-0900.10.

(1) Where disability did not exceed 90 days, compensation should be paid on a daily basis according to Section 5 U.S.C. 8114(c).

(2) Enumerators and crew leaders ordinarily worked 6.5 hours per day, six days per week. Where disability extended beyond 90 days and the claimant had similar employment during the year prior to the injury, compensation should be paid according to section 5 U.S.C. 8114(d)(1) and (2). Otherwise, it should be paid on a weekly basis using the following formula: 150 x the actual daily wage divided by 52 (the actual daily wage should be determined by multiplying the hourly pay rate by 6.5 hours).

(3) Likewise, the compensation of Clerks, Lead Clerks, Data Entry Clerks, and Lead Data Entry Clerks who are disabled longer than 90 days and who have had similar employment during the previous year should be determined using Section 5 U.S.C. 8114(d)(1) and (2).

b. Firefighters.

(1) Regular Firefighters. These employees normally work three 24-hour shifts per week. Compensation entitlement should be computed using the number of hours lost divided by 24 hours to arrive at the number of "work days" lost. The result of this computation should be divided by three, which represents the number of work weeks lost. The result should be multiplied by 3/4 or 2/3 of the pay rate to arrive at the amount of compensation to be paid. This formula is:

Hours lost/24 = Work days lost Work days lost/3 = Work weeks lost
Work weeks lost x Comp rate x Weekly pay rate =Amount payable

(2) Emergency Firefighters. The workday and workweek for firefighters recruited on an emergency basis by the Forest Service, National Park Service, and Bureau of Land Management (other than those who are "career seasonal" as outlined in FECA PM 2-0900.4a) may exceed eight hours per day and five days per week.

On an actual daily basis, the daily pay rate is the number of hours actually worked times the hourly pay rate reported, and compensation will be computed on the workweek reported. In other cases, the minimum weekly pay rate is determined by the following formula:

Hourly wage X no. of hours per day X 150 days/52

Where more than eight hours are worked per day, actual hours worked shall be used in the computation.

If the employing agency reports an additional allowance for subsistence or quarters, or if premium pay is received because of standby status, the amount(s) should be included in the pay rate.

2-0901-10 Minimum Compensation

10. Minimum Compensation. This paragraph discusses the effect of minimum rates on compensation payments. This rate was established by the 1966 amendments as 75 percent of the lowest pay for a GS-02 employee. This figure, which changes with the Federal pay scale, is compared to the compensation rate in a disability case, and to the pay rate in a death case. The rules for applying the minimum in each case are stated below. Minimums do not include locality pay, and they do not apply to Job Corps or foreign national claims.

Exhibit 1 can be used to determine if a new minimum (MIN) is applicable. Further information about MINs may be found in FECA PM 5-302.5. The ACPS automatically calculates the minimum rate when payments are entered, except for Job Corps and foreign national claims, which require entry of an activity code to prevent overpayments (see **Exhibit 6**).

a. Disability. In a disability case, the CE or BPC compares the minimum in effect during the period of entitlement to the claimant's weekly compensation. If the weekly pay is more than the MIN, but the weekly pay times the applicable compensation rate (66 $^{2/3}$ or 75 percent) would be less than the MIN, the claimant receives the MIN instead of the calculated compensation. If the weekly pay is less than the MIN, the claimant receives 100 percent of the pay rate, instead of 66 $^{2/3}$ or 75 percent.

The new MIN is always compared to the amount of compensation, including CPIs. Because CPIs are applied to the compensation, compensation for disability usually exceeds the MIN after the first year.

b. Death. In a death case, the CE or BPC compares the current MIN to the deceased employee's pay rate. If the pay rate is less than the minimum, the MIN is used as a basis for computing each beneficiary's entitlement. If the pay rate is greater than MIN, the pay rate is used as a basis for compensation payment.

Compensation to a beneficiary may not exceed the deceased's monthly pay rate for compensation purposes (except by the addition of CPIs effective September 7, 1974). Therefore, if the compensation rate times a new MIN would be more than 100 percent of the pay rate, the new MIN is not applied, and the basic compensation becomes 100

percent of the pay rate.

c. Schedule Awards. No minimum provision applies to schedule awards.

2-0901-11 Maximum Compensation

11. Maximum Compensation. This paragraph discusses the effect of maximum rates on compensation payments. The 1966 amendments provided that compensation could not exceed 75 percent of the monthly salary of a GS-15, step 10. This amount does not include allowances for an attendant, burial costs, medical expenses, or other additional allowances. Maximums do not include locality pay.

Exhibit 2 can be used to determine if a new maximum (MAX) is applicable. Further information about MAXs may be found in FECA PM 5-302.6. The ACPS automatically calculates the maximum rate when payments are entered.

a. Disability. If a claimant's weekly compensation rate is greater than the MAX, compensation is paid at the maximum amount. When a new maximum is established, it is compared to the amount of compensation in each case at MAX. If the compensation is greater than the old MAX but less than the new, compensation may be paid at the regular rate. Adjustments are made retroactive to the effective date of the new MAX, which is generally the date of an increase in the Federal pay scale.

b. Death. To determine whether a MAX applies in a death case, the combined compensation rate for all entitled beneficiaries must be computed and multiplied by the decedent's salary. All applicable cost-of-living increases must be added. If the total is greater than MAX, each beneficiary's entitlement is computed as a proportionate share of the MAX.

When a new maximum applies, each case previously paid at MAX must be recomputed to determine the new entitlement. If the recomputed total entitlement for all beneficiaries is less than the new MAX, each beneficiary may receive the regular entitlement. If not, a proportional share of the MAX is allotted to each beneficiary.

c. Schedule Award. Schedule award payments are limited by the MAX, and the procedures for disability compensation apply.

2-0901-12 Consumer Price Index (CPI) Adjustments

12. Consumer Price Index (CPI) Adjustments. This paragraph describes the periodic adjustments to compensation payments which are made to reflect increases in the cost of living. See Exhibit 3 for a list of these increases. CPIs are automatically calculated by ACPS.

a. Entitlement. The 1966 Amendments to the FECA provided for increases in compensation benefits based upon the Consumer Price Index. Under Section 5 U.S.C. 8146a, increases are granted where the disability (i.e., compensable disability or the date when an injured employee stopped work on account of the injury) occurred more than one year before the effective date of the increase.

(1) The disability need not have been continuous for the whole year before the increase. The use of a higher (recurrent) pay rate precludes addition of a CPI increase within one year following the application of such a pay rate.

(2) The increase is applicable to death cases where the compensable disability occurred more than one year prior to the effective date, although the death may have occurred less than a year before the effective date.

(3) Where a schedule award is being paid and the claimant had no disability for work prior to the date of maximum medical improvement, the one-year waiting period begins on the starting date of the award. This date represents the claimant's first entitlement to compensation, even though the effective date of the pay rate (date of injury) is earlier.

(4) CPI adjustments are rounded in disability cases to the nearest dollar on a four-weekly basis, and in death cases to the nearest dollar on a monthly basis.

(5) When the compensation rate changes (e.g., from 75 to 66 $^{2/3}$ percent), the CPIs must be recomputed entirely.

b. Inclusions and Exclusions.

(1) Entitlement to CPI increases extends to: emergency relief workers (CCC, WPA, CWA, FH and ERA); Reserve Officers Training Corps cadets (ROTC); Civil Air Patrol volunteers (CAP); maritime workers (R); civilian war benefits workers (CWB); Peace Corps Volunteers and Volunteer Leaders; VISTA Volunteers; Neighborhood Youth Corps enrollees; and Job Corps enrollees.

(2) Entitlement to CPI increases does not include military reservists or their survivors and members of the Women's Army Auxiliary Corps (WAAC) and the Coast Guard Auxiliary. Periodic increases under the Longshore and Harbor Workers' Act are applied to Enemy Action (EA) and War Hazard (WH) cases each October 1.

c. Application. The Omnibus Reconciliation Act of 1980, which amended Section 5 U.S.C. 8146a, provided that compensation payable on account of injury or death which occurred more than one year before March 1 of each year shall be increased each year on

that date by the amount determined to represent the change in the price index published for December of the preceding year over the price index published for December of the year before that, adjusted to the nearest one-tenth of one percent.

The first cost-of-living increase based on this law, on March 1, 1981, extended from the last month in which the price index resulted in an adjustment prior to enactment of the new legislation, which was August 1980.

2-0901-13 (RESERVED)

13. (Reserved)

2-0901-14 Schedule Awards

14. Schedule Awards. This paragraph addresses computations of schedule awards. FECA PM 2-0808 addresses the loss or loss of use of schedule members and organs in detail, including many aspects of payment.

a. Beginning Date. Schedule awards begin on the date of maximum improvement unless circumstances show a later date should be used (see Franklin L. Armfield, 28 ECAB 445), and Walter Karkainen, 28 ECAB 450).

b. Percentage of Loss. This percentage is applied to the number of weeks specified in section 8107 of the Act or in the regulations for total loss or loss of use of the body part or organ in question. (Exhibit 5 shows the number of days and weeks of entitlement for various degrees of partial disability.) The resulting number of weeks is multiplied by the weekly wage and the compensation rate (e.g., 205 weeks x 10 percent x $400 x 75 percent).

c. Computing the Award. Given a starting date and a number of days of entitlement, ACPS will compute the ending date of an award and terminate payments accordingly. To obtain the ending date for Form CA-180, the CE should either use the schedule award worksheet in ACPS or key the payment and use the information on the CP-040 report.

d. Fraction of Day (FOD). Where the award ends in a fraction of a day, the wording of Form CA-203, Schedule Award Worksheet, and Form CA-181, Schedule Award Compensation Order, should include the phrase "fraction of a day", instead of "inclusive".

For example: An award for 15 percent loss of use of a foot is 30.75 weeks of compensation. The two-place decimal is retained, and the partial day it represents is

called "fraction of a day", or FOD. The dates of payment might be shown as, "March 2, 1994 to October 4, 1994, fraction of a day".

e. MINs and MAXs. Schedule awards are paid at either the basic rate (66 2/3 percent) or the augmented rate (75 percent) of the pay rate for compensation purposes. MAXs are applied to the amount of compensation payable, but MINs are not.

f. Death of Employee. If an employee dies from a cause other than the injury before the end of a schedule award, the balance of the award payable to the survivors after the death, as provided in Section 5 U.S.C. 8109, is paid at the rate of 66 2/3 percent (not 75 percent) of the pay rate.

2-0901-15 Loss of Wage-Earning Capacity (LWEC)

15. Loss of Wage-Earning Capacity (LWEC). This paragraph addresses the elements specific to computing payments for awards for loss of wage-earning capacity. These awards are discussed in detail in FECA PM 2-0813 and 2-0814.

a. Compensation for Partial Disability. Where injury-related impairments prohibit the employee from returning to the employment held at the time of injury, or from earning equivalent wages, but do not render him or her totally disabled for all gainful employment, the employee is considered partially disabled and is entitled to compensation for LWEC.

(1) Section 8115 of the FECA provides that the wage-earning capacity is determined by the employee's actual wages if they fairly and reasonably represent his or her wage-earning capacity. If they do not, or if the employee has no actual earnings, the OWCP may reasonably determine the employee's wage-earning capacity giving due consideration to the factors enumerated in section 8115. (For further discussion of wage-earning capacity and the information needed in making such determination, see FECA PM 2-813.11.)

(2) Section 8106 of the FECA provides that the partially disabled employee shall be paid compensation equal to 66 2/3 (or 75) percent of the difference between the employee's pay and his or her wage-earning capacity. To satisfy this requirement, compensation for partial disability is computed using the formula described in paragraph 14c below.

b. Shadrick Formula. The method for computing the compensation payable where an employee has actual earnings or an earning capacity is called the Shadrick formula, as it reflects the principles set forth in Albert C. Shadrick, 5 ECAB 376. In that decision the ECAB found that section 5 U.S.C. 8106a does not state that compensation is to be based

on the difference between the employee's earnings at the time of injury and whatever variable dollar income the employee may have in the future. Rather, it is to be based upon the loss of capacity to earn wages. The ECAB stated that:

> Although capacity to earn and not wages received is the proper test under the law, an employee's actual wages may constitute compelling evidence of his capacity to earn and in a proper case may be used as a yardstick in determining an injured employee's diminished earning capacity. (378)

However, in applying this standard, the ECAB held that:

> ...wages received 2, 5 or 10 years after an employee has sustained an injury and during which period changes in business conditions have caused wages to double due to a business boom or to be cut in half due to a depression cannot be used as a conclusive factor in determining a claimant's diminished wage-earning capacity after he has been injured. (378)

The ECAB concluded that, "Actual dollar earnings received several years after injury may be used to determine wage-earning capacity only after they have been converted into terms of actual dollar earnings received at the time of injury."

c. Computation. The Shadrick formula is as follows:

(1) Pay rate when:

(a) injured ( )
(b) disability began ( )
(c) compensable disability recurred. ( ) . . . . $_________

(2) Current pay rate for job and step when injured . . . . . . $_________

(3) ( ) (a) is capable of earning
( ) (b) has actual earnings of . . . . $_________

(4) WEC [item (3) divided by item (2)] . . . . $________%

(5) WEC [item (4) times item (1)]. . . . . $_________

(6) Loss of WEC [item (1) minus item (5)] . . . . $_________

(7) Compensation [item (6) times ( ) 2/3 or ( ) 3/4] . . . . . . $_________

(8) CPI (expressed in decimal terms)

(a) Item (7) times 1._*_ = $________ (rounded)
(b) Item (8a) times 1._*_ = $________ (rounded)
(c) Item (8b) times 1._*_ = $________ (rounded)

The comparison of wage rates (i.e., the claimant's actual earnings or the salary of the selected position and the "current" salary of the job held at time of injury) need not be made as of the beginning of the period of disability (but see subparagraph f(2) below concerning rural letter carriers). Any convenient date may be chosen for this comparison, as long as the two wage rates are in effect on the date used for the comparison.

d. Additional Elements of Pay. When the job held at injury included such elements of pay as night differential, which would also be included in the pay rate for compensation purposes, the additional pay must be reflected in the current pay for the same job. This adjustment should be made by increasing the current base pay by the same percentage as the original base pay was increased by the additional pay elements.

For example: The claimant earned $200 per week base pay at injury and his night differential was $14.82 per week, or 7.41 percent of the base pay, for a total pay rate of $214.82. The current base pay for the same job is $300 per week. The CE should increase the current base pay for that job, $300 per week, by 7.41 percent, or $22.23, resulting in $322.23 as current pay for the same job to be used in the Shadrick computation.

e. Intermittent or Sporadic Earnings. Where the claimant has actual earnings which do not fairly and reasonably represent a wage-earning capacity, and a wage-earning capacity cannot be reasonably determined through application of section 8115, there is no basis for a finding that the claimant is permanently partially disabled.

However, while for practical purposes the employee will continue to be considered totally disabled, compensation payable for the period during which the employee had earnings should be reduced to reflect those earnings. Compensation for the period during which the employee had actual earnings should be computed using the formula described in paragraph 14c above. The reduction in compensation is not permanent but covers only the period of earnings.

f. Special Determinations.

(1) Locality Pay or "COLA" Pay. When the claimant is reemployed in a new locale with a lower percentage of locality pay than the job held on date of injury, or without the "COLA" (cost-of-living allowance described in FECA PM 2-0900.7b(16), the claimant may be paid less than previously even if reemployed at the same grade and step. However, the "current pay rate for the job and step when injured" should reflect the pay in the new locale, not the original one. The

claimant is not losing net pay if reemployed at a lower locality pay rate, or without COLA pay, since the cost of living is less in the new location as represented by the difference in locality pay or COLA pay.

(2) Rural Letter Carriers. While the salaries for these employees may vary over the life of the claim due to reevaluations of the employee's route, the only salaries that affect the pay rate for compensation purposes is the pay rate on the date of injury, when disability began, or at the time of a qualifying recurrence. The highest of the three is used to compute compensation.

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

(b) A rural carrier who returns to work but whose hours are restricted due to the effects of the job-related injury is entitled to compensation for any LWEC.

(c) A rural carrier who returns to full duty but whose route was reduced during the period compensation was received is not entitled to continuing compensation, since the reduction is not due to injury-related disability.

(d) The "current pay of job held when injured" is defined according to whether the boundaries of the carrier's route has changed.

If not, the hourly rate for the employee's grade and step when injured is multiplied by the number of hours representing the route's current evaluation.

If so, the date-of-injury job when injured no longer exists. Therefore, the current pay for the grade and step when injured should be multiplied by the number of hours representing the route's evaluation at the time of injury.

g. Reinjury. When a reemployed claimant who has been rated for LWEC is injured again, he or she continues to be entitled to receive compensation for LWEC on the basis of the first injury as well as compensation for temporary total disability for the second injury. The pay rate for the job held when the second injury occurred should be used to compute compensation for disability resulting from that injury.

2-0901-16 Wages Lost for Compensable Medical Examination or Treatment

16. Wages Lost for Compensable Medical Examination or Treatment. This paragraph defines the circumstances under which such wage loss may be reimbursed, and the procedures for doing so.

a. Entitlement. A claimant who has returned to work following an accepted injury or illness may need to undergo examination, testing, or treatment. Such a claimant may be paid compensation for wage loss under Section 5 U.S.C. 8105 while obtaining the medical services and for a reasonable time spent traveling to and from the provider's location. Of course, leave cannot be compensated until it is converted to leave without pay. (See Myrtle B. Carlson, 17 ECAB 644, and Jeffrey R. Davis, 35 ECAB 950.)

b. Pay Rate. Absence from work for the purpose of medical evaluation or treatment does not constitute a recurrence of disability. Therefore, such absence will not entitle the claimant to a higher pay rate under Section 5 U.S.C. 8101(4). In Andrew W. Eickbolt, 30 ECAB 360, the ECAB stated that in the definition of monthly pay at section 8101(4), the word "disability" means "incapacity because of injury." An absence to obtain medical services while otherwise capable of working does not reflect an incapacity for work and therefore does not establish "disability" in the context of section 8101(4), for purposes of changing the pay rate.

c. Schedule Award. If a claimant loses wages to obtain medical services during the period of a schedule award, the additional hours of compensation due may be paid at the end of the award, rather than interrupting the schedule award for payment of compensation.

d. OWCP-Directed Examination. If the OWCP directs a claimant who is working to undergo an examination, reimbursement for wage loss should be paid under the authority of Section 5 U.S.C. 8123, at 100% of gross wages lost. Payment should be made through the automated bill payment system, and it may be made without regard to any concurrent schedule award entitlement.

2-0901-17 Additional Death Benefits

17. Additional Death Benefits. This paragraph discusses the benefits payable in death claims in addition to compensation payments to dependents of employees. These benefits include funeral and burial expenses, the administrative expense of terminating the decedent's status as a Federal employee, transportation of remains, and lump-sum awards to remarried spouses. These topics and others related to death benefits are addressed in FECA PM 2-0700. The CE should use Form CA-24 to authorize these expenses.

a. Funeral and Burial Expenses. The FECA provides up to $800 for funeral and burial expenses. On Form CA-24, the CE should indicate the amount of payment to be made and the name and address of the person to whom payment is to be made (usually the person whose funds were used to pay the bills).

b. Administrative Termination. The amount of $200 is payable for the administrative costs of terminating a decedent's status as a Federal employee. This benefit may be authorized on the same Form CA-24 which is used for funeral and burial expenses.

c. Transportation Expenses. On Form CA-24, the CE should briefly describe the nature and amount of this payment.

2-0901-18 Other Payees

18. Other Payees. This paragraph discusses the parties other than the claimant (or the primary beneficiary in a death case) who may receive funds, as follows:

a. Employing Agency. When leave repurchase is authorized, the agency may be designated to receive the compensation due (see paragraph 13 above). The agency then becomes a case payee.

b. Office of Personnel Management (OPM). If funds are offset to repay the OPM for a period of dual benefits, the OPM becomes a case payee.

c. Secondary Beneficiaries. In a death case, a student or other adult beneficiary may receive checks in his or her own name (see FECA PM 2-0700.8d).

d. A State/Municipal Court or Agency. In cases were the injured worker is in arrears for alimony and/or child support payments the OWCP may allow for garnishment of compensation benefits. Such garnishment may be requested by providing a copy of the state agency or court order to the district office that has jurisdiction over the injured worker's claim.

e. Representative Payee. When OWCP determines that a beneficiary is incapable of managing his or her benefits because of a mental or physical disability, legal incompetence, or because he or she is under 18 years of age, OWCP in its sole discretion may approve a person to serve as the representative payee for funds due the beneficiary. Where a guardian or other party has been appointed by a court or administrative body authorized to do so, to manage the financial affairs of the claimant, OWCP will recognize that individual as the representative payee.

(1) Where the beneficiary is 18 years old or older and no guardian has been appointed, OWCP shall approve the person or institution in the following order of preference:

(a) an individual or institution having legal custody of the beneficiary;

(b) a spouse, other relative, or friend, in that order, who demonstrates strong concern for the personal welfare of the beneficiary;

(c) someone qualified and willing to serve as a payee for a beneficiary.

(2) Where the beneficiary is under age 18 and there is no parent or legal guardian, the following order of preference should be followed:

(a) an individual who has custody of the beneficiary;

(b) an individual who is contributing toward the beneficiary's support;

(c) an individual demonstrating concern for the beneficiary's well-being;

(d) an authorized social agency or custodial institution.

(3) Upon approval of a representative payee, the CE will advise the payee that they have the responsibility to spend or invest payments received only for the benefit of the beneficiary, in the order outlined in (4) below; that they must notify OWCP of any event that would effect the amount of benefits, such as status of dependents; that they must advise OWCP of any change in the payee's circumstances that would affect performance of the payee's responsibilities; and that they must submit to OWCP, upon request, a written report accounting for the benefits received.

(4) Ask the payee to submit a statement accounting for the benefits, where there is any question about the manner in which the payee is using the benefits. Examine the statement to ensure that the benefits are used in the following order:

(a) the beneficiary's maintenance, including food, shelter, clothing, medical care, and personal comfort items;

(b) institutional care, including expenses that will aid in recovery or release, and for personal needs;

(c) support of beneficiary's legal dependents;

(d) claims from creditors, only if the claimant's needs are met for the present and the foreseeable future;

(e) funds not needed for (4)(a) through (4)(d) above, conserved or invested on behalf of the beneficiary in non-speculative accounts, in accordance with rules followed by trustees. Any profit from an investment is the property of the beneficiary and not the payee.

(5) The services of the payee may be terminated when the payee has not used the funds according to (4)(a) through (4)(e) above, or has not timely discharged other responsibilities. Issues concerning misuse or questionable use of funds by a representative payee should be referred to the National Office. By administrative determination, a representative payee may be held responsible for repaying an overpayment.

2-0901-19 Reinstatement of Leave

19. Reinstatement of Leave. This paragraph discusses the steps required to reinstate leave. When an employee elects to use sick or annual leave during the period of disability, he or she may later, with the concurrence of the employing agency, claim compensation for the period of

disability and "buy back" the leave used. Form CA-7b is required as an attachment to Form CA-7 to request Leave Buy Back (LBB). CA-7a is an optional form for use when leave is used intermittently.

a. On receipt of the agency certified LBB claim, (CA-7, 7a, 7b), the mailroom staff will key it into the TPCUP system and deliver it to the office designated location. The CE will review the claim to ensure it is complete. If it is incomplete or unsigned, the CE will return the claim for completion, and advise the claimant by letter of what was missing.

b. The CE will first review the agency estimate of FECA entitlement on the CA-7b. If the estimate of entitlement is less than 10% above the amount determined to be accurate by the CE, the CE then reviews the medical documentation.

For example, let us assume that the agency has estimated FECA entitlement to be $1500 for 100 hours of leave used. 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 evidence.

c. Where 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 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.

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.

d. 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 paragraph 19b 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 OWCP is 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 Form 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. If the claimant is able to obtain medical support for the unpaid hours, he or she may initiate a new leave buy back claim specifically for those hours.

e. Where medical evidence does not support payment of any hours claimed, the CE will defer a decision on the claim and advise the claimant in writing of the deficiency of the claim, allowing 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 19c or 19d above.

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

f. Where the agency's estimate of FECA entitlement is off by more than 10 percent, the CE will review the medical evidence before proceeding further.

> Using the example in paragraph 19b above 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.
>
> (1) If there is medical evidence for all hours claimed the CE will issue a Form Letter CA-1207 showing the correct entitlement amount. If the claimant still wishes to pursue leave repurchase, he or she will then complete his or her portion of the enclosure EN-1207 and provide 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 Form Letter CA-1208 to the claimant, with a copy to the agency.

(2) Where 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 that additional medical documentation be submitted within 30 days. The CE may also contact the employer if there is a question as to the correct pay rate to be used.

(3) 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.

2-0901 Exhibit 1: Minimum Compensation Rates (Disability)

MINIMUM COMPENSATION RATES (DISABILITY)
AND MINIMUM PAY RATES (DEATH)

EFFECTIVE DATE	CPI (%)	SALARY RANGE [1] PER: Day @ 2/3 / Day @ 3/4	WEEK @2/3 / WEEK @3/4	DISABLITY MIN COMP RATES[2] PER DAY	/WEEK (4 WEEK)	DEATH MIN PAY RATES[3] PER MONTH
10/01/49 [4]		5.19- 7.78	25.96-38.94	5.19	25.96-(103.84)	150.00
		5.19- 6.92	25.96-34.61			
10/01/60 [5]		8.31-12.46	41.54-62.31	8.31	41.54-(166.16)	240.00
		8.31-11.08	41.54-55.39			
08/01/66 [6]		11.32-16.98	56.61-84.92	11.32	56.61-(266.44)	327.08
		11.32-15.10	56.61-75.48			
10/01/ 66	12.5					
10/08/67 [7]		11.85-17.77	59.25-88.87	11.85	59.25-(237.00)	342.33
		11.85-15.80	59.25-79.00			
01/01/68	3.7					
07/14/68 [7]		12.21-18.31	61.03-91.55	12.21	61.03-(244.12)	352.58
		12.21-16.27	61.03-81.37			
12/01/68	4.0					
07/13/69 [7]		12.58-18.87	62.88-94.32	12.58	62.88-(251.52)	363.33
		12.58-16.77	62.88-83.84			
09/01/69	4.4					
12/28/69 [7]		13.33-19.99	66.65-99.97	13.33	66.65-(266.60)	385.08
		13.33-17.77	66.65-88.87			

06/01/70	4.4					
01/10/71		14.13-21.19 14.13-18.84	70.63-105.95 70.63- 94.17	14.13	70.63-(282.52)	408.08
03/01/71	4.0					
01/09/72		14.90-22.35 14.90-19.87	74.51-111.77 74.51- 99.35	14.90	74.51-(298.04)	430.50

1 If salary is less than the minimum rate, pay 100% of salary.

2 In disability cases, minimum is viewed in terms of compensation rates. See FECA Program Memorandum No. 71. Minimum rates do not apply to compensation for partial disability or schedule awards.

3 In death cases, minimum is viewed in terms of pay rates. See FECA Program Memorandum No. 71.

4 Effective date where injury or death occurred before 10/14/49. If injury or death occurred on or after 10/14/49, adjustment is effective on date of injury or death.

5 Effective date where injury or death occurred before 09/13/60. If injury or death occurred on or after 09/13/60, adjustment is effective on date of injury or death.

6 The amendments of 07/04/66 established the minimum compensation rate in disability cases as 75% of the first step of GS-2 or the pay rate, whichever is less, and the minimum pay rate in death cases as the pay rate for the first step of GS-2.

7 One day earlier for Postal Service.

8 Maximum adjustment only. The minimum rate was not affected.

MINIMUM COMPENSATION RATES (DISABILITY)
AND MINIMUM PAY RATES (DEATH) - continued

EFFECTIVE DATE	CPI (%)	SALARY RANGE [1] PER: Day @ 2/3 / Day @ 3/4	WEEK @2/3 / WEEK @3/4	DISABLITY MIN COMP RATES[2] PER DAY/WEEK	(4 WEEK)	DEATH MIN PAY RATES[3] PER MONTH
05/01/72	3.9					
10/01/72		15.67-23.50 15.67-20.89	78.35-117.52 78.35-104.46	15.67	78.35-(313.40)	452.60
06/01/73	4.8					
10/14/73		16.39-24.58 16.39-21.85	81.95-122.93 81.95-109.27	16.39	81.95-(327.80)	473.50

01/01/74	5.2					
07/01/74	5.3					
10/13/74		17.30-25.94	86.48-129.72	17.30	86.48-(345.92)	499.67
		17.30-23.06	86.48-115.31			
11/01/74	6.3					
06/01/75	4.1					
10/12/75		18.16-27.24	90.81-136.22	18.16	90.81-(363.24)	524.67
		18.16-24.21	90.81-121.08			
01/01/76	4.4					
10/10/76		18.96-28.44	94.79-142.19	18.96	94.79-(379.16)	547.67
		18.96-25.28	94.79-126.38			
11/01/76	4.2					
02/27/77 [8]		18.96-28.44	94.79-142.19	18.96	94.79-(379.16)	547.67
		18.96-25.28	94.79-126.38			
07/01/77	4.9					
10/09/77		20.29-30.44	101.47-152.21	20.29	101.47-(405.88)	586.25
		20.29-27.05	101.47-135.29			
05/01/78	5.3					
10/08/78		21.41-32.12	107.05-160.58	21.41	107.05-(428.20)	618.50
		21.41-28.55	107.05-142.73			
11/01/78	4.9					
05/01/79[8]	5.5					
10/01/79 [8]	5.6	21.41-32.12	107.05-160.58	21.41	107.05-(428.20)	618.50
		21.41-28.55	107.05-142.73			
10/07/79		23.45-35.18	117.23-175.85	23.45	117.23-(468.92)	677.33
		23.45-31.27	117.23-156.31			
04/01/80	7.2					
09/01/80	4.0					

10/05/80		25.82-38.73	129.10-193.65	25.82	129.10-(516.40)	745.92
		25.82-34.43	129.10-172.13			
03/01/81	3.6					
10/04/81		27.06-40.59	135.30-202.95	27.06	135.30-(541.20)	781.75
		27.06-36.08	135.30-180.40			
01/01/82 [8]		27.06-40.59	135.30-202.95	27.06	130.30-(541.20)	781.75
		27.06-36.08	135.30-180.40			

MINIMUM COMPENSATION RATES (DISABILITY)
AND MINIMUM PAY RATES (DEATH) - continued

		SALARY RANGE [1] PER:		DISABLITY MIN		DEATH MIN
EFFECTIVE DATE	CPI (%)	Day @ 2/3 Day @ 3/4	WEEK @2/3 WEEK @3/4	COMP RATES[2] PER DAY/WEEK	(4 WEEK)	PAY RATES[3] PER MONTH
03/01/82	8.7					
10/03/82		28.14-42.18	140.71-210.96	28.14	140.71-(562.84)	813.00
		28.14-37.52	140.71-187.61			
12/18/82 [8]		28.14-42.18	140.71-210.96	28.14	140.71-(562.84)	813.00
		28.14-37.52	140.71-187.61			
03/01/83	3.9					
01/08/84		29.27-43.91	146.34-219.51	29.27	146.34-(585.36)	845.50
		29.27-39.03	146.34-195.12			
03/01/84	3.3					
01/06/85		30.29-45.44	151.46-227.19	30.29	151.46-(605.84)	875.08
		30.29-40.39	151.46-201.95			
03/01/85	3.5					
01/04/87		31.20-46.80	156.00-234.00	31.20	156.00-(624.00)	901.33
		31.20-41.60	156.00-208.00			

03/01/87	.7					
01/03/88		31.82-47.73	159.12-238.68	31.82	159.12-(636.48)	919.33
		31.82-42.43	159.12-212.16			
03/01/88	4.5					
01/01/89		33.13-49.70	165.63-248.45	33.13	165.63-(662.52)	957.00
		33.13-44.17	165.63-220.84			
03/01/89	4.4					
01/14/90		34.32-51.48	171.59-257.39	34.32	171.59-(686.36)	991.42
		34.32-45.76	171.59-228.79			
03/01/90	4.5					
01/13/91		35.73-53.60	178.63-267.59	35.73	178.63-(714.52)	1,032.00
		35.73-47.64	178.63-238.17			
03/01/91	6.1					
01/12/92		37.23-55.85	186.13-279.20	37.23	186.13-(744.52)	1,075.42
		37.23-49.64	186.13-248.17			
03/01/92	2.8					
01/10/93		38.60-57.90	193.01-289.52	38.60	193.01-(772.04)	1,115.17
		38.60-51.47	193.01-257.35			
03/01/93	2.9					
03/01/94	2.5					
01/08/95		39.38-59.07	196.88-295.32	39.38	196.88-(787.52)	1,137.50
		39.38-52.51	196.88-262.51			
03/01/95	2.7					
01/07/96		40.16-60.24	200.81-301.22	40.16	200.81-(803.24)	1,160.25
		40.16-53.55	200.81-267.75			
03/01/96	2.5					
01/05/97		41.09-61.64	205.43-308.14	41.09	205.43-(821.72)	1,186.92
		41.09-54.78	205.43-273.90			
03/01/97	3.3					

01/04/98		42.03-63.05	210.16-315.24	42.03	210.16-(840.64)	1,214.25
		42.03-56.04	210.16-280.21			
03/01/98	1.5					
01/03/99		43.34-65.01	216.68-325.02	43.34	216.68-(866.72)	1,251.92
		43.34-57.79	216.68-288.91			
03/01/99	1.6					
01/02/2000		44.98-67.47	224.91-337.37	44.98	224.91-(899.64)	1,299.50
		44.98-59.97	224.91-299.88			
03/01/2000	2.8					
01/02/2001		46.20-69.30	230.99-346.49	46.20	230.99-(923.96)	1,334.50
		46.20-61.60	230.99-307.99			
03/01/2001	3.3					

2-0901 Exhibit 2: Maximum Compensation Rates

EFFECTIVE DATE	CPI (%)	DISABILITY PER DAY	/ PER WEEK	(EACH 4 WEEKS)	DEATH [1] PER MONTH [2]
11/01/49 [3]		24.23	121.15	(484.60)	525.00
10/01/60 [4, 5]		24.23	121.15	(484.60)	525.00
08/01/66 [6]		66.38	331.92	(1,327.68)	1,438.31
10/01/66	12.5				
10/08/67 [7]		69.00	345.01	(1,380.04)	1,495.06
01/01/68	3.7				
07/14/68 [7]		74.17	370.83	(1,483.32)	1,606.94
12/01/68	4.0				
07/13/69 [7]		80.97	404.84	(1,619.36)	1,754.31

09/01/69	4.4					
12/28/69 [7]		85.82	/	429.12	(1,716.48)	1,859.50
06/01/70	4.4					
01/10/71		90.93	/	454.66	(1,818.64)	1,970.19
03/01/71	4.0					
01/09/72		95.94	/	479.71	(1,918.84)	2,078.75

1 Prior to 09/07/74, total monthly compensation could not exceed the monthly pay or the minimum compensation rate. Effective 09/07/74, total monthly compensation could not exceed the monthly pay except for CPI increases (5 USC 8146a), or the maximum monthly compensation rate.

2 In cases where maximum compensation is paid, proportionate shares are as follows:

Prior to 09/07/74:	Effective 09/07/74:
Widow/er only--All	Widow/er only--All
Widow/er--8/11, 1 child--3/11	Widow/er--3/4, 1 child--1/4
Widow/er--4/7, 2 children--3/7	Widow/er--3/5, 2/more children--2/5
Widow/er--8/15, 3/more children, 7/15	

3 Effective date where injury or death occurred before 10/14/49. If injury or death occurred on or after 10/14/49, adjustment is effective on date of injury or death.

4 Effective date where injury or death occurred before 09/13/60. If injury or death occurred on or after 09/13/60, adjustment is effective on date of injury or death.

5 Minimum adjustment only. The maximum rate was not affected.

6 The amendments of 07/04/66 established the maximum compensation rate as 75% of the highest step of GS-15.

7 One day earlier for Postal Service.

MAXIMUM COMPENSATION RATES (DISABILITY)
AND MAXIMUM PAY RATES (DEATH) - continued

EFFECTIVE DATE	CPI (%)	DISABILITY PER DAY/PER WEEK (EACH 4 WEEKS)	DEATH [1] PER MONTH [2]

05/01/72	3.9					
10/01/72		100.88	/	504.39	(2,017.56)	2,185.69
06/01/73	4.8					
10/14/73		103.85	/	519.23	(2,076.92)	2,250.00
01/01/74	5.2					
07/01/74	5.3					
10/13/74(5)		103.85	/	519.23	(2,076.92)	2,250.00
11/01/74	6.3					
06/01/75	4.1					
10/12/75		109.04	/	545.19	(2,180.76)	2,362.50
01/01/76	4.4					
10/10/76		114.23	/	571.15	(2,284.60)	2,475.00
11/01/76	4.2					
02/27/77		126.70	/	633.50	(2,534.00)	2,745.19
07/01/77	4.9					
10/09/77		135.65	/	678.25	(2,713.00)	2,939.06
05/01/78	5.3					
10/08/78		137.02	/	685.10	(2,740.40)	2,968.75
11/01/78	4.9					
05/01/79	5.5					
10/01/79	5.6	143.10	/	715.50	(2,862.00)	3,100.50
10/07/79		144.56	/	722.78	(2,891.12)	3,132.03
04/01/80	7.2					

09/01/80	4.0					
10/05/80 [5]		144.56	/	722.78	(2,891.12)	3,132.03
03/01/81	3.6					
10/04/81 [5]		144.56	/	722.78	(2,891.12)	3,132.03
01/01/82		165.87	/	829.33	(3,317.32)	3,593.75
03/01/82	8.7					
10/03/82 [5]		165.87	/	829.33	(3,317.32)	3,593.75
12/18/82		182.06	/	910.31	(3,641.24)	3,944.69
03/01/83	3.9					
01/08/84		189.35	/	946.76	(3,787.04)	4,102.63
03/01/84	3.3					
01/06/85		195.98	/	979.90	(3,919.60)	4,246.25
03/01/85	3.5					
01/04/87		201.85	/	1,009.27	(4,037.08)	4,373.50
03/01/87	.7					
01/03/88		205.90	/	1,029.48	(4,117.92)	4,461.06
03/01/88	4.5					
01/01/89		214.34	/	1,071.68	(4,286.72)	4,643.94
03/01/89	4.4					
01/14/90		222.06	/	1,110.32	(4,441.28)	4,811.38
03/01/90	4.5					
01/13/91		231.17	/	1,155.84	(4,623.36)	5,008.62
03/01/91	6.1					

01/12/92		240.87 /	1,204.36 (4,817.44)	5,218.88
03/01/92	2.8			
01/10/93		249.78 /	1,248.88 (4,995.52)	5,411.81
03/01/93	2.9			
03/01/94	2.5			
01/08/95		254.79 /	1,273.93 (5,095.72)	5,520.38
03/01/95	2.7			
01/07/96		259.88 /	1,299.38 (5,197.52)	5,630.63
03/01/96	2.5			
01/05/97		265.85 /	1,329.25 (5,317.00)	5,760.06
03/01/97	3.3			
01/04/98		271.98 /	1,359.91 (5,439.64)	5,892.94
03/01/97	3.3			
01/05/97		265.85 /	1,329.25 (5,317.00)	5,760.06
03/01/98	1.5			
01/03/99		280.39 /	1,401.94 (5,607.76)	6,075.06
03/01/99	1.6			
01/02/2000		283.59 /	1,427.93 (5,671.72)	6,144.38
03/01/97	2.8			
01/02/2001		298.91 /	1,494.56 (5,978.24)	6,476.44
03/01/2001	3.3			

2-0901 Exhibit 3: Cost-Of-Living Adjustments Under 5 USC 8146A

Effective Rate Days*/Month Effective Rate Days*/Months

Date	(%)	Since Last CPI	
10/01/66	12.5	---	---
01/01/68	3.7	457	15
12/01/68	4.0	335	11
09/01/69	4.4	274	9
06/01/70	4.4	273	9
03/01/71	4.0	273	9
05/01/72	3.9	427	14
06/01/73	4.8	396	13
01/01/74	5.2	214	7
07/01/74	5.3	181	6
11/01/74	6.3	123	4
06/01/75	4.1	212	7
01/01/76	4.4	214	7
11/01/76	4.2	305	10
07/01/77	4.9	242	8
05/01/78	5.3	304	10
11/01/78	4.9	184	6
05/01/79	5.5	181	6
10/01/79	5.6	153	5

Date	(%)	Since Last CPI	
04/01/80	7.2	183	6
09/01/80	4.0	153	5
03/01/81	3.6	181	6
03/01/82	8.7	365	12
03/01/83	3.9	365	12
03/01/84	3.3	366	12
03/01/85	3.5	365	12
03/01/87	.7	730	24
03/01/88	4.5	366	12
03/01/89	4.4	365	12
03/01/90	4.5	365	12
03/01/91	6.1	365	12
03/01/92	2.8	366	12
03/01/93	2.9	365	12
03/01/94	2.5	365	12
03/01/95	2.7	365	12
03/01/96	2.5	366	12
03/01/97	3.3	365	12
03/01/98	1.5	365	12
03/01/2000	1.6	365	12
03/01/2000	2.8	366	12
01/01/2001	3.3	365	12

---

*Calendar Days

Before 09/07/74, the new compensation after adding the CPI is rounded to the nearest $1.00 on a monthly basis or the nearest multiple of $.23 on a weekly basis ($.23, $.46, $.69, or $.92). After 09/07/74, the new compensation after adding the CPI is rounded to the nearest $1.00 on a monthly basis or the nearest multiple of $.25 on a weekly basis ($.25, $.50, $.75, or $1.00).

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

2-0901 Exhibit 4: (Reserved)

2-0901 Exhibit 5: Percentage Table of Schedule Awards

PERCENTAGE TABLE OF SCHEDULE AWARDS

(W = weeks; D = days)

MEMBER		01%	02%	03%	04%	05%	10%	15%	20%
Arm	W	3.12	6.24	9.36	12.48	15.60	31.20	46.80	62.40
	D	21.84	43.68	65.52	87.36	109.20	218.40	327.60	436.80
Leg	W	2.88	5.76	8.64	11.52	14.40	28.80	43.20	57.60
	D	20.16	40.32	60.48	80.64	100.80	201.60	302.40	403.20
Hand	W	2.44	4.88	7.32	9.76	12.20	24.40	36.60	48.80
	D	17.08	34.16	51.24	68.32	85.40	170.80	256.20	341.60
Foot/	W	2.05	4.10	6.15	8.20	10.25	20.50	30.75	41.00
Penis	D	14.35	28.70	43.05	57.40	71.75	143.50	215.25	287.00
Vulva/Vagina	W	2.05	4.10	6.15	8.20	10.25	20.50	30.75	41.00
Uterus/Cervix	D	14.35	28.70	43.05	57.40	71.75	143.50	215.25	287.00
Larynx/	W	1.60	3.20	4.80	6.40	8.00	16.00	24.00	32.00
Tongue	D	11.20	22.40	33.60	44.80	56.00	112.00	168.00	224.00
Eye	W	1.60	3.20	4.80	6.40	8.00	16.00	24.00	32.00
	D		11.20	22.40	33.60	44.80	56.00	112.00	168.00
224.00									
Kidney/	W	1.56	3.12	4.68	6.24	7.80	15.60	23.40	31.20

Lung	D	10.92	21.84	32.76	43.68	54.60	109.20	163.80	218.40
Thumb	W	.75	1.50	2.25	3.00	3.75	7.50	11.25	15.00
	D	5.25	10.50	15.75	21.00	26.25	52.50	78.75	105.00
1st Finger	W	.46	.92	1.38	1.84	2.30	4.60	6.90	9.20
	D	3.22	6.44	9.66	12.88	16.10	32.20	48.30	64.40
Great Toe	W	.38	.76	1.14	1.52	1.90	3.80	5.70	7.60
	D	2.66	5.32	7.98	10.64	13.30	26.60	39.90	53.20
2nd Finger	W	.30	.60	.90	1.20	1.50	3.00	4.50	6.00
	D	2.10	4.20	6.30	8.40	10.50	21.00	31.50	42.00
3rd Finger	W	.25	.50	.75	1.00	1.25	2.50	3.75	5.00
	D	1.75	3.50	5.25	7.00	8.75	17.50	26.25	35.00
Toe (Not Great Toe)	W	.16	.32	.48	.64	.80	1.60	2.40	3.20
	D	1.12	2.24	3.36	4.48	5.60	11.20	16.80	22.40
4th Finger	W	.15	.30	.45	.60	.75	1.50	2.25	3.00
	D	1.05	2.10	3.15	4.20	5.25	10.50	15.75	21.00
Hearing (1 ear)	W	.52	1.04	1.56	2.08	2.60	5.20	7.80	10.40
	D	3.64	7.28	10.92	14.56	18.20	36.40	54.60	72.80
Testicle/ Breast/Ovary*	W	.52	1.04	1.56	2.08	2.60	5.20	7.80	10.40
	D	3.64	7.28	10.92	14.56	18.20	36.40	54.60	72.80
Hearing (Both ears)	W	2.00	4.00	6.00	8.00	10.00	20.00	30.00	40.00
	D	14.00	28.00	42.00	56.00	70.00	140.00	210.00	280.00

* Includes Fallopian tube

PERCENTAGE TABLE OF SCHEDULE AWARDS, Continued

(W = weeks; D = days)

MEMBER		25%	30%	35%	40%	45%	50%	55%	60%
Arm	W	78.00	93.60	109.20	124.80	140.40	156.00	171.60	187.20
	D	546.00	655.20	764.40	873.60	982.80	1092.00	1201.20	1310.40
Leg	W	72.00	86.40	100.80	115.20	129.60	144.00	158.40	172.80
	D	504.00	604.80	705.60	806.40	907.20	1008.00	1108.80	1209.60

Hand	W	61.00	73.20	85.40	97.60	109.80	122.00	134.20	146.40
	D	427.00	512.40	597.80	683.20	768.60	854.00	939.40	1024.80
Foot/	W	51.25	61.50	71.75	82.00	92.25	102.50	112.75	123.00
Penis/	D	358.75	430.50	502.25	574.00	645.75	717.50	789.25	861.00
Vulva/Vagina	W	51.25	61.50	71.75	82.00	92.25	102.50	112.75	123.00
Uterus/Cervix	D	358.75	430.50	502.25	574.00	645.75	717.50	789.25	861.00
Larynx/	W	40.00	48.00	56.00	64.00	72.00	80.00	88.00	96.00
Tongue	D	280.00	336.00	392.00	448.00	504.00	560.00	616.00	672.00
Eye	W	40.00	48.00	56.00	64.00	72.00	80.00	88.00	96.00
	D	280.00	336.00	392.00	48.00	504.00	560.00	616.00	672.00
Kidney/	W	39.00	46.80	54.60	62.40	70.20	78.00	85.80	93.60
Lung	D	273.00	327.60	382.20	36.80	491.40	546.00	600.60	655.20
Thumb	W	18.75	22.50	26.25	30.00	33.75	37.50	41.25	45.00
	D	131.25	157.50	183.75	210.00	236.25	262.50	288.75	315.00
1st Finger	W	11.50	13.80	16.10	18.40	20.70	23.00	25.30	27.60
	D	80.50	96.60	112.70	28.80	144.90	161.00	177.10	193.20
Great Toe	W	9.50	11.40	13.30	15.20	17.10	19.00	20.90	22.80
	D	66.50	79.80	93.101	106.40	119.70	133.00	146.30	159.60
2nd Finger	W	7.50	9.00	10.50	12.00	13.50	15.00	16.50	18.00
	D	52.50	63.00	73.50	84.00	94.50	105.00	115.50	26.00
3rd Finger	W	6.25	7.50	8.75	10.00	11.25	12.50	13.75	15.00
	D	43.75	52.50	61.25	70.00	78.75	87.50	96.25	105.00
Toe (Not	W	4.00	4.80	5.60	6.40	7.20	8.00	8.80	9.60
Great Toe)	D	28.00	33.60	39.20	44.80	50.40	56.00	61.60	67.20
4th Finger	W	3.75	4.50	5.25	6.00	6.75	7.50	8.25	9.00
	D	26.25	31.50	36.75	42.00	47.25	52.50	57.75	63.00
Hearing	W	13.00	15.60	18.20	20.80	23.40	26.00	28.60	31.20
(1 ear)	D	91.00	109.20	127.40	145.60	163.80	182.00	200.20	18.40

Testicle/	W	13.00	15.60	18.20	20.80	23.40	26.00	28.60	31.20
Breast/Ovary*	D	91.00	109.20	127.40	145.60	163.80	182.00	200.20	218.40
Hearing	W	50.00	60.00	70.00	80.00	90.00	100.00	110.00	120.00
(Both ears)	D	350.00	420.00	490.00	560.00	630.00	700.00	770.00	840.00

* Includes Fallopian tube

PERCENTAGE TABLE OF SCHEDULE AWARDS, Continued

(W = weeks; D = days)

MEMBER		65%	70%	75%	80%	85%	90%	95%	100%
Arm	W	202.80	218.40	234.00	249.60	265.20	280.80	296.40	312.00
	D	1419.60	1528.80	1638.00	1747.20	1856.40	1965.60	2074.80	2184.00
Leg	W	187.20	201.60	216.00	230.40	244.80	259.20	273.60	288.00
	D	1310.40	1411.20	1512.00	1612.80	1713.60	1814.40	1915.20	2016.00
Hand	W	158.60	170.80	183.00	195.20	207.40	219.60	231.80	244.00
	D	1110.20	1195.60	1281.00	1366.40	1451.80	1537.20	1622.60	1708.00
Foot/	W	133.25	143.50	153.75	164.00	174.25	184.50	194.75	205.00
Penis/	D	932.75	1004.50	1076.25	1148.00	1219.75	1291.50	1363.25	1435.00
Vulva/Vagina	W	133.25	143.50	153.75	164.00	174.25	184.50	194.75	205.00
Uterus/Cervix	D	932.75	1004.50	1076.25	1148.00	1219.75	1291.50	1363.25	1435.00
Larynx/	W	104.00	112.00	120.00	128.00	136.00	144.00	152.00	160.00
Tongue	D	728.00	784.00	840.00	896.00	952.00	1008.00	1064.00	1120.00
Eye	W	104.00	112.00	120.00	160.00	160.00	160.00	160.00	160.00
	D	728.00	784.00	840.00	1120.00	1120.00	1120.00	1120.00	1120.00
Kidney/	W	101.40	109.20	117.00	124.80	132.60	140.40	148.20	156.00
Lung	D	709.80	764.40	819.00	873.60	928.20	982.80	1037.40	1092.00
Thumb	W	48.75	52.50	56.25	60.00	63.75	67.50	71.25	75.00
	D	341.25	367.50	393.75	420.00	446.25	472.50	498.75	525.00
1st Finger	W	29.90	32.20	34.50	36.80	39.10	41.40	43.70	46.00
	D	209.30	225.40	241.50	257.60	273.70	289.80	305.90	322.00

Great Toe	W	24.70	26.60	28.50	30.40	32.30	34.20	36.10	38.00
	D	172.90	186.20	199.50	212.80	226.10	239.40	252.70	266.00
2nd Finger	W	19.50	21.00	22.50	24.00	25.50	27.00	28.50	30.00
	D	136.50	147.00	157.50	168.00	178.50	189.00	199.50	210.00
3rd Finger	W	16.25	17.50	18.75	20.00	21.25	22.50	23.75	25.00
	D	113.75	122.50	131.25	140.00	148.75	157.50	166.25	175.00
Toe (Not	W	10.40	11.20	12.00	12.80	13.60	14.40	15.20	16.00
Great Toe)	D	72.80	78.40	84.00	89.60	95.20	100.80	106.40	112.00
4th Finger	W	9.75	10.50	11.25	12.00	12.75	13.50	14.25	15.00
	D	68.25	73.50	78.75	84.00	89.25	94.50	99.75	105.00
Hearing	W	33.80	36.40	39.00	41.60	44.20	46.80	49.40	52.00
(1 ear)	D	236.60	254.80	273.00	291.00	309.40	327.60	345.80	364.00
Testicle/	W	33.80	36.40	39.00	41.60	44.20	46.80	49.40	52.00
Breast/Ovary*	D	236.60	254.80	273.00	291.00	309.40	327.60	345.80	364.00
Hearing	W	130.00	140.00	150.00	160.00	170.00	180.00	190.00	200.00
(Both ears)	D	910.00	980.00	1050.00	1120.00	1190.00	1260.00	1330.00	1400.00

* Includes Fallopian tube

2-0901 Exhibit 6: Activity Codes

ACTIVITY CODES

In ACPS, it is necessary to assign an Activity Code to certain groups of cases. This code tells ACPS to perform certain calculations. For instance, the Federal Death Reserve cases are not entitled to the minimum pay rate computations nor to application of CPI's; thus, an Activity Code of "02" must be placed in ACPS. The default code is "01", so the keyer must backspace into the Activity Code area and change the code to "02".

The Activity Codes are:

ACTIVITY CODE	TYPE OF CASE	CASE PREFIX
01	Federal Civilian Employee	X, no prefix, or any district

		office prefix
02	Reservists (no minimum; no cost-of-living increases)	X, or any district office prefix
03	Civil Air Patrol	CP
04	Reserve Officer Training	TC
05	Maritime War Risk	RA
06	Federal Relief Projects	WP, NY, CC, FE, CA, FH
07	War-connected Benefits for Employees of Government Contractors	WH
08	Civilian War Benefits	CB
09	Total Benefits, War Claims	WC
10	Social Welfare Programs	X, VISTA, A50 prefix
11	Law Enforcement Officers	LE
12	Coast Guard Auxiliary	Any prefix (no minimum; no cost-of-living increases)
13	Job Corps (no minimum)	Any prefix

2-1000 DUAL BENEFITS

Paragraph	Subject	Date	Trans. No.
	Table of Contents	12/97	98-02
1	Purpose and Scope	02/95	95-08
2	Statutory Provisions	02/95	95-08
3	Responsibility	02/95	95-08
4	Annuity Benefits Paid by Office of Personnel Management	02/95	95-08
		01/97	97-08
5	Obtaining Elections Between OWCP and OPM Benefits	02/95	95-08
6	Entitlement to Other Benefits Under the FECA	02/95	95-08
7	Foreign Service Retirement and Disability System	02/95	95-08
8	Veterans' Benefits	02/95	95-08
		02/96	96-11
		12/97	98-02
9	Military Reservists	02/95	95-08
10	Armed Forces and Other Uniformed Services	02/95	95-08
11	Social Security Benefits	02/95	95-08
12	Tennessee Valley Authority	02/95	95-08
13	Black Lung Benefits	02/95	95-08
		10/96	97/01
14	Railroad Retirement Act Benefits	02/95	95-08
15	Department of Justice Benefits Paid for Survivors of Federal Law Enforcement Officers	02/95	95-08
16	Benefits for Judicial Officials Assassinated in Performance of Duty	02/95	95-08
17	Severance and Separation Pay	04/96	96-14

Exhibits

Exhibit	Subject	Date	Trans. No.
1	Restrictions on Payment of Benefits Under the FECA Concurrently with Benefits Under Other Federal Programs	02/95	95-08
2	OPM Contact List (Link to Image)	12/97	98-02

2-1000-1 Purpose and Scope

1. Purpose and Scope. This chapter explains dual benefits allowed and prohibited under the FECA and establishes procedures for obtaining required elections and for requesting refunds when dual payments have been made.

2-1000-2 Statutory Provisions

2. Statutory Provisions. 5 U.S.C. 8116 outlines the limitations on the right to receive compensation and the necessity for an election between certain prohibited dual benefits (see Exhibit 1).

2-1000-3 Responsibility

3. Responsibility. It is the responsibility of the Claims Examiner (CE) to determine if the claimant either qualifies for or is receiving benefits from another Federal agency. When a claimant is entitled to or is receiving a benefit from another agency, the CE must determine if that benefit constitutes a prohibited dual benefit and requires an election, or if it is an exception which will not affect the claimant's compensation entitlement.

Where receipt of dual benefits is prohibited, the CE must advise the claimant of the entitlement as well as the need for and terms of the election appropriate to that case. The CE should make every effort to obtain a timely election where necessary to ensure that the claimant does not suffer undue hardship while awaiting compensation payments.

2-1000-4 Annuity Benefits Paid by OPM

4. Annuity Benefits Paid by Office of Personnel Management. References: FECA Program Memoranda (ProM) Nos. 12, 27, 72, 90, 138 242, 249, 262, 263 and 267. (For non-Federal retirement systems standing in lieu of the Civil Service Retirement System, see ProM Nos. 242 and 262.)

a. Disability Compensation. When a claimant is entitled to disability benefits under the Federal Employees' Compensation Act (FECA), and annuity benefits from the Office of Personnel Management (OPM) under the Civil Service Retirement System Act (CSRS) or the Federal Employees' Retirement System Act (FERS), the employee must make an election between OWCP benefits and OPM benefits. The employee has the right to elect the monetary benefit which is the more advantageous. This policy also applies to reemployed annuitants (see Harold Weisman, Docket No. 93-1335, issued March 30, 1994). (The claimant may receive concurrent benefits from the Office of Workers' Compensation Programs (OWCP) and the Thrift Savings Fund.)

Section 5 U.S.C. 8337(f) provides that the prohibition against the payment of dual benefits does not bar the right of a claimant to the greater benefit conferred by either Act for any part of the same period of time. Thus, an election of disability compensation under the FECA or an election of an annuity benefit provided by OPM is not irrevocable.

b. Death Benefits. When compensation for death is payable under the FECA and fatal benefits are payable under CSRS or FERS, the eligible survivor(s) must make an election between OWCP benefits and OPM benefits. This includes the lump sum death benefit paid under the FERS, though any beneficiary may concurrently receive benefits from OWCP and the Thrift Savings Fund.
The Employees' Compensation Appeals Board held in the case of Adeline Etzel, 21 ECAB 151, that the statutory language concerning irrevocability of election was intended to apply only to those cases where:

> the disability or death of an employee has resulted from an injury sustained in civilian employment by the United States and the Veterans Administration has held that the same disability or death was caused by military service.

Therefore, except for those few cases where an election of veterans' benefits and FECA benefits is required for the reason stated in Etzel, the OWCP considers any election of death benefits provided by OWCP and OPM to be revocable. However, OPM considers an informed election of OWCP benefits in lieu of OPM benefits to be irrevocable.

Where a survivor is entitled to both an annuity from OPM in his or her own right because of his or her own Federal service, and an entitlement to death benefits under the FECA, no election is required between these two benefits. Similarly, if the money paid by the OPM is paid to the (former) employee and/or his or her estate, death benefits paid to the survivor would not constitute a dual benefit (unless the OPM benefit were paid directly to the survivor in his or her own right).

c. Communications with OPM's Office of Retirement Programs. All correspondence with OPM, whether by form or narrative letter, shall contain the claimant's full name, OPM claim number, date of birth and Social Security number. Where closed benefit periods are involved, they should be shown clearly in terms of inclusive dates (e.g., "Compensation was paid from (date) through (date), inclusive."). The type of FECA benefit (i.e., disability, schedule award, or death) must be identified also. Where OPM so requests, the CE should provide a copy of any later formal decisions or letters describing benefits to OPM.

d. Effect of Lump Sum Payment by OPM. 5 U.S.C. 8343a(b) provides that OPM shall offer alternative forms of annuities for employees retiring under the Civil Service Retirement Act. These forms include payment of a lump-sum credit plus payment of an

actuarially reduced annuity. Since the lump-sum credit is clearly part of the retirement benefit (and not simply a refund to the employee of the contributions the employee made to CSRS), it is considered a dual benefit which is prohibited under 5 U.S.C. 8116(a). Similarly, the lump-sum death benefit under FERS authorized in 5 U.S.C. 8442 is also considered a prohibited dual benefit.

e. Social Security Act Benefits. Social Security benefits are payable concurrently with FECA benefits, but the following restrictions apply:

(1) Social Security Act benefits paid for disability shall be reduced by the compensation payable;

(2) In disability cases, FECA benefits will be reduced by the Social Security Act benefits paid on the basis of age and attributable to the employee's Federal service;

(3) In death cases, FECA benefits will be reduced by the survivor's benefits paid under the Social Security Act attributable to the employee's Federal service.

2-1000-5 Obtaining Elections Between OWCP and OPM Benefits

5. Obtaining Elections Between OWCP and OPM Benefits.

a. In all death cases, and in disability cases where the record indicates that a claim has been made for benefits under CSRS or FERS, the CE should release Form CA-1101 to OPM during initial development of the claim. This request should help to ensure that the necessary information about the status of the claim for annuity is in file when entitlement to FECA benefits is determined. If the initial response from OPM is negative, but some time elapses before entitlement to FECA benefits is determined, the CE should make further inquiry to OPM before FECA benefits are paid if there is any reason to believe that a claim for OPM benefits was later made.

b. When an election is required in a disability case, the CE will release Form CA-1102 to the employee, with copies to all parties in interest. This letter provides information about the rate of compensation payable and the employee's right to elect the more advantageous benefit. Two copies of Form CA-1105, Election of Benefits, should accompany Form CA-1102.

(1) Pay Rates. The monthly rate of the compensation entitlement should be shown on Form CA-1102, so that the employee may compare the two benefits easily. The four-weekly rate should also be indicated.

(2) Retroactive Payment. When the claimant is entitled to retroactive

compensation and CPIs are applicable, the form should show the amount payable for each period from the beginning of entitlement to the present.

(3) Certification. The CE should have both the finding of entitlement and the determination of the compensation rate certified before releasing Form CA-1102.

(4) Lump Sum. Form CA-1102 also advises the employee that any lump sum paid by OPM under CSRS as part of an alternative annuity (equal to the employee's contribution) is considered a dual benefit which would have to be repaid to OPM either directly or out of any retroactive and continuing FECA benefits. No benefits under FECA can be paid to a claimant until the entire amount of benefits paid by OPM (including both regular annuity payments and the lump sum) has been recouped. Under no circumstance should OWCP pay any retroactive benefits to a claimant until the possibility of an outstanding debt to OPM is resolved.

c. When an election is required in a death case, the CE will release Form CA-1103 to the person claiming the death benefit, with copies to all parties in interest. This letter provides information about the rate of compensation payable and the right of election. Two copies of Form CA-1105, Election of Benefits, should accompany Form CA-1103.

(1) Terms of Entitlement. To permit an informed election, the CE should ensure that complete information is provided. The information should include the terms of and the termination dates of compensation for each beneficiary involved in the award.

(2) Retroactive Payment. When the beneficiary is entitled to retroactive compensation and CPIs are applicable, the election form should show the amount payable for each period from the beginning of entitlement to the present.

(3) Certification. The CE should have the findings of entitlement, the determinations of compensation rates, and periods of entitlement certified before releasing Form CA-1103.

(4) Lump Sum. Form CA-1103 also advises the claimant that any lump sum paid by OPM as part of the death benefit available under FERS is considered a dual benefit which would have to be repaid to OPM before any FECA benefits could be paid to the claimant. Such repayment would be made either directly by the claimant or through payment of all retroactive FECA benefits and a portion of the continuing benefits.

The FERS lump sum is paid to the surviving spouse only; FECA benefits paid to children would not be a dual benefit. In some cases, therefore, a spouse may find it more advantageous to elect FECA benefits for the children but not for herself or

himself and thus avoid repaying the FERS lump sum.

d. On return of Form CA-1105 electing FECA benefits, the CE should take the following actions:

(1) Contact the appropriate person at OPM using the list of telephone numbers provided in Exhibit 2. Inform the contact person in OPM of the claimant's election to receive benefits under the FECA, and request that the OPM annuity be suspended immediately. It will be necessary to provide OPM with the claimant's name, current address and OPM claim number.

(If this information is not on the election form, contact the claimant by telephone to obtain it. If the claimant does not know his or her OPM claim number, be prepared to provide OPM with the claimant's date of birth and Social Security number).

The CE should also furnish his or her telephone number to the OPM representative so that he or she can confirm that the annuity has been suspended. This confirmation should come within 72 hours. If it does not, follow up with OPM.

(2) When OPM confirms that the annuity has been suspended, the CE will take action to commence payment of compensation on the periodic roll. The effective date should be the date OPM benefits were suspended, except when repayment of a lump-sum benefit to OPM is necessary. (In this situation, the CE will follow the procedures outlined in subparagraph (5) below.)

(3) The CE will then release Form CA-1104, with copies to all parties of interest, advising OPM of the date FECA compensation began, and requesting that OPM transfer the health benefits enrollment and advise OWCP of the total amount of benefits paid by OPM from the effective date of the claimant's election until the annuity was suspended. A copy of the claimant's election form will be enclosed with the original letter to OPM.

If there is no retroactive compensation from which to reimburse OPM for benefits paid on and after the effective date of election, the CE should so advise OPM on Form CA-1104 and indicate the net amount of the FECA periodic payment. OPM will then afford the claimant appropriate due process and request offset from continuing FECA payments (see paragraph 6f below).

(4) Upon receipt of a reply to Form CA-1104, the CE should take action to pay the claimant retroactively to the effective date of the election, less reimbursement owed to OPM for annuity benefits, and to transfer the claimant's health benefits enrollment to OWCP. The CE will show the claimant's OPM

claim number when authorizing payment to OPM on Form CA-24, CA-25 or CA-25a. Under no circumstances should any retroactive compensation be paid until OPM has been reimbursed in full for the benefits it has paid.

(5) Where a lump-sum payment has been made to the claimant as part of an alternative annuity under CSRS or as part of the death benefit under FERS, FECA benefits should not be paid until OPM benefits can be fully reimbursed by the claimant or unless the retroactive benefits under the FECA fully cover the lump-sum annuity and OPM benefits. If the claimant has already been placed on the periodic roll and the retroactive compensation is insufficient to reimburse OPM, the case should be referred to National Office for further action.

e. On return of Form CA-1105 electing OPM benefits, the CE should take the following actions:

(1) If the claimant is not receiving compensation, close the case on Form CA-800, Nonfatal Summary, or Form 105, Fatal Summary, indicating that OPM benefits have been elected, refer the case to the inactive files; and enter the change of case status in the CMF.

(2) If the claimant is receiving compensation, take action to terminate compensation and compute any reimbursement that may be owed by OPM. Release Form CA-1107 to OPM, with a copy of Form CA-1105. This will notify OPM of the election of OPM benefits; advise that compensation benefits have ended and that OPM benefits should begin; inform OPM of the amount of the reimbursement (if any) due OWCP; and provide OPM with the information which will allow them to transfer the claimant's health benefits enrollment (and life insurance enrollment, if applicable) to their rolls.

2-1000-6 Entitlement to Other Benefits Under the FECA

6. Entitlement to Other Benefits Under the FECA.

a. Medical Treatment. Regardless of which monetary benefits the claimant elects, any medical treatment required for the effects of the compensable injury will continue to be provided under FECA.

b. Schedule Awards. These awards, payable under 5 U.S.C. 8107 for the permanent loss or loss of use of specified members, organs, or functions of the body, are the only FECA monetary compensation benefits payable concurrently within an OPM annuity. These dual benefits are allowable for injuries sustained on or after September 13, 1957. For injuries which occurred prior to that date, an election between these two benefits is required.

c. Vocational Rehabilitation. An employee in receipt of OPM retirement benefits is prohibited from receiving vocational rehabilitation assistance under FECA. See FECA ProM No. 27.

d. Attendant's Allowance.

(1) An employee entitled to total or partial disability benefits under 5 U.S.C. 8105 or 5 U.S.C 8106 who has elected to receive the benefits of the CSRS or the FERS Act may not receive an attendant's allowance under 5 U.S.C. 8111(a) during the time that benefits are being received under one of the retirement acts.

(2) When an employee is entitled to a schedule award under 5 U.S.C. 8107, the attendant's allowance is considered incidental to the award and may be paid concurrently with OPM retirement benefits during the period of the award. See FECA ProM No. 72.

e. Third-Party Credits. Where a claimant has made a third-party recovery resulting in a credit against the compensation entitlement, and it appears that additional compensation may be paid and medical expenses claimed, compensation payments are calculated and charged against the recovery credit to the case, as are injury-related medical expenses paid by the claimant. This procedure continues until the third-party credit is absorbed.

(1) OPM Annuity During Offset. There is no prohibition against receipt of an OPM annuity during the period that the third-party credit is being absorbed by OWCP. The claimant is not actually receiving compensation from OWCP during this period, so the payment of an annuity does not constitute a prohibited dual payment.

(2) Election After Offset. Receipt of an annuity during the third-party credit period does not prejudice the claimant's rights. Thus, when the credit has been exhausted, the claimant should be given an opportunity to elect between FECA benefits and continuation of the OPM annuity.

(3) As noted above, the OPM considers an informed election of OWCP death benefits (in lieu of OPM benefits) to be irrevocable. Thus, it is imperative that the claimant be informed fully of the available benefits, especially in cases involving possible third-party settlements.

(a) To make an informed election, the claimant must be made aware of the opportunity to receive OPM survivor benefits while the third-party credit is being absorbed. If an election is made without this knowledge, the election will be considered null and void.

(b) Inasmuch as the claimant is not required to make an election until after the third-party credit has been absorbed, the one-year time limitation of 5 U.S.C. 8116(b) will not begin to run until the third-party credit has been exhausted.

(4) Nonparticipants. Beneficiaries who do not participate in the third-party settlement are not affected by third-party credit offsets. (See FECA ProM No. 125.)

f. Refunds When Dual Benefits Have Been Paid.

(1) Refund Action When Repayment is Due OPM. A refund due OPM may be paid from accrued and/or continuing compensation, provided that the amount of the debt is at least $25.

(a) If there is an accrued amount of compensation payable by OWCP, OPM is not required to provide certification of due process before recovering the debt from the accrued OWCP benefits. Upon receipt of notification from OPM of the fact and amount of the debt, the district office will deduct the total amount of indebtedness from the accrued compensation and forward that amount to OPM.

(b) If there is accrued compensation but it is not sufficient to cover the total amount owed OPM, the district office will forward the entire accrued amount to OPM. When certification of due process is received from OPM as described below in subparagraph (c), the district office will make deductions from any continuing compensation payments until the debt has been repaid.

Where the claimant received a lump sum payment from OPM as part of an alternative annuity under CSRS or as part of the death benefit under FERS, OPM is not required to provide certification of due process. The district office may withhold continuing net compensation until OPM is fully repaid.

(c) Except where the claimant received a lump-sum payment from OPM as described above in subparagraph (b), OPM will certify in writing that the debt exists and that appropriate due process has been afforded the debtor to request offset from continuing compensation payments. OPM will advise the district office of either the dollar amount of the periodic deduction or the percentage of net compensation to offset each payment period.
In general, OPM will request a deduction of ten percent (10%) of the

periodic payment, but not less than $50. A greater or lesser amount may be requested based on an agreement reached between OPM and the debtor. Whenever possible, OPM will try to recover the debt within 36 months.

(2) Method of Setting Up Payments.

(a) The CE will authorize repayment to OPM as a case payee on Form CA-25A, CA-25, or CA-24. The CE must indicate the total amount owed OPM and the amount to be deducted from each compensation payment.

(b) Payment to OPM will be transferred via Treasury's OPAC transfer of funds. A case payee (CP) will be entered in ACPS for this transaction.

(3) OPM Contract. OPM's Debt Collection Branch (DCB) handles debts owed to OPM. Once the DCB contacts the district office, all future correspondence concerning the debt should be sent to the DCB. District office staff are encouraged to call the DCB at (202) 254-3094 to expedite resolution of cases.

(4) Refund action when repayment is due OWCP is described in FECA PM 5-505.11.

2-1000-7 Foreign Service Retirement and Disability System

7. Foreign Service Retirement and Disability System. References: FECA ProM Nos. 14 and 18.

a. Gratuities. Amounts equal to one year's salary at the time of death are paid to surviving dependents of Foreign Service employees who die as the result of injury sustained in the performance of duty outside the United States, excluding diseases proximately caused by the employment. These payments are considered gifts and are payable in addition to compensation or benefits from any other source.

b. Other Benefits. An election is required between FECA benefits and other benefits of the Foreign Service Retirement System. The injured employee is permitted, however, to receive for any period of time the greater of the two benefits. The provisions of this retirement system are substantially the same as those of the Civil Service Retirement System regarding the receipt of these dual benefits. The procedures as outlined in paragraph 4 above should be followed in regard to providing benefits and obtaining elections where benefits of the FECA and the Foreign Service Retirement System are involved.

2-1000-8 Veterans' Benefits

8. Veterans' Benefits. References: FECA ProM Nos. 80, 108, 123, 166, 169, 175, 180 and 200.

a. Contacting the DVA. Information from DVA files is often helpful in adjudicating claims and preventing dual payments. In particular, when the record shows that an applicant for FECA benefits is receiving veterans' benefits, the CE must determine the nature of those benefits. Such information should be obtained as follows:

(1) Form CA-1019 or Form CA-1077 will be used to request information from DVA whenever possible. Otherwise, a narrative letter should be sent. This letter must contain all identifying information indicated on the form. Requests for information from DVA files must be accompanied by a completed Form CA-57, Authorization for Release of Information.

(2) Preparing the Form. All available identifying information must be entered in the upper right corner of Form CA-1019 or CA-1077. Additional information, such as a Social Security number, can be added if available.

(3) Identification. Requests to the DVA must, if possible, include the veteran's DVA claim number. If the DVA claim number is not available, the request must include at least the veteran's date of birth and military service number. Other helpful identifying information would include the Social Security number, the approximate date the veteran's benefits were last received, the location where the veteran's claim was filed, and the location and approximate date DVA medical services were last received.

(4) Addresses. DVA benefit records are maintained in the DVA Regional Offices (DVARO). In some places the regional offices are combined with an insurance center, hospital, or domiciliary and are known as DVA Centers. In the District of Columbia, the equivalent of a regional office is known as the Veterans Benefits Office. The U.S. Government Organization Manual contains the addresses of DVA Regional Offices, DVA Centers, and DVA Hospitals.

If the location of the DVA claims folder is unknown, send the request to the DVARO or DVA Center which likely has jurisdiction over the claimant's address. Where regional boundaries are unknown, the Assistant District Director should obtain this information from the DVA. Any DVA office can locate a file on the computer system.

Requests for medical reports of examinations or treatment provided by a DVA Hospital should be sent to the hospital which provided the service.

(5) Information Received. If the reply shows that the veteran's award is other than "pension for service in the Army, Navy or Air Force," the CE must determine whether the award is based on a finding that the same disability or death for which FECA benefits are payable was caused by the military service, or whether the DVA increased an award or found an award was payable for service-connected disability, because of the civilian employment injury for which FECA benefits are claimed (see examples in paragraph b below).

(a) If so, an election between these benefits is required by 5 U.S.C. 8116(a)(3).

(b) If not, except for educational benefits as explained in paragraphs 8c and 8d below, no election is necessary.

b. Definitions. If the veteran's benefit was for a non-service-related condition, no election is required. The following discussion addresses claims involving service-related conditions.

(1) The prohibition against dual payment of FECA and veterans' benefits applies to those cases where the disability or death of an employee has resulted from an injury sustained in civilian employment by the United States and the Department of Veterans Affairs (DVA), formerly the Veterans Administration, has held that the same disability or death was caused by the military service. See Adeline N. Etzel, claiming as widow of Bernard E. Etzel (21 ECAB 151).

Example: Federal employee, a veteran, is disabled by or dies from pulmonary tuberculosis. DVA finds that the disease became manifest within the medical presumptive period after military service and grants benefits on the basis of military service connection. OWCP finds that the disability or death resulting from this disease is related to veteran's Federal civilian employment and grants FECA benefits. Employee or his survivors are eligible for both FEC and veterans' benefits for the same disability or death, namely, that resulting from pulmonary tuberculosis. An election is required.

(2) The prohibition also extends to an increase in a veteran's service-connected disability award, where the increase is brought about by an injury sustained while in civilian employment. See Louis Teplitsky (22 ECAB 142) and France Marie Kral (24 ECAB 157).

Example 1: A Federal employee is receiving benefits from the DVA for 50 percent disability due to a service-connected emotional condition, and has a civilian employment injury which causes a disabling aggravation of the pre-existing emotional condition. OWCP determines that the employee has a

total loss of wage-earning capacity due to the emotional condition. Subsequent to the employment injury, DVA increases its award to 100 percent as a result of the aggravation by the civilian employment injury.

An election between benefits is required in this case. The election will be between the amount of entitlement under FECA plus the amount received from the DVA for 50 percent prior to his civilian employment injury, on the one hand, and the total amount of entitlement from the DVA for 100 percent, on the other hand.

In other words, no election is required between the veteran's benefit the claimant was receiving at the time of the civilian employment injury and the FECA benefits to which the claimant is entitled for the civilian employment injury because these benefits are not payable for the same injury. When the DVA increased its benefits an election was required because the increased benefits were payable because of the same employment injury which formed the basis of entitlement to FECA benefits.

Example 2: A Federal employee is receiving benefits from the DVA for 20 percent disability based on a service-connected injury to the right knee. A subsequent injury to the same knee while in civilian employment results in 25 percent disability of the leg, for which FECA benefits are payable. The DVA increases its award to 30 percent because of the civilian employment injury.

The election required in this case is the same as that required in Example No. 1 above--i.e., between a schedule award, for the full extent of the permanent loss of the use of the leg under the FECA plus the amount received from the DVA prior to the employment injury, on the one hand, and the total benefits provided by the DVA subsequent to its increase, on the other hand.

(a) No reduction in a schedule award is required under 5 U.S.C. 8108 where the DVA has made an award for an earlier injury to the same member (see Example 2 above). It has been determined that the word "injury" as used in 5 U.S.C. 8108 means an earlier injury received while in Federal civilian employment.

(b) The claimant may be entitled to compensation for loss of wage-earning capacity (LWEC) at the expiration of the schedule award (see Example 2 above). If so, an informed election cannot be made until the claimant's LWEC is determined.

Thus, two elections are possible and permitted in such cases--the first between the schedule award under the FECA and the veteran's benefit, and the second between compensation for LWEC under the FECA and the

veteran's benefit. The conditions of both elections would be as outlined in Example 2 above.

(3) The prohibition does not extend to pensions, since Section 5 U.S.C. 8116(a)(2) expressly provides that there is no limitation on the right to receive FECA compensation because of the receipt of a pension for service in the Army, Navy or Air Force. The receipt of a pension from the DVA for a non-service-connected disability or death and the payment of compensation under the FECA is therefore not a prohibited dual benefit, and no election is required.

(4) The DVA pays other benefits to veterans and their survivors, which are variously termed compensation, dependency and indemnity compensation, and educational assistance, etc., other than for educational awards. The payment of compensation under the FECA concurrently with such veterans' benefits would constitute a prohibited dual payment only where the veteran's award is based on the finding that the same disability or death for which FECA benefits are payable was caused by the military service. See paragraph 8b above.

(5) When several kinds of disability are present, the DVA combines the percentages allowed for each disability (using a method of computation similar to the combined values chart in the AMA Guides to the Evaluation of Permanent Impairment). The resulting percentage is often less than the sum of all impairments. For instance, the veteran may have 40% disability due to one condition, 30% due to a second condition, and 10% due to a third condition, for a total award of 60%.

(a) When determining percentages for election, the CE should use the amount of the percentage for the work-related condition only.

(b) The amount of the percentage should not be pro-rated to account for use of the combination method. In the example given above, if the work-related condition is the one for which the DVA has granted 40% disability, the entire 40% should be used in determining the amount of the election.

(c) For privacy reasons, the DVA may not provide information about percentages of disability for conditions other than the work-related one. The CE may need to contact the claimant directly to obtain a copy of the notice of benefits showing the percentages paid for each disability.

c. Educational Benefits.

(1) Educational benefits provided under the GI Bill are based on the veteran's own military service. Educational benefits (i.e., benefits for students) under the

FECA are based on the employment and the related disability or death of the recipient's relative. The prohibition against concurrent payments contained in 5 U.S.C. 8116 applies only to payments based on the same disability or death. No election is required for educational benefits under the GI bill.

(2) Unless the veteran's educational award is designated a pension or is paid as outlined in the preceding paragraph, the following procedures apply:

(a) Where a widow(er) or child is eligible for benefits based on school attendance under both the FECA and laws administered by the DVA, an election is required, regardless of whether the eligibility for veterans' benefits is based on a finding that the disability or death was service-connected.

(b) Under certain circumstances, veterans' benefits for a widow(er) and the eligible children are divisible. Stated another way, the child or children have a "separate and independent right of election" to veterans' benefits.

(c) If a child does not have a separate and independent right of entitlement under the DVA law, the election by the veteran or the widow(er) is binding on the child in that the benefits for the child are payable only by the same agency paying benefits for the veteran or the widow/er.

(d) An election is binding only for the period of concurrent eligibility.

(e) The election of veterans' benefits by one or more beneficiaries in a family will not serve to increase the rate of compensation payable by OWCP to or on behalf of the other beneficiaries who continue to receive FECA benefits.

d. Obtaining Elections--Educational Benefits.

(1) In a disability case, if the payment of augmented compensation is contingent solely upon the eligibility of a child over 18 who is a student, the CE must determine whether the claimant is a veteran. If so, the CE must determine whether application has been made to the DVA for benefits (on behalf of the child) based on school attendance. This can be accomplished by use of Form CA-1615 or an equivalent narrative letter. Upon receipt of this information, the election procedure as described below in connection with death cases will be followed.

(2) In an accepted death case, the CE must determine whether the decedent

was a veteran. If so, and if the decedent is survived by children 18 years of age or older who are eligible for educational benefits under the FECA, send Form CA-1615 or an equivalent letter to determine whether application has been made to the DVA for benefits based on school attendance.

If such application has been made, or benefits are being received, and Form CA-1077 has not previously been released, the CE should send Form CA-1078 to the DVA to determine whether the claimant is eligible for or is receiving veterans' benefits based on school attendance.

(3) Upon receipt of this letter, the DVA will reply in duplicate concerning the type and amount of such benefits and the period during which they have been paid or may be payable. In addition, they will advise whether the child has a separate and independent right of entitlement and can thereby make a separate and independent election of benefits.

(4) The CE should then release an informational letter to the claimant, attaching the copy of the DVA letter and three copies of a narrative election letter for each claimant who is required to make an election. The letter will clearly state the amount payable, the period during which they may be paid, and the basis for their termination.

The letter should also note the copy of the attached DVA letter which outlines the benefits payable by that agency and ask the claimant to make an election in narrative form and return two copies of the election to OWCP.

There may be circumstances when it is not appropriate for the CE to attach the copy of the DVA letter. If this occurs, it will be necessary for the CE to provide a sufficient explanation of the DVA benefits to allow the claimant to make an informed election.

(5) If OWCP benefits are elected and the facts show that prior to the election both agencies made payments concurrently, the CE will ascertain the amount paid by the DVA for periods on or after July 4, 1966, and will deduct such an amount from future payments. The deduction should be made from each monthly payment using a method which will result in minimum financial hardship for the claimant, yet will recover the amount within a reasonable period.

If only the DVA was making payments prior to the election, the CE will ascertain the amount paid by the DVA for periods on or after July 4, 1966, deduct that amount from accrued OWCP payments, and pay the balance to the claimant.

(6) If veterans' benefits are elected, the CE should advise the DVA office of the amount of any OWCP payment to be deducted from future DVA payments.

The letter transmitting the election form to the DVA will reflect the amount of the OWCP payments, and the periods for which payments were made, on or after July 4, 1966.

(7) A copy of the election form must always be sent to the DVA. The letter transmitting the election will also request information regarding the amount paid by the DVA on or after July 4, 1966, A narrative letter must also be written to the claimant, with a copy to the DVA, explaining in full the payments, deductions, or method of recovery of dual payments.

(8) When OWCP educational benefits are terminated, a copy of the termination letter should be sent to the DVA office.

(9) The OWCP and the DVA have agreed that there will be no transfer of funds between agencies.

f. Obtaining Elections--Other Benefits. Cases requiring such an election will include those involving increases in service-connected awards made by the DVA because of civilian employment injuries, and those involving military reservists (see paragraph 9 below).

(1) When dual entitlement exists because of a disability which became manifest within the medical presumptive period after military service, as outlined in the example in paragraph 8b above, the CE should advise the DVA of OWCP's determination regarding the employment-relatedness of the condition. If DVA does not then change its determination as to service connection, an election between benefits is required.

(2) Where the DVA increases a service-connected award because of a civilian employment injury for which FECA benefits are payable, as outlined in the examples under paragraph 8b above, an election between benefits is required.

(3) The CE must advise the claimant of the full amount and terms of FECA entitlement and obtain an election in narrative form, between the two benefits.

(4) If FECA benefits are elected and OWCP and DVA made concurrent payments before the election, the CE will determine the amount paid by the DVA and deduct this amount from future payments. The deduction should be made from each monthly payment using a method which will result in minimum financial hardship for the claimant, yet will recover the amount within a reasonable period.

(5) If FECA benefits are elected and only the DVA made payments before the election, the CE will determine the amount paid by the DVA, deduct that

amount from accrued OWCP payments, and pay the balance to the claimant.

(6) If DVA benefits are elected, the CE should advise the DVA of the amount of any OWCP payment to be deducted from future DVA payments. The letter transmitting the election form to the DVA will reflect the amount of the OWCP payments, and the periods for which payments were made.

(7) A copy of the election form must always be sent to the DVA. A narrative letter must also be written to the claimant, with a copy to the DVA, explaining the payments, deductions, or method of recovery of dual payments.

(8) When OWCP benefits are terminated, a copy of the termination letter should be sent to the DVA.

(9) OWCP and DVA have agreed that no funds will be transferred between agencies.

2-1000-9 Military Reservists

9. Military Reservists.

a. Statutory Provisions. Before January 1, 1957, the benefits of the FECA were extended under certain circumstances to reservists of the armed forces and their beneficiaries where the injury or death of the reservist occurred in line of duty while on active duty. Public Law 81-881, approved August 1, 1956, terminated the FECA entitlement to these persons effective January 1, 1957.

Public Law 81-881 provided that the termination of coverage did not deprive any person of benefits to which there was eligibility by reason of disability or death occurring prior to January 1, 1957. It further provided that beneficiaries eligible for compensation for death occurring before January 1, 1957, could continue to receive benefits under the FECA or they could elect benefits from the DVA under PL 81-881.

b. Election Requirements. Since the eligibility for benefits provided by both the FECA and the DVA is based on the same period of service and the same death, an election is required.

c. Irrevocability of Election. The irrevocability of election provided by 5 U.S.C. 8116(b) applies to FECA benefits based on the injury or death of an "employee." Military reservists and their beneficiaries do not fall within the definition of employee as contained in 5 U.S.C. 8101(1). Thus, the beneficiaries in military reservist cases have the right, without time limitation, to elect veterans' benefits. However, under the provision of 38 U.S.C. 416, once an election is made to receive veterans' benefits, the beneficiary

cannot later elect FECA benefits.

2-1000-10 Armed Forces and Other Uniformed Services

10. Armed Forces and Other Uniformed Services. References: FECA ProM Nos. 116 and 131.

a. Dual Payment Not Prohibited. Effective September 7, 1974, 5 U.S.C. 8116(a) was amended to provide that retainer pay, retirement pay, or equivalent pay for service in the armed forces or other uniformed services may be continued while an employee is receiving FECA benefits subject to the limitations on receipt of dual compensation by retired officers contained in 5 U.S.C. 5532.

b. Injuries Before September 7, 1974.

(1) Before September 7, 1974, compensation due under the FECA was considered by OWCP to be the employee's basic benefit. Where the employee was receiving retirement or retainer pay, the employee and the military finance office making such payment were advised of the FECA entitlement. If the finance office found that the FECA payment would constitute a dual payment prohibited under 5 U.S.C. 8116, and if the employee agreed, OWCP would deduct the amount representing the dual payment and reimburse it to the finance center, paying the balance to the employee. If the employee did not agree to this arrangement, OWCP would pay the full amount of compensation due to the employee and notify the appropriate finance center of such payment. See Charles W. Akers, 24 ECAB 316.

(2) If compensation is claimed for an injury occurring before September 7, 1974, and the employee is receiving retirement or retainer pay, the full amount of the compensation entitlement will be paid to the employee. The CE, however, will write to the employee, with a copy to the military finance office, advising of the amendment and informing the employee that, effective September 7, 1974 and continuing, the employee may receive compensation and retirement or retainer pay concurrently.

c. Injuries On and After September 7, 1974. If the file reflects that the claimant is receiving retirement or retainer pay, compensation will be paid for appropriate periods. It will not be necessary to notify the military finance offices that compensation payments are being made. There is no need for OWCP to be concerned with reductions applicable to 5 U.S.C. 5532 since these reductions apply to the wages the recipient is receiving and will always have occurred before any injury compensable under the FECA.

2-1000-11 Social Security Benefits

11. Social Security Benefits. References: FECA ProM Nos. 10, 20 and 81.

a. OASD Benefits. Old age, survivors, and disability under Title II of the Social Security Act, as amended, are insurance benefits paid from the Social Security insurance fund. These payments are financed by the contributions of employees and employers through the Social Security tax, and are not financed by the United States. Social Security benefits are payable only to persons insured under the system by their respective payments to the system's insurance fund.

b. Dual Payment Not Prohibited. OWCP does not require an election between FECA benefits and Social Security benefits, except when they are attributable to the employee's Federal service (see paragraph 4e above). The Social Security Act was amended on July 30, 1965, providing for a reduction in Social Security benefits to certain individuals receiving workers' compensation. Inquiries concerning this situation should be referred to the Social Security Administration. That agency will inform the beneficiary concerning the possible reduction of Social Security benefits.

2-1000-12 Tennessee Valley Authority

12. Tennessee Valley Authority. References: FECA ProM No. 177.

a. Pension Plan. The Tennessee Valley Authority Retirement System is a private pension plan. The limitations in 5 U.S.C. 8116 apply solely to situations where there is concurrent entitlement to compensation and to some other Federal benefit(s).

b. Dual Payment Not Prohibited. An election between FECA benefits and benefits under the TVA Retirement System is not required by OWCP. Under certain circumstances, the TVA may find that all or part of its retirement benefits are not payable concurrently with FECA benefits. Requests for offset of FECA compensation payments to repay overpayments made under the TVA Retirement System will be honored only upon written authority of the affected beneficiary.

2-1000-13 Black Lung Benefits

13. Black Lung Benefits. Reference: FECA ProM No. 172.

a. Dual Entitlement Not Prohibited. An election between FECA benefits and benefits under the Black Lung Benefits Act (Title IV of the Federal Mine Safety and Health Act of 1977) is not required under the provisions of 5 U.S.C. 8116.

However, claims under the Black Lung Benefits Act (BLBA) filed on and after January 1, 1974 come under Part C of that Act, and section 422(g) of Part C provides for reduction of Black Lung benefits by the amount of "... any compensation received under or pursuant to any Federal or State workmen's compensation law because of death or disability due to pneumoconiosis."

Claims under Part C are under the jurisdiction of the Office of Workers' Compensation Programs, Division of Coal Mine Workers' Compensation (DCMWC), and the responsibility for making appropriate reduction of Black Lung benefits under section 422(g) rests with DCMWC.

b. Potential Dual Benefit Cases Under the FECA. For all practical purposes, the FECA cases in which there is a potential FECA/BLBA dual benefit situation are those involving cardiopulmonary conditions due to exposure to coal dust filed by employees of the Mine Safety and Health Administration (MSHA) of the U.S. Department of Labor. (MSHA's predecessor agency was MESA, the Mine Enforcement and Safety Administration, U.S. Department of the Interior. Its functions were transferred to MSHA on March 9, 1978.) All MESA and MSHA cases fitting the above criteria are under the jurisdiction of the Kansas City District Office.

c. Exchange of Information Between DFEC and DCMWC.

(1) To identify those cases in which dual entitlement exists and to permit DCMWC to make appropriate deductions in BLBA benefits, the timely exchange of case file information between DFEC and DCMWC is necessary. Therefore, in all cases involving a cardio-pulmonary condition where exposure to coal dust is alleged to have contributed to the development of the claimed condition, the National Operations Office will complete Form OWCP-33 and forward it to OWCP, DCMWC, District Office Operations Staff, Frances Perkins Building, Room C-3522, Washington, D.C. 20210.

If necessary, the CE should at this time also request the coal mine employment record and any medical evidence pertaining to the injured employee which may be in the possession of DCMWC. If a claim for the identified individual has also been filed under the BLBA, DCMWC will so advise and, if needed, will request compensation payment information from DFEC.

Based on information contained in their records, DCMWC will also use Form OWCP-33 to query DFEC regarding the existence of a claim under the FECA for a specific individual and, where appropriate, request information about the claim. Any such request should be handled expeditiously.

(2) In any case where a dual benefit situation has been identified and the

provisions of section 422(g) are applicable, DFEC is responsible for advising DCMWC of any changes in case or payment status, including commencement, increase, decrease and termination of compensation, as soon as possible after the change occurs. Further, such cases should be placed under periodic six-month call-up to ensure that DCMWC has been advised of all case/payment changes.

(3) Most cases under Part B of the BLBA (which also contains an offset provision) are handled by the Social Security Administration (SSA). Where a potential dual benefit situation of this type exists, DCMWC will request needed information from DFEC in the same manner as described above and will forward the information to SSA for appropriate action. The actions and responsibilities of DFEC in this situation are the same as described in paragraphs d(1) and (2) above.

d. Exchange of Information Between DFEC and DCMWC.

(1) To identify those cases in which dual entitlement exists and to permit DCMWC to make appropriate deductions in BLBA benefits, the timely exchange of case file information between DFEC and DCMWC is necessary. Therefore, in all cases involving a cardio-pulmonary condition where exposure to coal dust is alleged to have contributed to the development of the claimed condition, the National Operations Office will complete Form OWCP-33 and forward it to OWCP, DCMWC, District Office Operations Staff, Frances Perkins Building, Room C-3522, Washington, D.C. 20210.

If necessary, the CE should at this time also request the coal mine employment record and any medical evidence pertaining to the injured employee which may be in the possession of DCMWC. If a claim for the identified individual has also been filed under the BLBA, DCMWC will so advise and, if needed, will request compensation payment information from DFEC.

Based on information contained in their records, DCMWC will also use Form OWCP-33 to query DFEC regarding the existence of a claim under the FECA for a specific individual and, where appropriate, request information about the claim. Any such request should be handled expeditiously.

(2) In any case where a dual benefit situation has been identified and the provisions of section 422(g) are applicable, DFEC is responsible for advising DCMWC of any changes in case or payment status, including commencement, increase, decrease and termination of compensation, as soon as possible after the change occurs. Further, such cases should be placed under periodic six-month call-up to ensure that DCMWC has been advised of all case/payment changes.

(3) Most cases under Part B of the BLBA (which also contains an offset

provision) are handled by the Social Security Administration (SSA). Where a potential dual benefit situation of this type exists, DCMWC will request needed information from DFEC in the same manner as described above and will forward the information to SSA for appropriate action. The actions and responsibilities of DFEC in this situation are the same as described in paragraphs d(1) and (2) above.

2-1000-14 Railroad Retirement Act Benefits

14. Railroad Retirement Act Benefits. Although payments under the Railroad Retirement Act (RRA) are funded by direct appropriations from Congress, these funds are derived from taxes levied upon the railroads and their employees. A study of the legislative history shows that it was the intent of Congress that payments under the RRA be funded entirely by these taxes, which are channeled through the general fund of the Treasury only to avoid Constitutional problems which might be caused by their being earmarked for a specific purpose.

These benefits are therefore not received "from the United States." Furthermore, since RRA benefits are not payable because of the service of the employee as a civil employee of the United States, they are not "salary, pay, or remuneration." Thus, RRA benefits do not qualify as prohibited dual benefits for two independently sufficient reasons, and no election is required.

2-1000-15 Department of Justice Benefits for Survivors of Federal Law

15. Department of Justice Benefits Paid for Survivors of Federal Law Enforcement Officers. Public Law 98-473 amended the Omnibus Crime Control and Safe Streets Act of 1968 to authorize benefits to officers who die as the direct and proximate result of a personal injury sustained in the line of duty. This benefit, which is paid under the Department of Justice, is to be paid in addition to any other benefit that may be due from any other source. Thus, payment of this benefit does not constitute a dual benefit and is not subject to any offset or reduction.

2-1000-16 Benefits for Judicial Officials Assassinated in Performance

16. Benefits for Judicial Officials Assassinated in Performance of Duty. Public Law 101-650, approved December 1, 1990, provides that the surviving spouse of an assassinated judicial official may be paid both an annuity and compensation under the FECA. Judicial officials covered under this provision include a justice or judge of the U.S.; a judge of the District Court of Guam, the District Court of the Northern Mariana Islands, or the District Court of the Virgin Islands; or a full-time bankruptcy judge or a full-time U.S. magistrate. The annuity may be reduced if the total amount payable exceeds the current salary of the officer of the judicial official. Any such adjustment would be made by the employing agency, not OWCP.

2-1000-17 Severance and Separation Pay

17. Severance and Separation Pay. Employing agencies may grant severance pay to employees who are involuntarily separated as part of a reduction in force (RIF). Agencies may also offer separation pay ("buyouts") to encourage employees to leave Federal employment voluntarily. Certain severance and separation payments constitute dual benefits under the FECA.

a. Definitions.

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

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

Severance pay represents a certain number of weeks worth of salary or wages, and it is usually computed as a lump sum. Health benefits and optional life insurance coverage may continue during the period of severance pay as long as the OWCP eventually makes payments for the time period covered by the severance pay to the Office of Personnel Management (OPM).

(2) Separation pay is offered in different forms by different agencies. Sometimes it is defined as a number of weeks of pay, and other times as a specific amount of money, according to the law governing the agency in question.

For example, the Postal Service (in 1992) calculated its payments as six months of the employee's base pay, while the Department of Defense (starting in 1993) used the amount of severance pay to which the employee would have been entitled, or $25,000, whichever was less.

b. Information Needed. The CE should ask the employing agency to submit:

(1) A statement as to which benefit (severance or separation pay) the employee is to receive. If any doubt exists, a copy of the pertinent law (or a citation to it) should be sent.

(2) A statement as to the period and/or total amount of payments, and the date

of retirement or separation.

(3) A copy of the claimant's acceptance of the offer of separation or severance pay (if applicable), and a copy of the retirement or separation papers.

c. Entitlement. The kinds of benefits allowed and prohibited are identical for separation and severance pay.

(1) Compensation for temporary total disability (TTD) may not be paid for the period covered by severance or separation pay. For example, if a claimant receives 13 weeks worth of severance pay, compensation is not payable until the fourteenth week.

(2) Compensation for LWEC may be paid concurrently with severance or separation pay, since the pay is based on the employee's salary, not the payments for LWEC. If an employee who is receiving compensation for LWEC receives severance or separation pay and then retires, an election of benefits will be required at the time of retirement.

(3) Compensation for a schedule award may be paid concurrently with severance or separation pay.

(4) Medical benefits are payable concurrently with severance and separation pay.

d. Methods of Offset. All severance payments are based on specified numbers of weeks of pay. Some separation payments are also computed in this way, while others are based on an amount of money.

(1) Where the offset is based on weeks of pay, the CE should:

(a) Suspend compensation payments for the period in question, effective the date of separation or retirement, by 100% offset for the number of weeks (not the amount of money) which the severance pay represents. (See paragraph e below concerning health benefits and optional life insurance.)

(b) Determine the number of weeks for which compensation payments should be suspended, by dividing the total amount of severance pay by the salary used to compute it.

(2) Where the offset is based on an amount of money, the total dollar amount of separation pay should be applied to the amount of compensation for wage loss on a dollar-for-dollar basis.

(3) The claimant should be advised that benefits for TTD will cease immediately because he or she has elected to receive severance or separation pay. The claimant should also be advised of the approximate time the offset will end. The estimate may be affected by application of cost-of-living increases, etc.

(4) Where the OWCP later discovers that a severance or separation payment was made for a period when compensation was paid, an overpayment must be declared and the usual due process rights given.

e. Health Benefits (HB) and Optional Life Insurance (OLI).

(1) For claimants with HB and/or OLI coverage, compensation should be suspended at the net amount to allow OWCP to collect the proper deduction(s). Form CA-25 should show as payable only the amounts of deductions for HB and/or OLI, and the payee should be OPM. If payments are suspended at the gross rate, the CE will need to contact the claimant to arrange for payment of the premiums for the period in question.

(2) The agency will transfer the HB enrollment to OWCP effective the date that employment ceases. The claimant is responsible only for his or her own share of the premiums.

(3) The Temporary Continuation of Coverage (TCC) program allows involuntarily separated employees to continue HB coverage for a short period. The TCC program will not allow a person who is entitled to compensation to enroll, and it will terminate the enrollment of a person entitled to either of these benefits.

f. Claims for Additional Compensation.

(1) If a schedule award ends during the period covered by the separation or severance payment, the employee may claim additional compensation for disability (see subparagraph (2) below). If the claimant was not receiving compensation for disability before the schedule award, he or she would not be entitled to receive compensation afterwards unless the medical condition had worsened such that it disabled him or her from the regular or limited duty job performed before separation. Should entitlement to further compensation be established, the employee would need to elect between OWCP and retirement benefits (if eligible).

(2) A separated employee who was not receiving compensation at the time of separation because of placement in a modified job with no loss of pay will not be entitled to further compensation at the end of the period covered by separation or

severance pay solely because the modified job is no longer available. A claimant who has returned to duty, whether regular or light, has the burden of proof to show that injury-related disability had worsened to the point that he or she is now disabled for the limited duty position (see Terry L. Hedman, 38 ECAB 222).1

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

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

(5) Employees working part time, or working full time but at lower rates of pay, will be entitled to continue receiving compensation at the end of the period covered by separation or severance pay at the LWEC rate, if injury-related disability continues and they elect OWCP benefits in favor of retirement benefits. Should a recurrence be claimed, it will be the employee's burden to show that injury-related disability has worsened (see subparagraph (2) above).

(6) An employee who was performing regular duty at the time of separation would be entitled to receive compensation only if a true recurrence of disability were established (see subparagraph (2) above).

(7) An employee who accepts separation or severance pay and then changes his or her mind may not receive compensation for the duration of entitlement to separation pay or severance pay. 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.

2-1000 Exhibit 1: Restrictions on Payment of Benefits Under the FECA

RESTRICTIONS ON PAYMENT OF BENEFITS UNDER THE FECA CONCURRENTLY WITH BENEFITS UNDER OTHER FEDERAL PROGRAMS

I. Claimants must elect between Federal Employees' Compensation Act (FECA) benefits and the following benefits payable by other Federal agencies:

A. Civil Service Retirement System Act (CSRS) annuity benefits provided by the Office of Personnel Management (OPM), either regular or disability. The election is not irrevocable, but if a lump-sum payment has been made by OPM as part of an alternative annuity, this must be repaid in full either directly by the employee, or by OWCP from FECA benefits due, before the employee may begin receiving FECA benefits. If OPM benefits are elected, the employee is still entitled to payment of medical expenses for treatment of the accepted condition(s). If FECA benefits are elected, the employee may receive concurrently any benefits payable from the Thrift Savings Fund.

B. Federal Employees' Retirement System Act (FERS) annuity benefits provide by OPM, either regular or disability. The election is not irrevocable. If benefits provided by FERS are elected, the employee is still entitled to payment of medical expenses for treatment of the accepted conditions(s). If FECA benefits are elected, the employee may receive concurrently any benefits payable from the Thrift Savings Fund.

C. CSRS Act survivor benefits provided by OPM. When FECA benefits are elected, the beneficiaries may be paid by OPM the amount of the employee's contribution to the retirement fund in one lump sum. OWCP does not consider the election irrevocable. However, OPM considers an informed election of death benefits provided by OWCP to be irrevocable. If FECA benefits are elected, the beneficiary may receive concurrently any benefits payable from the Thrift Savings Fund.

D. FERS Act survivor benefits provided by OPM. OWCP does not consider the election irrevocable. However, OPM considers an informed election of death benefits provided by OWCP to be irrevocable. If OPM benefits have been paid, the lump sum payment provided as part of the FERS Act death benefit must be repaid in full either directly by the beneficiary, or by OWCP from FECA benefits due, before the beneficiary may begin receiving FECA benefits. If FECA benefits are elected, the beneficiary may receive concurrently any benefits payable from the Thrift Savings Fund.

E. Any retirement or survivor annuity which stands in lieu of either the CSRS or FERS Act, such as Foreign Service or Central Intelligence Agency disability and retirement programs. The election is not irrevocable.

F. Veterans' Disability or Death Benefits. The election is irrevocable only in those case where the disability or death of the employee has resulted from an injury sustained in civilian employment by the United States, and the Department of Veterans Affairs has held that the same disability or death was caused by military service.

II. Claimants need not elect between FECA benefits and the following, and may receive both concurrently:

A. Veterans' Pension (except as noted above in item F) .

B. Fleet Reservist Pay.

C. Miliary Retirement or Retainer Pay.

D. Social Security Act Benefits. The following restrictions apply:

(1) Social Security Act benefits paid for disability shall be reduced by the compensation payable.

(2) FECA disability benefits will be reduced by the Social Security Act benefits paid on the basis of age and attributable to the employee's Federal service.

(3) FECA death benefits will be reduced by the survivor's benefits paid under the Social Security Act attributable to the employee's Federal service.

E. CSRS or FERS Annuity, if the FECA benefit is in the form of a schedule award for a specified number of weeks on the basis of a permanent loss or loss of use of a member or function of the body.

F. Department of Justice Law Enforcement Officers' Survivor Benefits. The $50,000 benefit paid to survivors of Federal Law Enforcement Officers who die as a direct result of an injury sustained in the line of duty under the Department of Justice does not constitute a dual benefit.

2-1000 Exhibit 2: OPM Contact List
(Link to Image)

2-1100 FECA THIRD PARTY SUBROGATION GUIDELINES

TABLE OF CONTENTS

Paragraph and Subject	Page	Date	Trans. No.
Chapter 2-1100 - SUBROGATION AND OTHER REMEDIES			
Table of Contents	i	03/06	06-02

1	Purpose and Scope	1	03/06	06-02
2	Authority	1	03/06	06-02
3	Responsibilities of OWCP and SOL	3	03/06	06-02
4	Letters, Forms and Status Codes	4	03/06	06-02
5	Definitions	5	03/06	06-02
6	Initial Third Party Screening by the CE	6	03/06	06-02
7	Administration of Third Party Cases	7	03/06	06-02
8	SOL Administration and Case Management of Third Parry Cases .	15	03/06	06-02
9	Processing the Statement of Recovery	19	03/06	06-02
10	Compensation Status Following Refund to the United States . .	27	03/06	06-02
11	Establishment of Debt and Debt Management	30	03/06	06-02
12	USPS Cases	34	03/06	06-02

1. **Purpose and Scope.**

This subchapter outlines the procedures for administering the government's rights under §§ 8131 and 8132 of the FECA to require FECA claimants to seek damages from third parties potentially liable for damages as a result of the FECA-covered injuries, and to refund a portion of any money or other property recovered. This is referred to as "FECA subrogation." This subchapter addresses the responsibilities of the Office of the Solicitor (SOL) and District Office (DO) personnel in identifying and administering cases involving potential third party actions; the interrelationship between DO personnel and SOL personnel in the Division of Federal Employees' and Energy Workers' Compensation (FEEWC) (formerly the Division of Employee Benefits) at the National Office concerning these actions; and the handling of cases involving litigation in federal court. The necessity for careful evaluation of the appropriate course of action regarding a third party case occurs regularly in the claims adjudication process. Except to the extent specifically provided herein, these procedures apply to actions taken by the United States Postal Service (USPS) in pursuing third party claims. (See **FECA PM 2-700.13 and 2-800.3.**)

When a third party is or may be legally liable for a FECA-covered injury and any damages are recovered from the liable third party or the third party's insurance company, the OWCP has a right to a refund of a portion of any recovery. This is true even if the damages recovered from

the third party are not similar or identical to the benefits paid by the OWCP, such as where OWCP has paid for medical treatment and lost time and the recovery from the third party or the third party's insurance carrier is for pain and suffering only. See Lorenzetti v. United States, 467 U.S. 167 (1984).

Top

2. **Authority.**

a. Section 8131 of the FECA (5 U.S.C. § 8131) provides that, to the extent that an injury or death for which compensation is payable under this subchapter is caused under circumstances creating a legal liability on a person or persons other than the United States (a "third party") to pay damages, OWCP may require the FECA beneficiary to assign a right of action to enforce that liability to the United States, or to prosecute the action in his or her own name.

b. Section 8132 of the FECA (5 U.S.C. § 8132) sets forth the formula for computing the refund due to the United States after a FECA beneficiary receives money or other property from a third party in satisfaction of the third party's liability to the beneficiary.

c. 20 C.F.R. §§ 10.705-10.719, as revised effective January 4, 1999, contain further guidance concerning cases involving liability of a third party

Top

3. **Responsibilities of OWCP and SOL.**

All offices (owning DO's, FEEWC, USPS) are responsible for ensuring that attorneys and claimants are actively pursuing recoveries from third parties, filing any required Statement of Recovery, and paying the required refund.

a. OWCP.

(1) The Regional Director. With the exception of certain USPS cases (see paragraph 2-1100.12 below), Regional Directors (RDs) are responsible for dentifying and processing third party cases under 5 U.S.C. §§ 8131 and 8132. This responsibility has been delegated, through the District Director and Assistant District Director, to a limited number of claims examiners, or in certain instances,

to fiscal officers or workers' compensation assistants. These persons are known as designated claims examiners.

(2) Each Claims Examiner (CE) is responsible for identifying any potential third party liability during the primary examination of a case in accordance with guidelines contained in FECA PM 2-1100.6, below.

(3) The Designated Claims Examiners (DCE) are responsible for ensuring that third party cases are processed in a timely manner and in accordance with the procedures outlined in this subchapter. This includes the responsibility for timely communications with the appropriate party (i.e., the claimant, the employing agency, SOL, etc.).

(4) Cases in the Branch of Hearings and Review. Where a case has been transferred to the Branch and Review. If the case is one which has not previously been identified as one involving potential third-party liability, the initial notification letter (CA-1045) will be prepared and released by the owning DO, but the responsibility for handling the rest of the third-party issues will remain with the normally responsible entity (OWCP district office, SOL office, or USPS, as appropriate).

b. SOL. The Division of FEEWC, Office of the Solicitor, Department of Labor, Washington, D.C. is responsible for administering FECA subrogation aspects of any cases referred for that purpose, and for assisting the DO in regard to FECA subrogation issues in cases not referred to SOL pursuant to **FECA PM 2-1100.7.d**.

Pursuant to 20 C.F.R. § 10.705, SOL has been delegated authority to administer the third-party subrogation aspects of certain FECA claims for OWCP. FEEWC has responsibility over all delegated third party claims in the district offices and any other cases FEEWC has agreed to handle on the specific request of a DO or the USPS. In addition, FEEWC coordinates national policy concerning pursuit of refunds due to the United States, and, through the Chief, Subrogation Unit and the Deputy Associate Solicitor, serves as an adviser to the district offices.

c. Inquiries pertaining to a specific third party case will be referred to the DCE, FEEWC, or the USPS. The DCEs are responsible for responding to general questions concerning third party matters.

Top

4. **Letters, Forms and Status Codes.**

a. The following letters and forms are used in processing third party cases (Please note that, where the form has been approved by the Office of Management and Budget (OMB); OWCP, SOL, and USPS must use the OMB-approved form):

(1) Ltr. CA-1045, Notice of Third Party Rights and Obligations.

(2) CA-1121, Request for Information Concerning Third Party Aspect.

(3) Ltr. CA-1108, Notice of Third Party Obligations (sent by OWCP to attorney).

(4) Ltr. SOL-1108, Notice of Third Party Obligations (sent by SOL to attorney)

(5) Form EN-1108, Long Form Statement of Recovery.

(6) Ltr. CA-1109, Authorization to Anyone to Release Information to Claimant's Attorney.

(7) Form CA-161, Disbursements Made by the OWCP.

(8) Form CA-164, Third Party Recovery Worksheet.

(9) Form CA/EN-1122, Employee's Statement of Recovery Made Without an Attorney - Minor Case, Short Form Statement of Recovery.

(10) Ltr. CA-1111, Notice to Third Party Insurer.

(11) Ltr. CA-1044, Notice of Third Party Credit.

(12) Ltr. CA-1120, Notice of Closure When No Credit Was Created.

(13) Form CA-160, Referral of Third Party Material.

(14) Ltr. CA-1110, Request for or Transmittal of Third Party Information.

(15) CA-1032, Report of Earnings

b. The following status codes are used to track the progress of third party cases:

0 No 3rd Party Potential

1	Identified as 3rd Party, Not Referred to SOL
2	Referred to Solicitor
3	USPS Case, Responsibility of USPS
4	Closed Minor, Not Economical to Pursue
5	Closed Other
6	Settled, No Refund Due
7	Settled, Refund Not Received
8	Settled, Refund Received, No Credit Remaining
9	Settled, Refund Received, Credit Against Future Compensation
10	Closed, Applicable Statute of Limitations Has Expired
11	Closed, Negligent 3rd Party Cannot be Identified
12	Closed, Negligent 3rd Party Has Left Jurisdiction
13	Closed, Negligent 3rd Party Has No Assets
14	Closed, 3rd Party Identified is Clearly Not Liable

Top

5. **Definitions.**

a. Minor Injury. A minor injury is defined as an injury in which the employee's time lost from work (including sick or annual leave or continuation of pay used to cover the absence) does not exceed 30 days, or total disbursements from the Employees'Compensation Fund do not exceed the current amount for administrative short-form closures.

b. Third Party Case. A third party case is any case in which a third party other than the United States, or an employee of the United States acting within the scope of his or her employment, is potentially liable for an injury, illness, or death which is covered under the FECA.

c. Subrogation Aspects of a FECA Case. The subrogation aspects of a FECA case include the obligation of a FECA beneficiary to prosecute an action against a third party when required by OWCP or SOL,and the obligation of a FECA beneficiary to:

(1) Report any recovery from a third party; and
(2) Make the required refund as a result of such recovery.

Top

6. **Initial Third Party Screening by the CE.**

The case creation process includes the entry of certain codes and other information from the Notice of Injury. A predetermined combination of such codes and information automatically marks the computer record as having third party potential and prevents automated administrative closure of the case file. During the primary examination of a case the CE will review the initial claim form and other documents for any indication of potential third party liability which may not have been reflected in the data entered into the computer record at case creation. If the CE believes the injury, illness, or death may have been caused by someone other than a Federal employee acting within the scope of his or her employment, then he or she should refer the case to the DCE with a brief explanation.

The potential for third party liability exists in a variety of situations. Injuries occurring off government premises (a letter carrier slipping on a homeowner's steps or an employee tripping over an uneven pavement surface) or on government premises (a clerk falling over equipment left in a hallway by a contractor) may have third party potential. The use of equipment, or a substance, that causes injury due to faulty manufacture or because it is inherently harmful, may place a liability on the manufacturer or vendor. If the CE sees the existence of third party potential, however doubtful, the CE should refer the case to the DCE for determination.

Top

7. Administration of Third Party Cases by DCE.

a. Initial Actions.

(1) Review the case to determine the status of the third party aspect of the case. If no third party potential actually exists, the third party indicator code will be changed to reflect this. If the Employing Agency (EA) had made an explicit referral for third party action, notify the EA in writing of this decision.

(2) If third party potential exists, release Ltr. CA-1045 (or, in a death case, a narrative equivalent of Ltr. CA-1045) to the claimant, with a copy to the employing agency. If advice is received that the employee has retained an attorney to handle the third party action, the DCE should immediately initiate referral to the FEEWC, consistent with subsection d. of this section, below.

(3) Claims from certain Census Workers – Census Workers (enumerators and field representatives) are required by 13 U.S.C. § 9(a)(2) to maintain the confidentiality of information provided by a resident or establishment, and are subject to criminal penalties including imprisonment under 13 U.S.C. § 214 for the release of information protected by 13 U.S.C. § 9. For this reason, it has been determined that except where an injury is the result of a deliberate act by the

resident or the owner of a business establishment, OWCP will not require a Census enumerator or field representative who is injured on the private property of the resident or interviewee to pursue a third party claim against the resident. The Bureau of the Census has been instructed to answer "no" on Form CA-1 in response to the question of whether the injury was caused by a third party. Unless the DCE has confirmed with the Bureau of the Census that the injury was the result of a deliberate act by a resident, or an injury was sustained in transit between interview sites in such a way that the census worker can maintain confidentiality, the DCE hould not release Letter CA-1045. For a more detailed discussion, see FECA Bulletin 99-30, issued August 30, 1999.

(4) Develop information needed for the determination of the third party potential, in coordination with the responsible CE, to avoid duplication of effort and confusion on the part of the injured worker. Depending on the situation, such information may include accident reports, names and addresses of witnesses, statements of witnesses, diagrams and photographs, investigative reports, and other similar information that may be helpful in handling the third party aspects of the case. In cases involving dog bites, falls, trips and slips, auto accidents, and product liability, Ltr. CA-1121 should be used to obtain the needed information.**The case will be scheduled for review in 30 days.**

(5) If no reply to Ltr. CA-1045 is received within 30 days, release another Ltr. CA-1045 with the notation "SECOND REQUEST," and again schedule the case for review in 30 days. If no reply to the second Ltr. CA-1045 is received within 30 days, the DCE should release a letter notifying the claimant that, if a reply is not received within 30 days, the claimant's right to compensation will be suspended pursuant to 20 C.F.R. § 10.708. If no satisfactory response is received within 30 days, the DCE will release a letter notifying the claimant of the suspension of compensation entitlement.

(6) If total OWCP disbursements and/or days of disability have exceeded the established limit for a minor third party case, the case will be set for review by the DCE, with immediate referral to the appropriate office. In addition, any minor third party case should be set for review at three-month intervals. At each review, the DCE should review the case for any new information indicating a possible change in third party status.

(7) Determination Not to Require Action To Be Pursued Against a Third Party. Where a beneficiary makes a written request to OWCP or FEEWC pursuant to 20 C.F.R. § 10.709 to be released from section 8131's requirement that the beneficiary prosecute a claim against a third party, the beneficiary should include as much detailed information a possible regarding: the circumstances of the injury or death; the extent and amount of damages resulting from the injury or

death; the potential for recovery, including, in appropriate cases, an attorney's assessment of the chances of prevailing on the merits, and an attorney's assessment of the costs of suit relative to the potential recovery; and any other considerations the beneficiary or attorney believes to be relevant to OWCP/SOL'S determination whether to release the beneficiary from section 8131's prosecution requirement.

After considering the request of the beneficiary, and any further information or documentation requested from the beneficiary or the attorney, the beneficiary will be provided written notification of the determination on the request. **This notification will emphasize that this discharge extends only to the prosecution requirement of section 8131, and that, should a recovery from a third party be received, the refund requirement imposed by section 8132 is still in effect.**

b. DCE Action on Receipt of Statement of Recovery (SOR). (The OMB approved SOR, Form EN-1108, must be used.) When the SOR is received along with information concerning the amount of refund, the DCE should take the following actions:

(1) If the SOR has been approved by the SOL, then skip to step (2), otherwise review the claimant's SOR for accuracy. If accurate and complete, approve the SOR by initialing and dating the form.

(2) The DCE should send the appropriate notice to the claimant with a copy to the employing agency and the claimant's attorney. This notice confirms receipt of the refund and informs all parties of any surplus recovery against which future compensation payments must be credited (Ltr. CA-1044 if there is a third party credit, or Ltr. CA-1120 if there is no credit).

(3) If not accurate or complete, the DCE should complete a corrected version of the SOR, scan a copy into the file, and send a copy to the claimant for a new signature, re-submittal, and approval. If necessary, the DCE should request that the claimant provide any sum necessary to satisfy the adjusted amount of the refund. If the claimant has refunded too much money, the DCE should so advise the claimant and process a payment to repay that excess refund. If the SOR is based on old disbursement figures that are no longer accurate because further disbursements have occurred prior to the processing of the SOR, the DCE must revise the SOR to reflect the current (accurate) disbursement figures, and must follow the above procedure for the submission to OWCP of the revised SOR by the claimant, bearing the claimant's signature. Additional disbursements may not be added to the amount of the surplus which must be absorbed prior to reinstatement of compensation benefits.

(4) The DCE follows established procedures for depositing any checks that were directly received and for crediting of the refunded OWCP disbursements to the compensation fund. Where a multi-party check is received which bears proper endorsements of any party or parties in addition to OWCP, the DCE is authorized to endorse and deposit the check on behalf of OWCP, and should not return such a check merely because it is made out to more than one party. When the SOR is received, along with information from the fiscal section concerning the amount of the refund, the DCE should complete parts A, B, and C of Form CA-164 as appropriate, and forward it to the fiscal section. Form CA-164 allows the DCE to advise the fiscal section of the amount of refund due and the amount of refund actually received, and to indicate needed fiscal actions. The Form CA-164 also serves as documentation of the computation for crediting the refunded OWCP disbursements to the employing agency. The DCE should also ensure that the EN-1108, the completed CA-164, and a copy of the refund check are scanned into the case record.

(5) If the claimant is making a refund in installment payments, the DCE should establish an accounts receivable, and credit each partial payment received against that debt.

c. DCE Action on Receipt of Information Establishing a Recovery (without a completed SOR).

(1) Where a case is being handled directly by OWCP (one not referred to SOL or the USPS), if the DCE determines or has reason to believe that:

(a) A recovery has occurred, but the claimant has not submitted the required refund; or

(b) The claimant has not submitted sufficient information to establish the amount of the refund due; or

(c) The unpaid refund is less than $2000.00,

the DCE should release a letter notifying the claimant and his/her authorized representative that if the required refund, or requested information needed to determine the amount of the refund, is not received within 30 days, the claimant's right to compensation will be suspended pursuant to 20 C.F.R. § 10.716.

If no satisfactory response is received within 30 days, the DCE will issue a decision advising the claimant of the suspension of compensation entitlement, and provide the claimant with notice of the appropriate rights of administrative review.

(2) On a case not referred to SOL or the USPS, if the DCE receives information that a recovery has occurred which results in a refund owed by the claimant greater than $2,000, the DCE will not automatically refer the case to SOL. Rather, the DCE will attempt to collect from the claimant the refund due; if the claimant does not submit the required refund, the DCE will then attempt to collect the amount owed through the established debt collection procedures. Section 10.716 of 20 C.F.R. provides that the waiver provisions of 20 C.F.R. §§ 10.432 through 10.440 do not apply to actions taken to collect such refunds.

d. Referral to SOL by the DCE.

(1) After a case is identified as a potential third party case, the DCE will refer it to FEEWC. All cases not involving a "minor injury" as defined in 2-1100.5.a above are to be referred to FEEWC. In addition, the following classes of cases are to be referred:

(a) Cases which were properly not initially referred (because they met the definition of "minor injury"), but which no longer meet that definition;

(b) Cases where an attorney is involved; and

(c) Cases where FEEWC agrees to accept a third party case because of a particular issue identified by the owning DO in a written memorandum.

(d) Cases from the same incident arising in more than one district office, such as group injuries, plane crashes, class actions, and similar circumstances.

On the written recommendation of the owning DO, FEEWC may also agree to accept as a referral a case which does not meet the preceding criteria.

(2) When a case is identified for referral, the DCE will refer the case to FEEWC using Form CA-160. Copies of the CA forms, as well as copies of other pertinent documents such as witness statements, accident reports, medical reports, correspondence from an attorney, etc., must accompany the Form CA-160. The case record itself will be retained by the DO. If any disbursements have been made at the time of referral, they will be shown on the reverse of the Form CA-160. All disbursements shown should reflect the gross amount paid prior to any deductions. A copy of the Form CA-160 will be scanned into the case record.

(3) When a case is referred to FEEWC, the computer record will be updated to reflect the new third party indicator code.

(4) After initial referral, the DCE will furnish an updated disbursement statement on Form CA-160 to the FEEWC within five working days of receipt of the request, and will submit other pertinent information at the same time. Any material that, in the opinion of the DCE, is urgent should be sent immediately to the FEEWC.

e. Action by DCE on Receipt of Information from FEEWC.

(1) Notice of Settlement or Judgment. FEEWC will contact the DCE when notice is received that a settlement or a judgment has been received in a third party case which is expected to result in a surplus. On receipt of this information, the computer record will be updated to reflect the appropriate indicator code, and the DCE will calculate all benefits paid to the FECA beneficiary. The DCE will immediately forward this information to FEEWC, which will advise the FECA beneficiary's attorney, or the FECA beneficiary (if unrepresented) of the total amount of disbursements.

(2) On receipt of a memorandum from FEEWC recommending action by the owning DO (such as a memorandum under 2-1100.8.d.(2) recommending sanctions for failure to prosecute an action, file a SOR, or pay the required refund), the DCE will analyze the evidence, information, and recommendations from FEEWC, and will take appropriate action, including forfeiture or suspension of compensation benefits, based on the FEEWC's recommendations.

(3) Where the formal decision denies a request for payment of compensation benefits, or results in payment of past or continuing compensation benefits in an amount less than that requested or anticipated by the claimant, the formal decision should be accompanied by full appeal rights.

(4) Where the decision addresses an issue solely related to the calculation of the statutory right of reimbursement or the refund due to the United States under 5 U.S.C. § 8132, and does not suspend or terminate compensation benefits or deny a request for payment of benefits, the claimant should not normally receive notification of appeal rights. In such circumstances (for example, where there is no continuing compensation entitlement, and OWCP requests that the claimant refund an additional amount beyond that which the claimant has already paid to OWCP), OWCP should notify the claimant that it will evaluate any additional evidence or argument that the claimant wishes to submit supporting a contention that the formal decision is incorrect.

f. Other Duties of the DCE. The DCE performs other duties as set forth in this subchapter. For example, the DCE may be required to take action based on receipt of information or requests from FEEWC (2-1100.8), and is responsible for debt collection

on cases that have not been referred to FEEWC. (2-1100.11.a). In addition, paragraphs c. and d. of 2-1100.12 describe the DCE's responsibilities regarding third party cases handled by the USPS pursuant to the memorandum of agreement between OWCP and USPS.

Top

8. **SOL Administration and Case Management of Third Party Cases.**
FEEWC is responsible for supervising the subrogation aspects of FECA third party damage claims referred by the DO. They will monitor the progress of all third party claims transferred to their offices for handling and will keep the FECA beneficiary's attorney, or the FECA beneficiary, if unrepresented, apprised of the current disbursement amounts. When responsibility for administration of third party liability is transferred to the FEEWC, the FECA beneficiary's attorney, or the FECA beneficiary, if unrepresented, will be notified of the transfer, and will be advised of the obligation to prosecute an action for damages against the party responsible for the injury.

a. Once the DO has referred a third party claim to FEEWC, FEEWC will:

(1) Review the claim to ensure that there is third party liability and that the claim meets the criteria to be referred to SOL; if either of these requirements is not satisfied, the case will be returned to the owning DO, with an explanation for the return;

(2) Advise the claimant or the claimant's attorney of the provisions of 5 U.S.C. §§ 8131 and 8132. Also, the attorney should be advised that if it is the attorney's opinion that the claim is not economical to pursue, the attorney should make a written request under 20 C.F.R. § 10.709 for release of the obligation to pursue a recovery (providing the information described above in 2-1100.7.a.(6)). FEEWC will then make a determination whether to discharge the claimant's obligation under the Act to pursue an action against a third party; and

(3) Provide the claimant or attorney with current disbursements including printouts of the compensation and bill payment histories. In death claims, the disbursements will be reported separately for each beneficiary.

b. Initial FEEWC Action on Receipt of Referral. On receipt of a case, FEEWC will make an initial analysis to ensure that the case receives sufficient attention in advance of the expiration of the statute of limitations.The FEEWC will establish and use an automated reminder system (docket, AR, or similar system) to track cases pending in the office, and will request periodic status reports from the claimant and/or the claimant's

attorney.

c. Beneficiary's Failure to Respond. A FECA beneficiary is required to take action against a responsible third party to satisfy the requirements of §§ 8131 and 8132 of the FECA. A FECA beneficiary is also required to provide periodic status updates and any other relevant information in response to requests from OWCP or FEEWC, 20 C.F.R. § 10.707. If a FECA beneficiary refuses or fails to respond to requests for information, it may be determined that he or she has forfeited his or her right to compensation, or that the right to compensation is suspended, under 20 C.F.R. § 10.708. FEEWC will send two warning letters to the FECA beneficiary's attorney or the FECA beneficiary, if unrepresented, before notifying OWCP of its recommendation concerning the appropriate action to be taken due to the FECA beneficiary's failure to respond. Also note that when a FECA beneficiary is represented by counsel, the primary responsibility for providing periodic status updates and any other relevant information is counsel's.

When a FECA beneficiary is represented by an attorney, all SOL contact should be made with the FECA beneficiary's attorney. In such circumstances, FEEWC should not communicate directly with the beneficiary on matters within the scope of the attorney's representation, unless the attorney has provided FEEWC specific written permission for such practice.

If a represented FECA beneficiary contacts FEEWC by telephone, the beneficiary should be advised that FEEWC will not discuss any matters with him or her without the attorney's express permission. If FEEWC receives written correspondence from a represented FECA beneficiary, the written response by FEEWC should be sent to the FECA beneficiary's attorney.

d. Failure to Prosecute an Action.

(1) What constitutes failure to prosecute? 20 C.F.R. § 10.707 sets forth the minimum that is required of a FECA beneficiary who has been notified that action against a third party is required. Paying the required refund alone, after a recovery from a third party has been received, is not the only requirement that must be satisfied. Among other responsibilities, the beneficiary is responsible for providing periodic status reports and other information when specifically requested to do so by OWCP or FEEWC. In addition, as provided by § 10.707(c), unless specific permission is granted by OWCP or FEEWC, the beneficiary may not settle or dismiss a case for any amount less than the refundable disbursements as defined in § 10.714.

(2) Sanctions for Failure to Prosecute. Under 20 C.F.R. § 10.708, OWCP/SOL may determine that a FECA beneficiary who fails to satisfy the statutory and regulatory requirements for prosecution of a third party action has forfeited all past and future compensation benefits. Rather than declare all

compensation forfeit, CP/FEEWC may also suspend compensation benefits until the beneficiary complies with the request.

When FEEWC believes that sanctions for failure to prosecute an action are appropriate, FEEWC should prepare a referral memorandum to the owning DO which includes suggested findings of fact and statements of reasons for the imposition of sanctions. The memorandum from SOL will also make a specific recommendation whether suspension or forfeiture is the appropriate sanction in the particular case, and should also contain an analysis of the expiration date of the statute of limitations for the filing of the underlying third party action.

e. Release of Obligation to Prosecute an Action. In addressing requests from claimants and/or their attorneys, FEEWC will use the same procedures set forth above in 2-1100.7.a.(6) for the DCEs.

f. Notice of Settlement or Judgment. FEEWC should notify the DCE of all settlements and judgments. If a settlement or judgment is expected to result in a surplus, SOL will notify the DCE that payment of continuing compensation benefits should therefore be suspended pending exhaustion of the surplus.

g. Approval of the SOR. Once the signed SOR is submitted, SOL will review it for accuracy and compliance with the FECA and these procedures. If the SOR is signed and filled out completely and correctly, it should be approved as submitted. If the claimant or the attorney does not sign the SOR, or if the SOR must be revised or redrafted, it should be returned for a proper signature. However, if a check is received, even if the check is not accompanied by a SOR, or by an incorrect SOR, the check should be forwarded to OWCP. Upon approval of the SOR, it will be forwarded to the claimant or his/her attorney, with a request that the government's refund, if not already received, be submitted within thirty days of the receipt of the letter. Also, an approved copy of the SOR is forwarded to the owning DO. Detailed instructions for completing a SOR are contained in 20 C.F.R. § 10.711 and section 2-1100.9 of this subchapter. In case of disputed ssues, see subsection i below.

h. Procedures for Processing Refund Checks Received in FEEWC. FEEWC must have, at a minimum, a manual system for maintaining a log of all checks received. In addition, all third-party refund checks received in the office must be kept in a secure location.

Upon receipt of the government's refund by FEEWC, FEEWC will forward the check to the OWCP National Office, which in turn will send the check and the approved SOR to the appropriate lockbox depository. FEEWC should notify the DCE whether completion of this action closes the third party subrogation aspects of the case. For any SOR for which a refund check has not been received, the debt should be collected in accordance with the procedures described in 2-1100.11.

i. Actions on Disputed Issues. Where a claimant or an attorney expresses a disagreement with the action of FEEWC in handling the third party aspects of a claim, and this disagreement cannot be resolved, FEEWC should advise the claimant's attorney to request that a formal determination be issued regarding the disputed issue or issues. Where FEEWC receives such a request, it should prepare a referral memorandum to the owning DO. This emorandum should include suggested findings of fact and statements of reasons, as well as a specific recommendation for a course of action. All formal decisions regarding disputed issues arising out of the processing of third party claims will be issued by OWCP. See 2-1100.7.e, above, describing the duties of the DCE on receipt of a recommendation from SOL.

The Department of Labor cannot waive or compromise the statutory right of reimbursement that arises as a result of the language of § 8132. If an attorney requests that the statutory right of reimbursement be waived or compromised, the attorney should be referred to the Employees' Compensation Appeals Board (ECAB) decision in Willie E.Cantrell, 13 ECAB 490, at 493 (1962), in which the ECAB stated that the "terms of the [FECA] are specific as to what shall be charged against the proceeds of a third-party recovery and neither the Bureau (OWCP's predecessor agency) nor the Board has the authority to waive or compromise the requirements of the Act." See also Charles Howell, 38 ECAB 421 (1987), and cases cited therein.

Top

9. Processing the SOR

a. Submission of the SOR. A FECA beneficiary (or the beneficiary's attorney) is required to submit detailed information about the amount recovered and the costs of suit on the SOR form pursuant to 20 CFR 10.707(e). The FECA beneficiary or attorney should notify OWCP or FEEWC, in writing, within 30 days of receipt of a third party settlement. A SOR must be filed for each recovery received by a FECA beneficiary. When multiple settlements or recoveries after settlement or judgment are obtained from different third parties on account of the same injury or illness, a SOR must be filed and any indicated refund due to the United States must be made within 30 days after receipt of each recovery.

b. Failure or Refusal to Submit a SOR.

(1) Action to be Taken When the Beneficiary Has Failed or Refused to Submit a SOR. Whenever OWCP/FEEWC becomes aware that a FECA beneficiary (or the beneficiary's attorney) has failed or refused to submit a SOR

within 30 days of a recovery, OWCP/FEEWC shall issue a letter by certified mail notifying the FECA beneficiary of the failure and allowing the FECA beneficiary or the beneficiary's attorney 30 days from the date of the letter to file a statement of recovery. If good cause is demonstrated by the FECA beneficiary, OWCP/FEEWC can extend that time for 30 days. Should the FECA beneficiary or the beneficiary's attorney fail to file the SOR within the required time frame and OWCP/FEEWC has a copy of the settlement agreement or equivalent information regarding the gross recovery, OWCP/FEEWC shall prepare an approved statement of recovery based on the available information and the appropriate OWCP/FEEWC personnel shall sign it demonstrating the approval. The approved statement of recovery should be mailed by certified mail to the FECA beneficiary and the beneficiary's attorney if any within 30 days after the deadline established for filing the SOR. The approved statement of recovery becomes final unless objected to by the FECA beneficiary or the beneficiary's attorney within 30 days of the date the approved statement of recovery is mailed to the FECA beneficiary and the beneficiary's attorney if any. In filing his or her objections, the FECA beneficiary and the beneficiary's attorney shall request a formal determination as defined in the disputed issues procedures above (2-1100-8(i)) and set forth the reasons for the objections.

(2) Sanctions for Failing or Refusing to File an SOR. The duty to file a SOR is part of a beneficiary's duty to prosecute. Whenever OWCP/FEEWC determines that the beneficiary has failed to timely file a SOR, OWCP/FEEWC may at its discretion utilize the procedures and sanctions listed above in 2-1000-8(d)(2).

c. Allocation of Joint Recoveries. When a settlement or judgment is paid to, or for, one individual, the entire amount is reported as the gross recovery on Line 1 of the SOR. If a settlement or judgment is paid to, or for, more than one individual, or in more than one capacity, such as a joint payment to a husband and wife for personal injury and loss of consortium or a payment to a spouse representing both loss of consortium and wrongful death; the entire amount is still reported as the gross recovery on Line 1 of the SOR, from which certain deductions may be made to arrive at the amount to be allocated to the injured employee. If a judge or jury specifies the percentage of a contested verdict attributable to each of several plaintiffs, that division will be accepted.

In any other case, where a judgment or settlement is paid to or on behalf of more than one individual, a determination will be made concerning the appropriate amount to be allocated to the injured employee, and the FECA beneficiary will be advised of that determination. The FECA beneficiary may accept the determination or demonstrate good cause for a different allocation. Whether to accept a specific allocation is at the discretion of OWCP and FEEWC. Recurring circumstances involving allocations

include:

(1) Loss of Consortium. Any proposed deduction (Line 4) from the gross recovery reported on Line 1 of a SOR by attributing a portion of the settlement or judgment to damages for loss of consortium by a family member must be approved by OWCP or FEEWC. A portion of a settlement or judgment may be attributed to a cause of action for loss of consortium and thus not included in the gross recovery of the FECA beneficiary set forth on a SOR only under the following conditions:

(a) State law in the relevant state provides a cause of action for loss of consortium for the family member to whom the recovery is attributed, and

(b) A cause of action for loss of consortium was actually asserted by that family member, either in the same action or in separate actions, or in negotiation of the settlement where a settlement was obtained without the actual filing of litigation.In support of a request for an allocation of a portion of a settlement or judgment to a spouse or a child or children, the FECA beneficiary must demonstrate that the above referenced conditions are met by citation to appropriate state case law or statutes and by submission of a copy of the complaint filed on behalf of the spouse and/or children, or other relevant evidence.

Upon receipt of such a request, absent unusual circumstances, an allocation of a joint settlement or judgment to loss of consortium in an amount of 25% or less for the spouse and 5% or less for each child up to a maximum of 15% for all children will be approved. In the event a FECA beneficiary seeks to justify an allocation in excess of these figures, it will be necessary for him or her to establish to the satisfaction of OWCP or FEEWC, through submission of evidence and legal argument, that a higher percentage is appropriate. Use of this formula is generally not appropriate in circumstances where a FECA beneficiary has died prior to settlement or judgment.

(2) Death Cases. Under appropriate circumstances, an injury to an employee of the United States can result in payments to the employee and/or his or her estate, spouse, and children. Thus, in the event an employee incurs an illness or injury covered by FECA and subsequently dies, separate causes of action may exist for his or her pain and suffering, for a spouse or a child's loss of consortium and for wrongful death. A recovery attributable to each of these causes of action must be reported by means of a SOR filed on behalf of the person receiving the recovery (e.g. estate, spouse or child) if that person received any benefits under FECA.

(a) A SOR filed on behalf of the deceased employee should report all funds received by the estate attributable to any causes of action possessed by the employee. This would include a cause of action for pain and suffering while the employee was alive.

(b) A surviving spouse who received FECA benefits on account of the death of a federal employee becomes a FECA beneficiary obligated to file a SOR upon receiving a third party recovery as a result of the death of his or her spouse. This would include a cause of action for the wrongful death of the employee. A surviving child who receives FECA benefits and a third party recovery is in the same situation and has the same obligation as the surviving spouse. A surviving spouse and/or child who receives an award for loss of consortium/society during the deceased employee's life is not required to file a SOR reporting that award or to include that recovery in the gross recovery reported on a SOR otherwise required to be filed.

c. Any apportionment made by the court or by a jury in a contested judgment will be accepted. However, joint judgments or settlements in other circumstances are subject to SOL review for purposes of determining any appropriate allocation for FECA purposes. FECA beneficiaries may utilize certain allowable percentages in any case involving a deceased federal employee and a surviving spouse or child where it is determined that the settlement or judgment represents causes of action attributable to more than one person.

(1) In order to utilize the following acceptable percentage allocations below in (2) and (3), a FECA beneficiary must demonstrate that:

(a) State law in the relevant state recognizes each cause of action to be utilized in the allocation; and

(b) Each cause of action was asserted by the family member, either in the same action or in a separate action, or in negotiations of the settlement in situations where a settlement was obtained without filing litigation.

(2) Upon such demonstration, in cases where causes of action were asserted for pain and suffering of the employee prior to his or her death and for loss of consortium, but not for wrongful death, the following standard allocation percentages will be allowed:

(a) 25 percent of the total to be allocated to the spouse;

(b) 5 percent of the total to be allocated to each child, up to a total of

15 percent for all children; and

(c) The remainder to be allocated to the deceased federal employee.

(3) In cases where causes of action are asserted for pain and suffering of the employee prior to his or her death, for loss of consortium, and for wrongful death, the following standard allocation percentages will be allowed:

(a) 15 percent of the total to be allocated to the spouse's claim for loss of consortium;

(b) 5 percent of the total to be allocated to each child up to a total of 10 percent for all children for loss of consortium;

(c) 35 percent of the remainder after subtraction of the amounts attributed to loss or consortium to be allocated to the deceased federal employee, survival claim; and

(d) 65 percent of the remainder after subtraction of the amounts attributed to loss of consortium to be allocated to the spouse, wrongful death claim.

d. Malpractice.

(1) Medical Malpractice. When a FECA beneficiary's FECA-covered injuries are aggravated by medical malpractice, any settlement or judgment relating to the malpractice is a recovery subject to §8132. In omputing the required refund, a claimant may request to utilize only the disbursements attributable to the medical malpractice in filing his or her SOR. The claimant must provide probative evidence and analysis to allow a determination to be made by OWCP/FEEWC regarding the amount of the disbursements that would have been paid absent the malpractice, in order to subtract that amount from the total disbursements actually paid.

Where none of the expenses properly attributable to the malpractice have been paid for or reimbursed by OWCP under the FECA, the claimant is still required to file a SOR for the malpractice recovery. This will normally result in a substantial third party surplus, which is unlikely to be absorbed (because any subsequent medical expenses and compensation benefits properly borne by OWCP would be attributable to the original compensable injury, rather than the injury caused by the malpractice).

(2) Legal Malpractice. A recovery from a third party for legal malpractice is not considered a recovery subject to § 8132.

e. Structured Settlements. One particular type of settlement agreement, generally referred to as a structured settlement, in which a third party makes an initial cash payment and also arranges, usually through the purchase of an annuity, for periodic payments over an extended period of time, raises a number of issues that must be carefully considered. The dollar amount to be included on Line 1 is the present value of the right to receive all of the payments included in the structured settlement, allocated in the case of multiple recipients in the same manner as single payment recoveries. See (20 CFR § 10.713). In situations where the periodic payments are funded by the purchase of an annuity by the responsible third party, the cost of the annuity to the third party will be accepted by OWCP and FEEWC as the present value of the right to receive the future payments. If the FECA beneficiary (or the beneficiary's attorney) wishes to use a different method of computing the present value, the beneficiary should make a written request for a formal determination on this issue. For purposes of filling out the SOR and making the required refund, it is the beneficiary's burden to provide probative evidence and analysis to allow a determination to be made by OWCP/FEEWC regarding the use of a different method of computing the present value of the right to receive periodic payments.

f. Refundable Disbursements. The refundable disbursements of a claim consist of the total money paid by OWCP from the Employees' Compensation Fund. However, charges for medical file review done at the request of OWCP are excluded. Any medical file review charges will automatically be deducted from the bill pay history.See (20 C.F.R. § 10.714). Continuation of pay is not compensation and is not subject to the subrogation and refund provisions of FECA. See Paul L. Dion, 36 ECAB 656 (June 19, 1985; petition for reconsideration denied, November 14, 1985).

Where the FECA beneficiary requests that the total disbursements be reduced by the cost of medical examinations required to be made available to the employee by the employing agency or at the employing agency's cost under a statute other than the FECA, the beneficiary has the burden of establishing that the examinations were so required. OWCP or FEEWC will notify the beneficiary in writing of its determination on this matter. See (20 C.F.R. § 10.714).

g. Attorney's Fees. Reasonable attorney's fees can be deducted from the gross recovery and from the refundable disbursements. Attorney's fee percentages are computed by dividing the amount of fees actually paidby the net recovery listed on Line 7. The percentage must be considered reasonable by OWCP or EEWC.Generally, any fee in excess of 40% would be deemed inappropriate and such deduction would be disallowed. If an attorney representing a FECA beneficiary reduces his or her fee from the amount originally agreed to by the FECA beneficiary, the reduced percentage would apply to the OWCP refundable disbursements.

h. Costs of Suit. The costs of suit, as allowed by OWCP or FEEWC, may be deducted on the SOR and must be itemized when submitted to OWCP or FEEWC. If such itemization of costs is not received by OWCP or FEEWC, those costs will be disallowed. Examples of costs which are permitted are out of pocket expenditures that are not part of the normal overhead of a law firm's operation, e.g., filing fees, travel expenses, record copy services, witness fees, court reporter costs for transcripts of hearings and depositions, postage, and long distance telephone calls. Examples of costs which are not permitted are normal overhead costs of a firm, e.g., in-house record copying, secretarial or paralegal services, and co-counsel fees. If, for example, a firm lists as a separate cost item a specific charge (for computer time or metered access time for legal research on Westlaw or some other legal research provide), and this charge is specific to the individual case, this would be an allowable cost. On the other hand, a cost item for a "percentage" of a firm's legal research costs would not be allowable, because this amounts to the firm attempting to recover for overhead costs.

To determine the amount to be listed on Line 10 of the SOR, multiply the court costs allowed by the percentage shown at Line 4, and subtract this amount from the allowed court costs. Multiply the balance by the percentage shown at Line 6 and enter this amount on Line 10. The United States does not contribute to or pay costs associated with the third party action. The FECA does not provide for or authorize the payment of costs other than as a deduction from the third party recovery. See Alonzo R. Witherspoon, 43 ECAB 1120, 1124 (1992).

i. Releases. In any case where a claimant requests that OWCP execute a release in connection with the subrogation aspects of a third-party case, that request should be referred to FEEWC. Since the United States is not a party to the underlying litigation between the claimant and the third party, it is not appropriate to execute a release of the liability of the third party to the FECA claimant. It is appropriate, however, to furnish the claimant a letter acknowledging compliance with the provisions of 5 U.S.C. §§ 8131 and 8132.

Top

10. Compensation Status Following Refund to the United States.

a. Under section 8116(a) of the FECA (5 U.S.C. § 8116(a)), a beneficiary may not receive compensation under the FECA simultaneously with salary, pay, or remuneration from the United States. With certain exceptions, a beneficiary must elect whether to receive benefits under the FECA, or benefits to which the beneficiary is entitled by virtue of the employee's status as a federal employee. A beneficiary may receive OPM benefits for any period for which a refund has been made, and is not considered in receipt of compensation during any such period (see Program Memoranda Nos. 90, 130,

and 277).

b. Exhaustion of Surplus.

(1) During the period of exhaustion of the third party surplus, the beneficiary is not considered to be in receipt of compensation. If he or she elects OPM retirement benefits, payment of this annuity does not constitute a prohibited dual benefit. When the surplus has been exhausted, the beneficiary should be given the opportunity to elect between FECA benefits and the OPM annuity. Compensation benefits may be elected effective the day after the absorption of the third party surplus (see Program Memorandum No. 130).

(2) Where a beneficiary who has received a recovery from a third party has made the required refund, but subsequent events result in payment of compensation benefits (including medical benefits) for a period of time during which a third party surplus was in the process of being absorbed from continuing compensation entitlement, this results in an overpayment of compensation. Such an overpayment of compensation should be adjudicated and processed by OWCP according to the usual overpayment procedures set forth in Part 6 of the Procedure Manual.

(3) Where a beneficiary has received a third party recovery resulting in a surplus, this surplus is noted in the computer record, and the adjudication status code is changed to A0 to prevent the further payment of benefits. Compensation payments are calculated and continue to be charged against the surplus, as are medical expenses that have been paid by the claimant and submitted for reimbursement. Claimants should be encouraged to submit reimbursement requests for medical expenses as they are incurred, even though the amounts paid for such expenses will result in reduction of the surplus, rather than actual payment of additional benefits.

(4) Directed Medical Exams and File Reviews in Third Party Cases. Although benefits are not otherwise payable when a third party surplus exists, if the responsible CE finds it necessary, in the course of normal case management, to obtain a Second Opinion Exam, a Referee Exam, or a medical file review, then the costs will be directly paid by OWCP and any reasonable expenses incurred by the claimant will be reimbursed. These expenses should not be added to the surplus against future compensation entitlement.

(5) Vocational Rehabilitation in Third Party Cases. Vocational rehabilitation expenses are not payable if a third party surplus exists (see

Program Memorandum No. 34). The claimant may pay for a rehabilitation counselor, training, and related expenses in an pproved vocational rehabilitation program. If approved by OWCP after its review, such expenses may be used to reduce the amount of the third party surplus.

(6) Section 8133(a) of the FECA provides differing percentage distributions depending on the existence of certain eligible beneficiaries; § 8133(b) specifies that entitlement to compensation ceases upon the occurrence of certain events; and § 8133(c) provides for reapportionment of compensation "on the cessation of compensation under this section to or on account of an individual." Only the occurrence of one of the events described in §8133(b) (e.g., remarriage of a widow prior to age 55) can trigger the reapportionment of compensation among the other beneficiaries. The stoppage of compensation payments to an eligible beneficiary to offset a third party surplus is not one of the events enumerated in § 8133(b), and thus does not constitute a basis for reapportionment under §8133(c). The percentage rates to be used are those specified in § 8133(a), regardless of whether the compensation otherwise payable to another eligible beneficiary is being credited against a third party surplus. As an example, if a widow participated in a third party recovery and is offsetting a third party surplus, and a minor child did not participate in the recovery, or participated but has offset his or her portion of the surplus, compensation for the child would continue to be paid based on 15 percent of monthly pay. See Beverly Grunder, claiming as widow of Franklin W. Grunder, 36 ECAB 456 (1985).

Top

11. **Establishment of Debt and Debt Management.**

When a debt to the United States is established by OWCP/SOL's approval of a SOR, OWCP/SOL has an obligation to collect the debt. Each office (DO, FEEWC) should maintain a log of every debt (i.e., a collection docket) which has been established as a result of a recovery from a third party.

a. OWCP District Office Responsibility for Debt Collection in Non-Referred Cases. Upon establishment of the debt, OWCP should advise the claimant that a debt is owed to the United States, and make an initial demand for payment of this debt. For non-referred cases, the DCE is responsible for releasing the initial demand letter. This initial demand letter must notify the debtor of:

(1) The basis for the debt;

(2) The applicable standards for imposing interest, penalties, or administrative costs;

(3) The date by which payment should be made;

(4) The name, address and telephone number of a contact person or office within the agency;

(5) That the debtor may enter into a mutually agreeable written repayment agreement; and

(6) That the debtor may make a written request for a review of the determinations regarding the amount of the debt, its past-due status, and its legal enforceability.

The initial demand letter in any non-referred case should also note that, unless payment is received within 30 days, interest shall accrue as of the date of the initial demand letter. If payment is not received on such case, a second letter will be released notifying the claimant that the debt remains outstanding and that entitlement to compensation is subject to suspension for failure to satisfy the debt. The computer record will be updated to reflect the fact that the debt remains unpaid. If a claim for further benefits is received prior to the payment of the debt, the CE should consider whether to issue a formal decision suspending or forfeiting entitlement to benefits, under 20 C.F.R. §10.708.

Pursuant to 20 C.F.R. § 10.715, interest shall accrue, at the U.S. Treasury rate (Current Value of Funds), on the refund due to the United States from the date of the request, if the refund is not submitted in full within 30 days of the receipt of the request for payment. OWCP or SOL may waive the collection of interest in accordance with 29 C.F.R. § 20.61.

b. SOL Responsibility for Debt Collection in Referred Cases.

(1) For referred cases, FEEWC should advise the claimant and/or the attorney that a debt is owed to the United States, and make an initial demand for payment of this debt. The initial demand letter must notify the debtor of:

(a) The basis for the debt;

(b) The applicable standards for imposing interest, penalties, or administrative costs;

(c) The date by which payment should be made;

(d) The name, address, and telephone number of a contact person or office within the agency;

(e) That the debtor may enter into a mutually agreeable written repayment agreement; and

(f) That the debtor may make a written request for a review of the determinations regarding the amount of the debt, its past-due status, and its legal enforceability.

(2) The initial demand letter in any referred case should also note that, unless payment is received within 30 days, interest shall accrue, at the U.S. Treasury rate (Current Value of Funds), as of the date of the initial demand letter. If payment is not received on such case within 30 days, a second letter should be released notifying the debtor that the debt remains unpaid, and that the attorney, firm, and client are subject to the provisions of 5 U.S.C. § 8132 which apply to any individual who disburses funds received from a third party recovery without satisfying, or assuring the satisfaction of, the interest of the United States. If payment is not received within 30 days of this second letter, FEEWC should make a determination whether to collect the debt, plus applicable interest, through any of the following ptions:

(a) Periodic payments (installment payment plan);

(b) Deduction from continuing compensation;

(c) Suspension or forfeiture;

(d) Referral to the Department of the Treasury;

(e) Referral to the Department of Justice; or

(f) Salary offset.

(3) The following is a concise description of the details regarding these six options for FEEWC collection of debts:

(a) Periodic payments — if a debt can be collected through periodic payments within three years, FEEWC may enter into an agreement with the debtor for periodic payments. Such agreements shall provide that the payments will be made directly to OWCP; once the agreement is signed, FEEWC will notify OWCP of the terms of the agreement, and will close the file and delete it from the collection docket. OWCP will then enter

the debt into its system.

(b) Deduction from continuing compensation — in appropriate cases, FEEWC will prepare a memorandum to the DCE recommending collection of the debt from continuing compensation entitlement. On receipt of such a memorandum, the DCE will enter the debt into the system, will request financial information from the claimant, and will then make a determination regarding the amount to be collected from each continuing compensation payment. In making such determination, the DCE should follow the procedures set forth in the Federal (FECA) Procedure Manual, Part 6-Debt Management, except that the waiver provisions of Part 6 do not apply to these determinations. After referral to the DCE, FEEWC will close the file and remove it from the collection docket.

(c) Suspension or forfeiture — where FEEWC concludes that suspension or forfeiture is an appropriate response to nonpayment of the debt, FEEWC will prepare a memorandum to the DCE recommending suspension or forfeiture. After evaluation of this memorandum, the DCE will issue a formal decision with appropriate appeal rights.

(d) Referral to Department of the Treasury — where payment is not received within 60 days of the date of the initial demand letter, and FEEWC concludes that referral to the Department of the Treasury is appropriate, FEEWC will send a third letter which notifies the debtor(s) of its intent to collect the debt by referral to Treasury, and will prepare a memorandum to OWCP's National Office requesting referral of the debt to Treasury for collection. FEEWC will prepare the necessary background materials and refer these materials to OWCP.The debt will remain on the FEEWC's collection docket until SOL receives notice from Treasury that the debt has been collected, or that Treasury has ceased collection efforts. Where Treasury notifies OWCP/FEEWC that it has ceased collection efforts, FEEWC will make a determination whether to close the file and remove it from the collection docket.

(e) Referral to the Department of Justice — where payment is not received within 60 days of the date of the initial demand letter, and FEEWC concludes that referral to the Department of Justice is appropriate, FEEWC will prepare a memorandum to the Department of Justice, and will submit a Claims Collection Litigation Report to the Department of Justice Intake Facility in Silver Spring, Maryland. With respect to filing suit to enforce collection of a debt, 28 U.S.C. § 2415(a) provides that any such action must be filed within 6 years after the right of

action accrues or within 1 year after a final administrative decision has been rendered on the matter, whichever is later. The debt will remain on the FEEWC collection docket until FEEWC receives notice from Justice that the debt has been collected, or that Justice has ceased litigation efforts. Where Justice notifies OWCP/FEEWC that it has ceased litigation efforts, FEEWC will make a determination whether to close the file and remove it from the collection docket.

(f) Salary offset – In an appropriate case, FEEWC may initiate salary offset proceedings, and must follow the Department of Labor Salary Offset regulations set forth in 29 C.F.R. §20.74 through 20.90.

Top

12. USPS Cases.

a. General responsibilities for the processing of third party cases under 5 U.S.C. §§ 8131 and 8132 are outlined above in FECA PM 2-1100.3. However, to more efficiently and effectively accomplish the stated purpose of the FECA with regard to third party recoveries, the Director of OWCP has entered into a memorandum of agreement with the USPS whereby the OWCP has agreed that the USPS may supervise the third party aspects of certain cases. The USPS cannot enter into litigation on behalf of the United States under 5U.S.C. § 8131, and may not make direct referral to the Department of Justice for litigation on behalf of the United States.

The USPS may pursue the collection of damages from the responsible third party by administrative means, including obtaining the employee's assignment to the USPS of any right of action the employee may have to enforce the liability, provided that such assignment is voluntary on the part of the employee. The USPS cannot require the employee to make such assignment. The USPS must follow the guidelines established by OWCP for processing any funds recovered from the third party, including the use of the OMB-approved SOR (Form EN-1108).

Pursuant to the memorandum of agreement, the USPS supervision of the third party aspects of FECA cases is limited to cases of traumatic injury, except those traumatic injury cases which fall within one or more of the following categories:

(1) Where the traumatic injury results in the death of the employee;

(2) Where the injury occurred outside of the United States or Canada;

(3) Where the injury occurred when the employee was a passenger in a

common carrier conveyance;

(4) Where malpractice or product liability is involved;

(5) Where injuries are sustained by more than one employee in the same incident (group injuries).

b. The USPS is responsible for sending OWCP an initial status report within 3 months of the date the employee files any notice of injury on which the official superior has marked the injury as being caused by a third party. This report may be a copy of correspondence to the injured worker or memorandum directed to OWCP documenting the initial actions of the USPS regarding pursuit of recovery from the third party. If the USPS has decided not to pursue recovery from a third party, this should be stated in the initial report. If the USPS does pursue recovery, then it should provide a status report each 6 months after the initial report.

c. Responsibilities of the DCE for USPS Cases.

(1) The DCE takes no action unless the USPS reports it is pursuing recovery, or the DCE receives information from some other source that the FECA beneficiary is pursuing recovery.

(2) If information is received that the third party aspect has been or will be pursued by the USPS, the computer record will be updated to reflect this. The DCE will monitor the case on a periodic basis (every 6 months) until the case is closed. During this period, the DCE will cooperate with the USPS and will provide any needed assistance, including the furnishing of a statement of disbursements (Form CA-161) within five working days of receipt of a request from the Postal Service.

(3) If information is received indicating the FECA beneficiary is pursuing recovery, the DCE will send a letter to the USPS asking for the status. If the USPS responds that it is pursuing recovery, the DCE proceeds as described above. If the USPS fails to respond within 30 days or states it is not pursuing recovery, then the DCE assumes jurisdiction of the case. The DCE should proceed in accordance with the established procedures for initiating third party recovery action, and so notify the USPS.

(4) If the USPS refers the third party case back to OWCP for any reason, the DCE will accept the referral without question and follow existing procedures for regular third party cases.

(5) While the third party aspect of a case is being pursued by the USPS, the case should not be referred to the FEEWC until the USPS has exhausted its options and the third party activity comes back within the jurisdiction of the

OWCP, unless referral to the FEEWC is otherwise indicated. An example of such a situation would be if an attorney advises that a settlement is imminent but there are communication or logistical issues with the USPS. In this instance, the DCE should assume jurisdiction for OWCP, provide disbursement figures and make immediate referral to the FEEWC.

d. Settlements.

(1) If, while the third party aspect is being handled by the USPS, information is received that a recovery or settlement has been received and will result in a third party surplus, the DCE will suspend all payments and will furnish the USPS with a final disbursement statement.

(2) After settlement has been made, the USPS will furnish the DCE with a completed SOR (Form EN-1108) and a check representing the refund of OWCP disbursements. Following receipt, the DCE will finalize the process in accordance with established procedures, including the release of Ltr.CA-1044 or Ltr. CA-1120, as appropriate.

Top
FECA PT-2 index

2-1200 FEES FOR REPRESENTATIVES' SERVICES

Paragraph	Subject	Date	Trans. No.
	Table of Contents	**02/05**	**05-02**
1	**Purpose and Scope**	**02/05**	**05-02**
2	**Authority**	**02/05**	**05-02**
3	**Correspondence with Representatives**	**02/05**	**05-02**
4	**How Fees for Services Are Paid**	**02/05**	**05-02**
5	**Fees Which May Not Be Approved**	**02/05**	**05-02**
6	**Fee Approval**	**02/05**	**05-02**
7	**Authority to Approve Fees**	**02/05**	**05-02**
8	**Timely Case Action**	**02/05**	**05-02**

9	Fee Requests in Disallowed Claims	02/05	05-02

Exhibits

1	Sample Formal Decision	02/05	05-02

2-1200-1 Purpose and Scope

1. **Purpose and Scope.** This chapter sets forth the procedures to use when advising representatives of the status of cases and the requirements of the Act; and the procedures and standards to use when evaluating a representative's fee application.

2-1200-2 Authority

2. **Authority**

a. Under 5 U.S.C. § 8127(a), and in accordance with 20 C.F.R. § 10.700, a claimant may authorize an attorney or other individual to represent his or her interests in any proceeding before OWCP.

b. 20 C.F.R. § 10.700 also provides the following guidance with regard to representatives:

(1) A statement signed by the claimant is required to establish the representative's appointment. See 20 C.F.R. § 10.700(a).

(2) As there can only be one representative at any given time, OWCP will not recognize another person as representative until the claimant has withdrawn the authorization of the first individual. See 20 C.F.R. § 10.700(b).

Once OWCP has received the claimant's letter of authorization, the representative's name and address will be entered into the case record. Thereafter, copies of all correspondence and decisions should be sent to both the claimant and the authorized representative. See 20 C.F.R. § 10.127; Travis Chambers, Docket No. 02-1650 (issued April 17, 2003).

c. 20 C.F.R. § 10.701 sets forth restrictions on who may act as a representative. A claimant may authorize any individual to act as his or her representative, provided that the individual's service would not violate any applicable provision of law (such as 18 U.S.C. §§ 205 and 208). However, a Federal employee may now act as a representative

only:

(1) On behalf of immediate family members, defined as a spouse, children, parents, and siblings of the representative, provided no fee or gratuity is charged; or

(2) While acting as a union representative, defined as any officially sanctioned union official, and where no fee or gratuity is charged.

Should any documentation be received identifying a representative as a Federal employee, the claims examiner (CE) should issue a letter to the claimant inquiring as to the nature of the relationship between the claimant and representative, and whether remuneration is involved for the representative's services. If necessary, the representative's federal agency may be contacted for additional information. The National Correspondence Library includes a letter for this purpose.

2-1200-3 Correspondence with Representatives.

3. **Correspondence with Reprentatives.** Once OWCP has received the claimant's signed authorization letter, both the claimant and the designated representative will be advised via the revised form CA-0143 (which comes attached with form CA-0155) of the procedures relating to fee applications. Form CA-0143 (with attached form CA-0155) is located in the National Correspondence Library. In addition, the CE should prepare a letter advising the representative of the status of the case, including the accepted facts in the case and the issues which are in question. The letter should advise the representative of the information needed from the claimant as well as the information being obtained by OWCP.

2-1200-4 How Fees for Services are Paid

4. **How Fees for Services Are Paid.** A representative may charge the claimant (except as noted above in 2.c(1)-(2)) a fee in addition to other costs associated with the representation before OWCP. The claimant is solely responsible for paying the fee and other applicable charges. OWCP will not reimburse the claimant, nor is OWCP in any way liable for the cost of the representation. 20 C.F.R. 10.702.

a. Under 5 U.S.C. § 8127(b) and in accordance with 20 C.F.R. § 10.702, fees for representatives' services must first be approved by the Secretary. Fees may not be collected by the representative without such approval. Collecting a fee without this approval may constitute a misdemeanor under 18 U.S.C. § 292. A representative can be prosecuted under 18 U.S.C. § 292, which carries criminal penalties upon conviction of not more than $1000 or imprisonment not to exceed one year, or both.

b. However, funds deposited into an appropriately segregated account, such as a client trust or escrow account, until receipt of the Secretary's approval will not be considered receipt or collection of a fee by the representative. Under these circumstances, the representative's claim for services will be considered valid.

c. In Eugene F. Carbonneau, 39 ECAB 392 (1988), the Employees' Compensation Appeals Board (ECAB) ruled that OWCP is not prohibited from approving a fee after a fee has been collected. Consequently, OWCP is permitted to approve a fee even when the representative is withholding money from the claimant in violation of 18 U.S.C. § 292 and 20 C.F.R. § 10.702. As ECAB noted in the above decision, the "remedy against a representative who collects a fee without the prior approval by the Office is not withholding approval of a fee but rather the criminal sanctions" imposed by 18 U.S.C. § 292.

2-1200-5 Fees Which May Not Be Approved

5. **Fees Which May Not Be Approved.** OWCP may not approve fees for certain services or in certain situations.

a. Fees for service in matters which have no relation to the claim, or for work done before another government agency, or before the ECAB will not be approved. Representatives who inquire about payment for work done before the ECAB should be instructed to submit their request for fee approval to the ECAB. See 20 C.F.R. § 501.11.

(1) Administrative expenses (mailing, copying, messenger services, travel, and the like, but not including secretarial services, paralegal and other activities) **need not** be approved before the representative collects them. **However**, if they are included in the fee application, the representative should be informed that OWCP does not rule on administrative expenses, as ECAB has ruled: "The matter of expenses are a matter between appellant and his attorney and are not the appropriate subject of a fee application" (Francesco C. Veneziani, 48 ECAB 572 (1997)). Consequently, such expenses must not be included in any fee total that is approved by OWCP.

A representative may, however, use the services of a paralegal, legal assistant, legal intern, or secretary and **include** the charges for those services in the fee request.

(2) Time spent in preparing the request for fees, writing letters, holding conferences, or any other activity connected with the preparation and filing of a claim for fee approval may not be considered. See Robert G. Anderson, 21 ECAB 344(1970), and William Lee Gargus, 25 ECAB 187 (1974).

b. OWCP does not recognize any contract or agreement between representatives and clients for payment of a fee for services on a contingency basis, and such contract or agreement, if one exists, will not be considered in determining a reasonable fee. Further, a fee will not be approved merely on the basis of a percentage of the amount of compensation awarded. In Angela M. Sanden, Docket No. 04—1632 (issued September 20, 2004), ECAB found the representative's contingency fee arrangement illegal, and ruled that the representative must calculate the money owed for services rendered on an hourly basis.

2-1200-6 Fee Approval

6. **Fee Approval.** (See 20 C.F.R. § 10.703)

a. Fee application. It is sometimes the case that services have been provided before both the custodial district office and the Branch of Hearings and Review during the life of a claim. As a result, representatives will often present one application for fee approval containing services performed before both the district office and the Branch. It is not uncommon that the application will be presented to either or both of these offices.

In light of this, the location of the case record at the time the fee application is received will determine who should consider the request and issue the decision. There is no need to split fee charges based upon where services were provided. There is also no need to request the case file from the custodial office to consider a portion of services performed before another office. If, however, questions arise regarding the propriety of any contested charge for services performed before another office, that office should be consulted.

The fee application must contain each of the items listed below.

(1) An itemized statement showing:

(a) The representative's hourly rate,

(b) The number of hours worked,

(c) A description of the specific work performed,

(d) And the total amount charged for the representation, exclusive ofa dministrative costs.

(2) A statement of agreement or disagreement with the amount charged, signed

by the claimant. The statement must also acknowledge that the claimant is aware that he or she must pay the fee and that OWCP is not responsible for paying (or reimbursing) the fee or other costs associated with the representative's services.

b. Should an application be submitted which is missing any item cited in 6.a(1)a-d above, it will be returned to the representative with a letter advising him or her to resubmit the fee application with the identified missing item(s). See 20 C.F.R. § 10.703(a)(2). The National Correspondence Library contains a letter for this purpose.

However, if the application is missing the claimant's signed statement of agreement or disagreement (as described in 6.a(2) above); the CE must submit the fee application directly to the claimant and provide him or her with an opportunity (30 days) to agree with, or submit a statement or evidence disputing, said application. If a statement is received, the CE will follow the procedures outlined at either 6.c or 6.d below, depending on the nature of the claimant's response. If no response is received, the CE will then either approve or deny the fee request on the basis of "whether the amount of the fee is substantially in excess of the value of services received" by evaluating the factors outlined at 20 U.S.C. § 10.703(c). (See also 6.d(1)-(4) below.)

c. Approval Where There is No Dispute. Where a fee application is accompanied by a signed statement indicating the claimant's agreement with the fee (as described in paragraph 6.a(2) above), the application will be deemed approved. See 20 C.F.R. § 10.703(b).

While this is similar to the procedures prior to the regulatory change effective January 4, 1999, in those instances where the claimant has specifically agreed to the charges as submitted by the representative, OWCP personnel are no longer required to evaluate the services provided or the hourly rate at which the claimant was charged in order to determine the propriety of the representative's fees.

Instead, the fees will be deemed approved and a simple notice confirming such approval will be issued to avoid any confusion on this matter. The National Correspondence Library contains a letter for this purpose entitled "Representative Fee Approval."

d. Disputed Requests. Where the claimant disagrees with the amount of the fee, as indicated in the statement accompanying the application, OWCP will evaluate the objection and issue a formal decision that approves, modifies, or denies the fee. (See Exhibit 1 for a sample decision.) In order to make this determination, OWCP will provide a copy of the fee request to the claimant and ask him or her to provide any additional information in support of his or her objection within 15 days from the date the fee request was forwarded to the claimant. See 20 C.F.R. § 10.703(c).

After that period has passed, OWCP will evaluate any information received to determine whether the amount of the fee is substantially in excess of the value of the services

received by examining the following factors:

(1) Usefulness of the Representative's Services. The CE should take into account the advantages which the claimant received by having a representative. What was at issue? Was the representative, by reason of knowledge, experience, etc., able to accomplish that which would have been difficult or unlikely for the claimant to accomplish without such aid? The impediments to the claim and the evidence submitted to overcome them should be discussed briefly, as well as any other pertinent facts about the worth of the representative's services.

(2) The Nature and Complexity of the Claim. Representatives appear in all types of cases from the routine and simple to the unusual and complicated. The decision should discuss whether any unusual or complex questions of law or medicine were involved, discuss the issues in general, and describe what the representative did to overcome the defects in the claim. Any unusual measures needed to obtain factual or medical evidence should be noted.

(3) The Actual Time Spent on Development and Presentation of the Claim. The CE must consider not only the time spent in conferences with the claimant (and others) which had a bearing on the claim, but the time spent on investigations, study of the case record, travel, and appearances at hearings as well. In addition, the accuracy of the representative's description of letters written and phone calls made to OWCP, as well as any other evidence submitted, should be verified by a thorough review of the case record. The time claimed by the representative should be commensurate with the actual services performed. The CE should bear in mind, however, that the ECAB has found that a representative has broad latitude in exercising professional judgment in connection with the preparation of a client's case. A representative has the responsibility to study and research the client's case. Such work, insofar as it is within reasonable bounds, is entitled to consideration in fixing the fee, even though all the work may not prove helpful in producing relevant evidence or legal precedent. The test of necessary services is whether such services seemed reasonably necessary at the time they were performed (Anna Palestro (Vincent Palestro), 15 ECAB 241 (1964)).

(4) Customary local charges for similar services. The CE should also consider the customary charges for similar services in the representative's locality. Consequently, in the event of a disputed fee, the CE may ask the representative to state the customary local charges for services of the type he or she has rendered. If necessary, the CE may request this information from the local bar association, state compensation boards and commissions, or any other appropriate source.

e. Fee Reduction. In each instance where a claimant disputes the representative's fee request and files an objection (the signed statement of disagreement is sufficient); OWCP

will make a formal determination and issue an appropriate decision. This decision will include appeal rights for both the claimant and the representative.

It is important to note, however, that ECAB has ruled "that where the Office proposes to reduce a requested fee, including the hourly rate the representative may charge, the representative is entitled to notice of the reasons for the proposed reduction and an opportunity to respond with written comments and by affidavit prior to a decision [being issued]" Edgar Aikman, 32 ECAB 1570 (1981).

Therefore, in these instances, the Office will issue a letter to the representative explaining the reasons for the proposed fee reduction, and advising him or her to submit evidence or argument against the reduction within 30 days from the date of the letter.

Form CA-996 is a formal decision that is used when no controversial or complex issues are involved and the requested fee is reduced due to a disallowance of time claimed (or simply the elimination of administrative expenses from the fee application, per 5.a(1) above). If the representative's services are totally or mostly of a routine nature and there is no novel point of law or medicine, the determination of a reasonable fee rests largely upon the time spent in necessary services on the claimant's behalf. In these situations, the CE should prepare an annotated copy of the representative's itemized statement or an entirely separate statement showing the time claimed but not approved and the reasons for the reduction. The statement should accompany Form CA-996 and both the claimant and the representative should be provided a copy.

In all other cases, a narrative decision must be prepared. The decision must clearly show the precise reasons for the final determination. Rationale must be given for any reduction in hours or exclusion of other items such as expenses. If the claimant contested the amount of fee requested as excessive or unreasonable, the decision must also provide rationale for the amount of fee allowed.

2-1200-7 Authority to Approve Fees

7. **Authority to Approve Fees.**

a. District office personnel are authorized to evaluate and approve disputed fee requests in the following amounts:

(1) Senior Claims Examiners: Up to $15,000

(2) Supervisory Claims Examiners: Up to $50,000

(3) Assistant District Director or

District Director: Over $50,000

b. The Supervisory CE may delegate in writing the authority to approve disputed fee requests to GS 9-12 CEs in amounts up to $10,000.

The formal decision should be signed and released by a CE, Senior CE, Supervisory CE, Assistant District Director, or District Director, depending upon who approved the fee request.

2-1200-8 Timely Case Action

8. **Timely Case Action.**

a. Notice of Award. Where the representative has submitted an application for fee approval prior to or at the time of submission of the evidence needed to reach a decision in the case, the CE should issue the notification of case acceptance, the notice of payment of compensation or notice of award along with the ruling on the fee request. Compensation should be coordinated with the decision on the fee request. Otherwise, the representative's chances of collecting the fee may be jeopardized.

b. Payment. Compensation checks will not be forwarded routinely to a representative, either with or without the claimant's approval, since this would provide an element of assistance in collecting the fee. Such assistance is prohibited by the regulations and the spirit of 5 U.S.C. §8130, exempting compensation payments from the claims of creditors.

In some instances, however, it may be appropriate to send the compensation check in care of another party, i.e. court appointed guardian, executor, or administrator of the estate. In questionable instances the CE should refer the case to the Assistant District Director with an appropriate recommendation.

2-1200-9 Fee Requests in Disallowed Claims

9. **Fee Requests in Disallowed Claims**. Where a compensation claim is disallowed, a formal decision will be made on the representative's fee application. It will be sent to the representative with a copy of the disallowance. In such cases, a reasonable representative's fee may be approved after full consideration is given to all factors discussed in paragraph 6 above. The fact that the compensation claim is disallowed is insufficient to deny a representative a reasonable fee for services necessary to pursue the claim. See Robert D. Shaw, 30 ECAB 257 (1978).

2-1200 Exhibit 1: Sample Formal Decision

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

. . . .

In the matter of the claim for representative's fee under Title 5 U. S. Code 8101 et seq. of

NAME OF CLAIMANT

NAME OF REPRESENTATIVE

. . . .

COMPENSATION ORDER

APPROVAL OF REPRESENTATIVE'S FEE

CASE NUMBER:

Such investigation in respect to the application for fee approval having been made as is considered necessary, and after due consideration of such application and information of record, this Office makes the following:

FINDINGS OF FACT

(1) The representative named above has requested approval of fees for services rendered during the following periods:

April 19, 1994 to November 8, 1995, inclusive: $6,237.69

November 12, 1995 to July 7, 1996, inclusive: $237.00

(2) Approval is required only for the representative's professional services. A representative's expenses for items such as long distance calls and travel are not considered under the FECA, and the district office does not rule on payment of such expenses. This is a private matter between the representative and claimant. Expenses in the amount of $104.03 included in the request for fee approval, therefore, are not being considered.

(3) Time spent by a representative in preparation of a fee request cannot be charged to the claimant. Such efforts are on behalf of the

representative rather than the claimant. For this reason, the fee has been reduced by $67 because 40 minutes of time reported represents time devoted by the representative to the fee request.

(4) The claimant did contest the amount of $6,237.69 claimed from April 19, 1994 to November 6, 1995, as excessive and unreasonable. The claimant further states that the representa- tive did very little to help and that the claimant personally contacted witnesses by telephone to obtain statements. The fact that the claimant did actively pursue the claim is not disputed.

The record establishes that the claim, previously denied by formal decision dated August 24, 1991, was subsequently approved because of the diligent efforts of the claimant's representative. The representative succeeded in presenting persuasive evidence to support the claim where other representatives had previously failed. For instance, on September 3, 1994, the attorney submitted a 12-page letter with 38 exhibits and skillfully provided evidence to establish the claimant's right to compensation retroactive for a period of nine years. The claimant received accrued compensation of $41,068.22 as a result of this effort.

After examining the case record and the following criteria: usefulness of the representative's services, the nature and complexity of the claim, the actual time spend on development and presentation of the claim, the amount of compensation accrued and potential future payments, customary local charges for similar services, professional qualifications of the representative, and all other pertinent factors in the record, it is determined that a fee of $6,303.66 is reasonable.

Upon the foregoing Findings of Fact, it is determined that a fee in the amount of $6,303.66, is reasonably commensurate with the actual necessary work performed in representing the claimant before this district office. A fee is approved in such amount. The payment of this fee is the responsibility of the claimant.

Given under my hand at

this day of

Director, OWCP

By:

Senior Claims Examiner

2-1300 LUMP SUM PAYMENTS

Paragraph	Subject	Date	Trans. No.
	Table of Contents	07/03	03-07
1	Purpose and Scope	09/92	92-35
		07/03	03-07

2	Authority	09/92	92-35
		07/03	03-07
3	Requests for Lump-Sum Payments	09/92	92-35
		04/94	94-20
		07/03	03-07
4	Calculating Lump-Sum Schedule Awards	07/03	03-07
5	Requests for Reconsideration of Lump-Sum Decisions	09/92	92-35
		07/03	03-07

Exhibits

1	Sample of Initial Response Letter to Claimant who Inquires About A Lump-Sum	09/94	94-36
	Disability Payment	07/03	03-07
2	Sample Appealable Decision Letter for Claimant Who Request Lump-Sum	09/94	94-36
	Disability Payment	07/03	03-07
3	Sample Letter to Claimants Inquiring About Lump-Sum Payments for Schedule	09/94	94-36
	Awards	07/03	03-07
4	Sample Letter to Claimants Requesting Lump-Sum Payments for	09/94	94-36
	Schedule Awards	07/03	03-07

2-1300-1 Purpose and Scope

1. Purpose and Scope. This chapter describes the provisions of 5 U.S.C. 8135(a) concerning the issue of lump-sum payments, and describes the limits on considering such payments in effect as of September 10, 1992 as a result of the Office's revised regulations at 20 CFR 10.311.

2-1300-2 Authority

2. Authority. Section 8135(a) provides that the liability of the United States for compensation to a beneficiary in the case of death or of permanent total or permanent partial disability may be discharged by a lump-sum payment equal to the present value of all future payments of compensation computed at four percent true discount compounded annually. A

lump-sum payment may not be made, however, unless: (a) compensation to the beneficiary is less than $50 a month; or b) the beneficiary is or is about to become a non-resident of the United States; or c) the Secretary of Labor determines that it is for the best interest of the beneficiary.

However, in the revised regulations (originally published as 20 C.F.R § 10.311 and effective September 10, 1992), the Secretary determined, in the exercise of discretion afforded under section 8135(a), that lump-sum payments of wage-loss compensation will no longer be made. Thus, compensation which is based on loss of wages will be paid in periodic payments only. The implementing regulation, now found at 20 C.F.R. § 10.422(a)**,** provides:

> (a) In exercise of the discretion afforded by section 5 U.S.C. 8135(a), OWCP has determined that lump-sum payments will not be made to persons entitled to wage-loss benefits (that is, those payable under 5 U.S.C. 8105 and 8106). Therefore, when OWCP receives requests for lump-sum payments for wage-loss benefits, OWCP will not exercise further discretion in the matter. This determination is based on several factors, including:
>
> > (i) The purpose of the FECA, which is to replace lost wages;
> >
> > (ii) The prudence of providing wage-loss benefits on a regular, recurring basis; and
> >
> > (iii) The high cost associated with the long-term borrowing that is needed to pay out large lump sums.
> >
> > However, a lump-sum payment may be made to an employee entitled to a schedule award under 5 U.S.C. 8107 where OWCP determines that such a payment is in the employee's best interest. Lump-sum payments of schedule awards generally will be considered in the employee's best interest only where the employee does not rely upon compensation payments as a substitute for lost wages (that is, the employee is working or is receiving annuity payments). An employee possesses no absolute right to a lump-sum payment of benefits payable under 5 U.S.C.8107.

It should be noted that upon remarriage prior to age 55, a widow or widower entitled to compensation under section 8133 shall be paid in accordance with section 8135(b) of the FECA. See details in paragraph 3(c) below.

2-1300-3 Requests for Lump-Sum Payments

3. Requests for Lump-Sum Payments. When an application for a lump-sum payment is received, the Claims Examiner (CE) should first determine whether the benefit being paid the claimant or survivor is for compensation under sections 8105 or 8106; a schedule award under section 8107; survivor's benefits under section 8135; or, survivor's benefits under section

8133--as described in section 8135(b). The claimant should then be advised by the appropriate letter (see exhibits and details below) about the regulations and how they affect the question of lump-sum payments.

a. Wage Loss Benefits. A beneficiary who initially inquires about the availability of a lump-sum payment of his or her claim for wage-loss benefits should be advised that such lump-sum payments will not be considered. The letter should refer the claimant to the rules at 20 C.F.R. § 10.422, which state that "OWCP has determined that lump-sum payments will not be made . . ." and that "OWCP will not exercise further discretion in the matter." A sample letter to the claimant is provided as Exhibit 1 for inquiries concerning wage-loss benefits. No appeal rights should accompany the letter of explanation to the claimant.

However, should the claimant or representative persist in requesting a lump-sum award, a decision with appeal rights will be issued. This decision should simply refer to the regulation (20 C.F.R. § 10.422(a)) and deny consideration of the lump-sum request, as set forth in Exhibit 2.

b. Schedule Benefits. A lump-sum payment of schedule award benefits may still be made where the evidence shows that such a payment would be in the claimant's best interest. The regulations make it clear that there is no absolute right to a lump-sum payment of schedule benefits and every case must be considered on its individual merits using the best interest test. The regulations also state that a lump-sum payment of schedule benefits will not generally be considered in the claimant's best interest where the compensation payments are relied upon as a substitute for lost wages.

In cases where the claimant is back to work or is receiving an OPM annuity of a sufficient amount, the schedule award is not replacing the claimant's regular income which is necessary to meet his or her living needs, and consequently a lump-sum settlement may well be in his or her best interest. Any decision denying a request for a lump-sum payment of schedule benefits should include an analysis of the facts in the case considered when exercising discretion.

One factor **precluding** payment of a lump-sum schedule award is garnishment of compensation benefits. Although schedule award payments may be garnished, no future payment may be garnished. Because a lump sum award is a payment of future benefits, the party entitled to payments from garnishment would no longer be able receive these payments. Therefore, a claimant whose benefits are being garnished should not be awarded a lump sum for schedule benefits.

For administrative convenience, where the claimant is working or receiving an OPM annuity adequate to meet living expenses, the CE should advise the claimant of his or her eligibility for a lump-sum payment in cases where a schedule award is being paid. Payment of a lump sum for a schedule award should be considered as early in the period

of the award as possible. When a schedule award letter is issued in a case meeting the above requirements, the CE should routinely notify the claimant of the lump-sum option and the commuted value of the remaining period of the award. A sample letter to the claimant is shown at Exhibit 3.

In a case where the claimant is receiving a schedule award and requests a lump-sum payment, yet it has not been established that the schedule award is not the claimant's source of regular income, the CE must obtain the necessary information. In a letter, the CE should advise the claimant of the best interest standard and request the information which would establish whether or not the claimant has another source of regular income sufficient to meet his or her living needs. Exhibit 4 provides a sample letter for this purpose.

The CE should further advise the claimant that if he or she elects a lump-sum payment of a schedule award, it will be paid at the four percent discount rate, and that it represents full and final compensation payment for the period of the award, even if he or she suffers a recurrence of total disability. The claimant must sign an agreement to this effect before any lump-sum award is issued. **Exhibit 3**.

c. Death Benefits. A beneficiary in a death case should be advised that the lump-sum payment to a spouse of a deceased employee may not exceed 60 months of compensation. Any such lump-sum award would also be subject to the proviso that the periodic payment of survivor's benefits was not the main source of income for the beneficiary.

However, a surviving spouse who remarries before age 55 is still entitled as a matter of right to a lump-sum payment equal to 24 months of compensation. **There is no discretion in the application of section 8135(b) of the Act.**

If applicable, the CE should also advise the claimant that a lump-sum payment to a widow or widower under section 8135(a) will not result in an increase in the amount of compensation paid to dependent children. On the other hand, in cases of a lump-sum payment under subparagraph (b), which relates to remarriage before age 55, the claimant should be advised in the letter from the CE that the lump-sum payment to the widow or widower does result in an increase in the periodic compensation payments to the dependent children.

2-1300-4 Calculating Lump-Sum Schedule Awards

4. Calculating Lump-Sum Schedule Awards. The responsible CE will determine the commuted value of the schedule award using the Lump-Sum Schedule Award Calculator.

a. The CE will need the following information to correctly compute the amount of the lump-sum payment:

(1) Claimant's file number;

(2) Name of the claimant;

(3) Total period of the award;

(4) Total number of days of the award (including fraction of a day);

(5) Amount of four-week compensation being paid; and

(6) Actual commutation (start) date of the lump-sum award.

The CE will enter a commutation date that is at least one **FULL**, periodic roll cycle in the future from the date the actual lump-sum calculation is made. Once the CE has printed out a copy of the completed lump-sum calculation document, it must be reviewed and approved by both a SrCE and an SCE before the lump-sum payment agreement letter is issued to the claimant, regardless of the amount of the lump-sum award. (A journey-level CE (GS-12) may certify another journey-level CE's lump-sum award calculation document; however, an SCE must still approve the calculation, as the three signature requirement is mandatory.)

b. When recalculating a lump-sum award payment (due to an amended award, additional award for a different body part, etc.), the CE enters the original start date in the "Period of Award" field, but then keys in the appropriate new ending date (and fraction of day, if applicable). The CE must then subtract the total amount previously paid from this newly calculated lump-sum total to correctly obtain the additional amount due the claimant.

2-1300-5 Requests for Reconsideration of Lump-sum Decisions

5. Requests for Reconsideration of Lump-sum Decisions. If a petition for reconsideration is made of a lump-sum decision where the claimant is receiving benefits under section 8105 or 8106 and that decision was issued prior to September 10, 1992, the Office should reopen the case on its merits and issue a denial of the lump-sum request on the basis of the new regulation. This decision should recite the language of the regulation as set forth at 20 C.F.R. § 10.422(a). A sample decision for this purpose is provided as Exhibit 2. This action should be taken notwithstanding the timeliness of the request.

If a petition for reconsideration is made of a decision issued after September 10, 1992, such request should be handled in accordance with the Office's standard procedures for handling such petitions.

2-1300 Exhibit 1: Sample of Initial Response Letter to Claimant who Inquires About Lump-Sum Disability Payment

Dear CLAIMANT NAME:

I am writing in response to your inquiry concerning receipt of a lump-sum payment of wage-loss benefits in your case under the Federal Employees' Compensation Act (FECA).

Pursuant to regulations governing the administration of the FECA at 20 CFR 10.422, lump-sum payments of wage-loss compensation are no longer considered. The rule states that the Director has determined that lump-sum payments will no longer be made for benefits under sections 8105 and 8106. See 20 CFR 10.422(a).

Although no lump-sum payments are made under the FECA for wage-loss benefits, please note that monthly compensation benefits will continue for the period of your entitlement.

Sincerely,

CLAIMS EXAMINER

2-1300 Exhibit 2: Sample Appealable Decision Letter for Claimant Who Request Lump-sum Disability Payment

Dear CLAIMANT NAME:

Your request for a lump sum payment of your wage-loss benefits under section 8105/8106 of the Federal Employees' Compensation Act (FECA) has been received by this office. Regulations governing the administration of the FECA at 20 CFR 10.422(a) provide:

> (1) In the exercise of the discretion afforded by section 8135(a), the Director has determined that lump-sum payments will no longer be made to individuals whose injury in the performance of duty as a federal employee has resulted in a loss of wage earning capacity. This determination is based on, among other factors:
>
> (i) The fact that FECA is intended as a wage-loss replacement program;
>
> (ii) The general advisability that such benefits be provided on a periodic basis; and
>
> (iii) The high cost associated with the long-term borrowing that is necessary to pay out large lump sums.

(2) Accordingly, where applications for lump-sum payments for wage-loss benefits under section 8105 and 8106 are received, the Director will not exercise further discretion in the matter.

Based on the foregoing, your request for a lump-sum payment will not be considered and is hereby denied. Your appeal rights are attached.

Sincerely,

CLAIMS EXAMINER

Case Number:

FEDERAL EMPLOYEES' COMPENSATION ACT APPEAL RIGHTS

If you disagree wi tthe attached decision, you have the right to request an appeal. If you wish to request an appeal, you should review these appeal rights carefullly and decide which appeal to request. There are 3 different types of appeal: HEARING (this includes either an Oral Hearing, or a Review of the Written Record), RECONSIDERATION, and ECAB REVIEW. YOU MAY ONLY REQUEST ONE TYPE OF APPEAL AT THIS TIME. Place an "X" on the attached form indicating which appeal you are requesting. Complete the information requested at the bottom of the form. Place the form on top of any material you are submitting. Then mail the form with attachments to the address listed for the type of appeal that you select. Always write the type of appeal you are requesting on the outside of the envelope ("HEARING REQUEST", or "ECAB REVIEW"). Your appeal rights are as follows:

1. HEARING: If your injury occured on or after July 4, 1966, and you have not requestedreconsideration, as described below, you may request a **Hearing.** To protect your right to a hearing, any request for a hearing must be made before any request for reconsideration by the District Office (U.S.C. 8124(b)(1)). Any hearing request must also be made in writing, within 30 calendar days after the date of this decision, as determined by the postmark of your letter.
(20. C.F.R. 10.616). There are **two forms of hearing**. You may request either one or the other, but not both.

a. One form of Hearing is an **Oral Hearing**. An informal oral hearing is conducted by a hearing representative at a location near your home. You may present oral testimony and written evidence in support of your claim. Any person authorized by you in writing may represent you at an oral hearing.

b. The other form of a Hearing is a **Review of the Written Record**. This is also conducted by a hearing representative. You may submit additional written evidence, which must be sent with your request for review. You will not be asked to attend or give oral testimony.

2. RECONSIDERATION: If you have additional evidence or legal argument that you believe will establish your claim, you may request, in writing, that OWCP reconsider this decision. The request must be made within on calendar year of the date of the decision, clearly state the grounds upon which reconsideration is being requested, and be accompanied by relevant evidence not previously submitted. This evidence might include medical reports, sworn statements, or a legal argument not previously made, which apply directly to the issue addressed by this decision.

In order to ensure that you receive an independent evaluation of the new evidence, persons other than those who made this determination will reconsider your case. (20 C.F.R. 10.605-610)

3. **REVIEW BY THE EMPLOYEES' COMPENSATION APPEALS BOARD (ECAB):** If you believe that all available evience that would establish your claim has already been submitted, you have the right to request review by teh ECAB (20 C.F.R. 10 625). The ECAB will review only the evidence received prior to the date to fhis decision (20 C.F.R. Part 501). Any request for review by the ECAB should be made within 90 days from the date of this decision. The ECAB may waive failure to file within 90 days if you request review within one year of the date of this decision and show a good reason for the delay.

If you request reconsideration or a hearing (either oral or review or the written record), OWCP will issue a decision that includes your right to further adminitrative review of that decision.

Case Number:
Employee:

APPEAL REQUEST FORM

If you decide to appeal this decision, read your Appeal Rights and these instructions carefully. Specify which procedure you request by checking one option below. Place this form on top of any materials specified below that you are submitting. Mail THIS FORM, along with any additional materials TO THE APPROPRIATE ADDRESS. YOU MAY REQUEST ONLY ONE TYPE OF APPEAL AT THIS TIME.

__________ **HEARING - ORAL**

__________ **HEARING - REVIEW OF THE WRITTEN RECORD:**

1) Submit this form within 30 calendar days of the date of the decision
2) You may submit additional written evidence with your request.

Write "HEARING REQUEST" on the outside of your envelope and mail it to:

Branch of Hearings and Review
Office of Workers' Compensation Programs
P.O. Box 37117
Washington, DC 20013-7117

__________ **RECONSIDERATION:**

1) Submit your request within 1 calendar year of the date of the decision.
2) You must state the grounds upon which reconsideration is being requested. Your request must include relevant new evidence or legal argument not previously made.

Write "RECONSIDERATION REQUEST" on the outside of your envelope and mail it to:
DOL DFEC Central Mailroom
P.O. Box 8300
London, KY 40742

__________ **ECAB APPEAL:**

1) Submit this form within 90 calendar days of the date of the decision.
2) No additional evidence after the date of the decision will be reviewed.
3) To expedite the processing of your ECAB appeal, you may include a completed copy of the AB 1 form used by ECAB to docket appeals available on othe Department of Laobr Web Site at www.dol.gov/ecab

Write "ECAB REVIEW" on the outside of your envelope and mail it to:
Employees' Compensation Appeals Board
200 Constitution Avenue NW, Room N-2609
Washington, DC 20210

SIGNATURE ______________________________ TODAY'S DATE ______________________

PRINTED NAME __________________________ DECISION DATE ____________________

ADDRESS _______________________________________ PHONE ____________________

CITY ______________________ STATE _________________ ZIP ______________________

2-1300 Exhibit 3: Sample Letter to Claimant Offering to Payoff Balance of Schedule

Award

Dear CLAIMANT NAME:

I am writing in reference to the schedule award you ahve been granted by this office. As the enclosed award notice indicates, the award will run through **DATE**. If you wish, however, the amount of the remaining schedule may be paid in a lump sum if you are working or receiving benefits from the Office of Personnel Management or a comparable Federal retirement system. You may, of course, choose to receive the remaining schedule award in regular payments each 28 days as stated in the award notice.]

The law provides that the liability of the United States for compensation may be discharged by a payment equal to the present value of all future payments of compensation computed at a four percent true discount rate compounded annually. In your case this would be $**0000.00**, as of **DATE**. Additional benefits which may be awarded at a later date for temporary total disability or LWEC will not be considered in computing any lump-sum entitlement.

Any lump-sum payment will represent full and final compensation payment for the period of the award even if you suffer a recurrence of total disability. If you elect to receive your schedule award in this form, please sign the attached agreement and return it to this Office.

Sincerely,

CLAIMS EXAMINER

Date of Injury:

AGREEMENT TO ACCEPT LUMP SUM SETTLEMENT OF SCHEDULE AWARD

To proceed with my claim for a lump-sum settlement of my schedule award in accordance with 5 U.S.C. 8135(a), I wish to enter into the following agreement:

1. That I **CLAIMANT NAME**, agree to accept the sum of **$0000.00** in payment of compensation for the remainder of the schedule award payable from (**DATE**) to (**DATE**).

2. That I understand and agree that payment of such lump sum will represent full and final settlement of my schedule award for the period noted above in connection with my injury of (**DATE**), and that no further monetary compensation benefits will be extended to me for the duration of the schedule award.

Signature ___________________________________
Date _______________

2-1300 Exhibit 4: Sample Letter to Claimants Requesting Lump-sum Payments for Schedule Awards

Dear CLAIMANT NAME:

We have received your request for a lump-sum payment of your schedule award benefits under the Federal Employees' Compensation Act (FECA). Lump-sum payments are made at the discretion of the Director, based on a determination of whether such a payment would be in your best interest.

To show that such a payment would be in your best interest, you should submit evidence which shows that the schedule benefits are not a substitute for wages. Compensation payments are intended as income replacement. As such, it is generally advisable that those payments be made on a periodic basis, since this form of payment is consistent with the wages these benefits are designed to replace. As such, it is generally advisable that those payments be made on a periodic basis, since this form of payment is consistent with the wages these benefits are designed to replace. If you have returned to work or receive a retirement annuity from the Office of Personnel Management at a level which can meet your basic living needs, then a lump-sum payment may be in your best interest. In the event you wish to receive a lump-sum payment of your schedule award, please submit a signed statement indicating you have returned to work or currently receive income from OPM sufficient to meet your basic living expenses.

Please be advised that any lump-sum payment will represent full and final compensation payment for the period of the award even if you sustain a recurrence of total disability.

Sincerely,

CLAIMS EXAMINER

2-1300 Exhibit 5: Information Needed by National Office to Compute Lump-sum Payment for Remainder of a Schedule Award

The following information should be provided to the Branch of Technical Assistance in the National Office, preferably by telefax (202-219-7260) or telephone (202-219-8463), to obtain an estimated or final commuted value of the remaining portion of a schedule award:

Name of Claimant

File Number

Period of Award

Total Number of Days of Award (Including Fraction of a Day)

Amount of Four-Weekly Compensation Being Paid

The Effective Date of the Pay Rate

The Actual or Projected Commutation Date

2-1400 DISALLOWANCES

Paragraph	Subject	Date	Trans. No.
	Table of Contents	03/97	97-09
1	Purpose and Scope	03/97	97-09
2	Policy	03/97	97-09
3	Additional References	03/97	97-09
4	Notices of Decision	03/97	97-09
5	How to Write Notices of Decision	03/97	97-09
6	When to Issue Pre-Termination and Pre-Reduction Notices	03/97	97-09
7	How to Issue Pre-Termination and Pre-Reduction Notices	03/97	97-09
8	Responses to Pre-Termination and Pre-Reduction Notices	03/97	97-09
9	Cover Letters	03/97	97-09
10	Appeal Rights	03/97	97-09
11	Issuing Decisions	03/97	97-09
12	Convictions for Fraud and Other Felonies	03/97	97-09

Exhibits

1	Sample Notice of Proposed Termination	03/97	97-09
2	Sample Letter Conveying Proposed		

	Termination	03/97	97-09
3	Sample Notice of Proposed Reduction	03/97	97-09
4	Sample Letter Conveying Proposed Reduction	03/97	97-09
5	Sample Notice of Decision--Cumulative Evidence	03/97	97-09
6	Sample Notice of Decision--Insufficient Evidence	03/97	97-09
7	Sample Letter Conveying Final Notice of Reduction	03/97	97-09
8	Sample Letter Conveying Final Decision--New Evidence Establishes Continuing Entitlement	03/97	97-09
9	Definition of Fraud (18 U.S.C. 1920)	03/97	97-09
10	Sample Letter Denying Benefits Due to Fraud	03/97	97-09

2-1400-1 Purpose and Scope

Purpose and Scope. Section 5 U.S.C. 8124(a) of the FECA requires the OWCP to make findings of fact with respect to each claim filed and to make an award for or against the payment of compensation. When the outcome is negative, the OWCP must issue a formal decision. This chapter describes how to prepare such decisions, including pre-termination and pre-reduction notices.

2-1400-2 Policy

Policy. This paragraph addresses when formal decisions are to be released and the steps which the Claims Examiner (CE) must take before considering issuance of a disallowance. It also discusses the contents, form, and signature authority for disallowances.

a. When Decisions are Required. Formal decisions must be issued when claim forms have been submitted, and they may also be issued in response to letters requesting benefits or on the OWCP's initiative. Further information on various kinds of disallowances is referenced in paragraph 3 below.

(1) Initial Decisions. A formal decision is required in any case where the OWCP has received a Form CA-1, CA-2, CA-5, CA-5b, CA-7 or CA-8 and it is clear after suitable development that one or more of the five basic requirements of the claim is not met.

(2) Specific Benefits. If a particular benefit (e.g., a certain kind of medical treatment or an attendant's allowance) must be disallowed, a letter to the claimant explaining why the benefit cannot be granted will often suffice. However, any request by the claimant for a formal decision should be granted.

(3) Continuing Entitlement. Where a claimant who is receiving compensation benefits is no longer entitled to them, benefits must be terminated or reduced. The OWCP initiates such decisions.

b. Due Process. Before preparing a disallowance of benefits, the CE must adequately develop the claim and, where necessary, advise the claimant of his or her burden of proof in establishing entitlement to benefits. Where ongoing benefits are at issue, the CE is responsible for advising the claimant of the planned termination or reduction and the reasons for it.

(1) Advice to Claimant. The CE must notify the claimant in writing of the specific additional evidence which is needed before denying any claim. The contents of such notices are described in FECA PM chapters addressing various kinds of entitlement (see paragraph 3 below for a list of references).

The only exception to this rule is where the evidence clearly shows that there is no basis to accept the case (e.g., the claimant is not a civil employee, or the claimant's statement contains no factors of employment to support the claim).

(2) Form of Notice. In unadjudicated cases, or where a specific benefit is claimed, the CE may use a form or narrative letter to notify the claimant of the information needed. Where ongoing benefits are being paid, the CE should prepare a pre-termination or pre-reduction notice (see paragraphs 6 and 7 below).

(3) Time Frames. The notice should advise the claimant of his or her burden of proof and state how much time the claimant has to submit the evidence requested before a formal decision will be issued.

(4) Parties Advised. The CE should send the notice to the claimant, with a copy to the employing agency. If a representative is present in the case, the CE should send the letter to this person, with copies to the claimant and the employing agency.

(5) Subsequent Actions. After releasing the letter, the CE should set a call-up for the number of days specified in the letter. The CE should consider fully any new evidence submitted in response to the request. If disallowance is still indicated, the CE should prepare a formal decision as outlined in paragraphs 4 and 5 below. The CE should also prepare a formal decision if the indicated amount of time has elapsed with no response.

c. Contents of Disallowance. Each disallowance must contain findings of fact sufficient to identify the benefit being denied and the reason for the disallowance. The disallowance must also contain a description of the claimant's appeal rights. For initial decisions, the Letter Generator system contains pre-formatted text. The CE may include additional text if needed. See paragraph 5 below concerning preparation of decisions which are not pre-formatted.

d. Signature Authority. Designated CEs at the GS-11 level may deny the following: initial claims for traumatic injury and occupational disease; claims for recurrence; claims for continuation of pay; requests for medical treatment, equipment, or supplies; requests for surgery; claims for schedule awards in hearing loss cases with no rateable loss; and periods of intermittent wage loss where the claimant has not met the burden of proof to establish entitlement to compensation.

All other disallowances except for disfigurement awards will be prepared for the signature of the Senior Claims Examiner (SrCE). The Assistant District Director or higher-level manager must sign disallowances of disfigurement awards.

2-1400-3 Additional References

Additional References. This paragraph describes where detailed information about various kinds of disallowances may be found. Weighing factual evidence is discussed in FECA PM 2-0809, and weighing medical evidence is discussed in FECA PM 2-0810.

a. Initial Disallowances. Such disallowances are usually based on the claimant's failure to meet his or her burden of proof to establish one of the five basic elements of the claim, i.e., time, civil employee, fact of injury, performance of duty, or causal relationship.

(1) Burden of Proof. FECA PM 2-0800 discusses the claimant's responsibilities in primary cases.

(2) Evidence Required. FECA PM 2-0801 through 2-0805 discuss the information needed to establish the basic elements of a claim.

(3) Affirmative Defense. FECA PM 2-0804 discusses injuries caused by the claimant's intoxication, willful misconduct, or intent to injure oneself or another [see 5 U.S.C. 8102(a)]. The Employees' Compensation Appeals Board (ECAB) has ruled that the OWCP may not raise an affirmative defense for the first time on appeal (see Hope Kahler, 39 ECAB 588). Therefore, in any case where one of these factors is present, the CE must consider it in the original disallowance of benefits.

The decision should include a finding that even if the element in question were met, the claim would be denied based on the reason supporting the affirmative defense. For example: "Even if it were found that your injury occurred in the performance of duty, coverage under the FECA would be denied for the reason that your intoxication was the proximate cause of your injury."

b. Terminations of Continuing Compensation Payments. Such terminations may or may not include medical benefits.

(1) No Continuing Injury-Related Disability. Such a determination requires careful weighing of medical evidence.

(2) Failure to Seek or Accept Suitable Employment. The legal authority is found at section 5 U.S.C. 8106(c). See FECA PM 2-0814.

(3) Conviction for Defrauding the FECA Program. The legal authority is found at section 5 U.S.C. 8148(a). See paragraph 12 below.

c. Disallowances of Particular Benefits.

(1) Continuation of Pay (COP). Form CA-1050 may be used to deny COP. See FECA PM 2-0807.10.

(2) Particular Periods of Disability. In an accepted claim, the medical evidence may not establish entitlement to benefits for all periods of time claimed. See FECA PM 2-0807.

(3) Recurrences of Disability. Claims for recurrence may arise from changes in the claimant's medical condition or work status. See FECA PM 2-1500.

(4) Permanent Partial Impairment. A claim for permanent impairment may be denied, either because the part of the body claimed is not specified in the schedule, or because the medical evidence does not establish entitlement. See FECA PM 2-0808.

(5) Specific Medical Services or Medical Provider. The kinds of medical services which may be at issue are too numerous to list. See FECA PM 2-0810 and 3-0400 for discussions of commonly claimed treatments. The services of a particular provider may be denied if the OWCP does not approve a requested change of physician, or if the physician has been excluded from participation in the FECA program. See FECA PM 3-0800.

(6) Change in Status of Dependents. Such changes may occur because a child reaches the age of 18, marries, becomes a student, ceases to be a student, becomes incapable of self-support, or ceases to be incapable of self-support. For disability cases, see FECA PM 2-0812.10. For death cases, see FECA PM 2-0700.8-10.

(7) Attendants' Allowances. See FECA PM 2-0812.8.

(8) Housing and Vehicle Modifications. See FECA PM 2-1800.

(9) Lump Sums Payments of Compensation. See FECA PM 2-1300. The legal authority for disallowance is found at 20 C.F.R. 10.311.

d. Suspensions. Compensation payments are suspended under certain well-defined circumstances when the claimant fails to cooperate with the OWCP's directions. Benefits are usually restored once the claimant follows the directions given. Suspensions may occur for the following reasons:

(1) Failure to Appear for Medical Appointment. The legal authority is found at section 5 U.S.C. 8123(a). See FECA PM 2-0810.14.

(2) Failure to Submit Reports of Earnings. The legal authority is found at 20 C.F.R. 10.125(a). See FECA PM 2-0812.10.

(3) Failure to Cooperate with Vocational Rehabilitation Efforts. The legal authority is found at section 5 U.S.C. 8104(a). See FECA PM 2-0813.

(4) Refusal to Undergo Treatment for Substance Abuse. The legal authority is found at section 5 U.S.C. 8113. See FECA PM 2-0813.

(5) Conviction and Imprisonment for a Felony. This situation differs from the one described in paragraph b(3) above. Here, the imprisonment must occur for a felony conviction of a crime other than fraud related to a claim under the FECA. The legal authority is found at section 5 U.S.C. 8148. See paragraph 12 below.

e. Forfeiture. A claimant who knowingly fails to report earnings on Form CA-1032 forfeits his or her benefits for the period specified by the form. This situation differs from the one noted in paragraph d(2) above. Here, the report of earnings has been submitted, but it contains false information. The legal authority is found at section 5 U.S.C. 8148(b). See FECA PM 2-0812.10.

f. Rescissions. Section 5 U.S.C. 8128(a) allows the Secretary of Labor to "(1) end, decrease or increase the compensation previously awarded; or (2) award compensation previously refused or discontinued." This authority includes rescission of claims as a whole, or of specific entitlements. However, when the OWCP has accepted a claim and paid benefits, it has the burden of proof to establish that any such acceptance and payment were in error.

Rescission in a death case should never be attempted absent blatant error or clear indication of fraud (see FECA PM 2-0700.17a). Rescission always requires careful and thorough evaluation of all evidence in the context of the OWCP's burden of proof.

g. Other Kinds of Formal Decisions. These decisions, which do not necessarily represent disallowances, include:

(1) Loss of Wage-Earning Capacity Determinations. See FECA PM 2-0814.

(2) Representatives' Fees. See FECA PM 2-1200.

(3) Overpayments. See FECA PM Part 6.

(4) Reconsiderations. See FECA PM 2-1602.

2-1400-4 Notices of Decision

Notices of Decision. This paragraph describes the elements which notices of decision should contain. (The pre-formatted decisions described in paragraph 2c already contain the elements.)

a. Issue. In one or two sentences, the CE should identify the matter(s) under consideration. The CE should include all aspects of the claim which are being denied and clearly state the period of time covered by the disallowance, if such a time frame applies. If more than one issue is involved, subparagraphs should be used to identify each issue separately. If compensation is denied for certain periods, the CE should specify the dates.

b. Requirements for Entitlement. In this section, the CE should outline the criteria which the claimant must meet to establish entitlement to the benefit in question. The CE may use standard language to describe these criteria to the extent that the criteria are generic. However, the description must be sufficiently tailored to the case at hand to provide the reader with a clear picture of the kind of evidence needed in that particular case.

c. Background. In one paragraph, the CE should provide a framework for the reader to understand the issue at hand. This information will usually include:

(1) The name and location of the employing agency;

(2) The claimant's occupation;

(3) The date, location, and circumstances surrounding the injury (claimed or accepted);

(4) The condition(s) claimed or accepted;

(5) Any pertinent prior decisions and remands; and

(6) Any other facts necessary to understand the issue at hand.

d. Discussion of Evidence. In this section, the CE should identify and discuss all evidence which bears on the issue at hand, including any unsuccessful attempts to obtain significant evidence. (Paragraph 5 below discusses evaluation of evidence and effective writing.) As briefly as possible, the CE should:

(1) Summarize the relevant facts and medical opinions, including any new evidence received in response to pre-reduction or pre-termination notice.

(2) Note discrepancies where a conflict of evidence exists and state which version or medical reasoning is being accepted and why.

(3) Avoid discussing repetitive material and evidence (e.g., medical reports) which does not address the issue at hand.

e. Basis for Decision. Here the CE should weigh the evidence overall and describe how the factors described in "Requirements for Entitlement" relate to that evidence. The reasoning behind the CE's evaluation should be clear enough for the reader to understand the precise defect of the claim and the kind of evidence which would overcome it. This section may include citations to and quotes from ECAB decisions, the FECA, the regulations, and/or the FECA PM, as appropriate.

f. Conclusion. Where the decision is prepared for the signature of the SrCE, the CE should provide a specific recommendation for action. Where the CE has signature authority, he or she should state the conclusion reached.

(1) The recommendation or conclusion should usually not exceed one or two sentences for each issue considered. Again, if more than one issue is involved, subparagraphs should be used to identify each issue separately [e.g., (1), (2), etc.]

(2) The content and scope of the statement(s) should correspond with those given under "Statement of Issue". That is, each issue identified at the beginning of the decision must be addressed at the end.

(3) The CE should note the effective date of the disallowance if necessary. For instance, if periodic benefits are being terminated, some time may elapse between the date of the medical evidence establishing that disability ceased and the date of the decision. To avoid creating an overpayment, the CE may specify the end of the next periodic roll cycle as the date on which entitlement ceases.

g. Signature and Date. The CE's or SrCE's name and title should appear at the end of the decision, along with the date. The CE or SrCE should sign the original decision.

2-1400-5 How to Write Notices of Decision.

How to Write Notices of Decision. This paragraph addresses the contents of a notice of decision and how the material should be presented. The decision is a legal document which serves as the basis for further actions in the claim, including appeals, and it must therefore be technically accurate. The decision is also an explanation of the disallowance to individuals who are usually not expert in workers' compensation matters, and it must therefore also be clearly written.

a. Evaluating the Evidence. The CE should observe the following guidelines in preparing findings of fact:

(1) Consider all of the evidence which bears on the issue at hand. It may be useful to list all pertinent documents in file before starting to write.

5. How to Write Notices of Decision. (Continued)

(a) Acknowledge the existence of evidence which lacks probative value but omit it from the discussion.

(b) Disregard all evidence not pertinent to the issue and any evidence which has been correctly summarized in previous memorandums.

(2) Make findings from the evidence. The finding of fact is the conclusion drawn from the evidence, not a recitation of that evidence.

(a) For example, a proper finding would be that "the claimant is not disabled for work as a result of the injury," not "the medical report shows that the claimant's injury caused no disability for work."

(b) A finding that claimant failed to meet the burden of proof is properly made from the evidence, or lack of it, and not simply because the claimant did not respond to a request for information from the OWCP.

(3) State the findings in an orderly sequence. Doing so will help ensure that the reason for disallowance follows logically from the facts. Chronological order is often most effective.

For example, in discussing medical evidence leading to termination of benefits, the CE should address the evidence presented by the attending physician, the second opinion medical examiner, and the referee medical specialist, in that order as far as possible. It may then be necessary to discuss clarifying opinions or subsequent reports, but the basic findings and opinions of the three physicians will be clearly set forth, affording a firm basis for further discussion.

(4) State the findings clearly. The CE should phrase the findings so that the reader can interpret them in only one way.

For example, the finding that "the claimant did not sustain a personal injury while in the performance of duty" could mean either that he did not sustain a personal injury or that he was not in the performance of duty at the time of injury. Thus, the meaning would not be clear to the reader.

(5) Confine the discussion to relevant issues. These are the issues which need resolution (i.e., which have not already been resolved in a prior decision).

For example, if the issue is continuing injury-related disability, it is not necessary to make a finding about the claimant's ability to earn wages. The CE needs to make findings about the claimant's medical status only. Or, if the issue is

continuing disability during a specific period of time, it is not necessary to address medical evidence which pertains to other time periods.

b. Writing Effectively. The basic "audience" for each decision consists of the claimant and a supervisor or injury compensation specialist. It may also include the claimant's representative, a Congressional staff member, and/or appellate reviewers. To convey the meaning of the decision to all of these parties clearly, the CE should:

(1) Use simple words and short sentences. Avoid technical terms and OWCP "jargon", and explain any abbreviations used in the text. This approach will assist readers at every level of education and knowledge about workers' compensation claims.

(2) Use the active rather than the passive voice.
For example, state that "The OWCP received the medical report," rather than "The medical report was received by OWCP."

(3) Use the second person. For example, state that "Your psychiatrist diagnosed manic-depressive illness", rather than "Mr. Smith's psychiatrist diagnosed manic-depressive illness".

(4) Divide lengthy discussions into short paragraphs (under 10 lines).

2-1400-6 When to Issue Pre-Termination and Pre-Reduction Notices

When to Issue Pre-Termination and Pre-Reduction Notices. This paragraph discusses when such notices are required, and when they are not. Paragraph 7 addresses their preparation.

a. Notice Required to Terminate/Reduce Compensation. The OWCP must provide notice in all cases where benefits are being paid on the periodic roll, and also before taking the following actions:

(1) Terminating augmented compensation because a dependent unmarried child over 18 years of age is no longer incapable of self-support.

(2) Terminating a survivor's benefit on the ground that the survivor is over 18 years of age and is no longer incapable of self-support.

(3) Terminating or reducing a schedule award before its expiration date because:

(a) The OWCP miscalculated the award, resulting in a decrease in the amount payable. The kinds of error include, but are not limited to, incorrect determinations of: the percentage of impairment; the number of weeks of the award or the expiration date of the award; the application or amount of a cost-of-living increase; or the pay rate.

(b) The medical evidence justifies only an award of shorter duration than that already granted.

Where the adjustment is made after the original award expired, the CE should prepare an amended award and consider applying overpayment procedures as needed.

b. Notice Required to Terminate Medical Benefits. The OWCP must provide notice before terminating any of the following:

(1) An authorization for treatment (e.g., Form CA-16) which was issued 60 days or less in the past.

(2) The services of a specific physician, even with no written authorization, if the OWCP has paid the physician to treat the claimant's work-related injury.

(3) A specific service which the claimant has received, or expects to receive, on a fairly regular and recurring basis for 60 days or more, and for which the OWCP has paid. In this instance, the OWCP has *de facto* authorized the service and led the claimant to expect that payment for it will continue. (If any doubt exists about whether these conditions apply, the CE should prepare a pre-termination notice.)

For example, a claimant who receives psychotherapy twice a week for three months, and is expected to receive it once a week for the next two months, is clearly receiving the service on a regular and recurring basis. If the OWCP proposes to disallow any further psychotherapy at the OWCP's expense after the second month, pre-termination notice must be given.

(4) All medical treatment. Such terminations are usually associated with disallowances of all compensation payments because the claimant is no longer disabled, or the disability is no longer related to the work injury. (However, a claimant who has not received treatment for a long period of time should file a claim for recurrence. See FECA PM 2-1500.) The CE should include specific reference to medical benefits in preparing the pre-termination notice.

c. Notice Not Required to Terminate/Reduce Compensation. Pre-termination notice is not needed to end daily roll payments if such payments have continued less than a year, or before terminating or reducing benefits when:

(1) The claimant dies.

(2) The claimant returns to work.

(3) The claimant is convicted of defrauding the FECA program.

(4) The claimant forfeits compensation by failing to report earnings.

d. Notice Not Required to Terminate Medical Benefits. Pre-termination notice is not needed when:

(1) The physician indicates that further medical treatment is not necessary or that treatment has ended.

(2) The OWCP denies payment for a particular charge on an exception basis. For example, disallowance of a bill because the treatment was not given for the accepted condition does not represent a termination of an authorization of medical benefits, and pre- termination procedures do not apply.

e. Notice Not Required to Suspend Compensation.
Pre-termination notice is not needed before suspending compensation payments because the claimant did not undertake certain actions required by the OWCP, as follows:

(1) Failure to report earnings from employment as required by 5 U.S.C. 8106(b);

(2) Failure or refusal to seek or accept suitable employment as required by 5 U.S.C. 8106(c);

(3) Refusal to undergo a medical examination required by 5 U.S.C. 8123; or

(4) Refusal to undergo treatment for substance abuse (see 5 U.S.C. 8113).

(5) Conviction and imprisonment for a felony other than defrauding the FECA program (see 5 U.S.C. 8148).

The CE must, however, notify the claimant of the legal basis for the action and the consequences of failure to comply, and provide the claimant an opportunity to comply with the OWCP's instructions, before suspending benefits.

2-1400-7 How to Issue Pre-Termination and Pre-Reduction Notices

How to Issue Pre-Termination and Pre-Reduction Notices.
This paragraph discusses the contents of such notices, their review and release, and the status of payments to the claimant while a termination or reduction of benefits is pending. Such notices do not by themselves constitute decisions to terminate or reduce compensation.

a. Contents of Notice. The notice outlines the basis for the planned action, and it should be accompanied by a copy of the evidence which the OWCP is using to make its determination. Where periodic compensation payments are to be terminated or reduced, the CE will prepare the following:

(1) Notice of Proposed Decision. This document discusses the proposed action and the reasons for it, including a detailed discussion of the weight of the medical evidence, if appropriate. It also recommends termination or reduction of benefits.

Where the CE recommends reduction of compensation based on a constructed wage-earning capacity, the notice should contain the title, description, and requirements of the selected position, and the computation of the proposed reduction of compensation (a copy of Form CA-816).

Sample notices of proposed decisions are shown as Exhibit 1 (termination) and Exhibit 3 (reduction).

(2) Letter to Claimant. This letter, which is prepared for the signature of the SrCE, serves to:

(a) Notify the claimant of the proposed action;

(b) Advise the basis for that action by furnishing a copy of the notice of proposed decision and a copy of the evidence on which the determination is based; and

(c) Give the claimant the opportunity to submit evidence or argument relevant to the proposed action within 30 days from the date of the letter.

Where termination of compensation is proposed, the letter should also advise the claimant to contact the Office of Personnel Management (or the servicing personnel office, for USPS employees) concerning restoration rights. Sample letters are shown as Exhibit 2 (termination) and Exhibit 4 (reduction).

b. Review and Release of Proposed Decision. The CE should refer the case file,

with the notice of proposed decision and a copy of the evidence on which the determination is based (e.g., the medical report which represents the weight of the medical evidence) to the SrCE for review. The SrCE will review the notice of proposed decision and the attachments. The SrCE may not delegate responsibility for reviewing and signing notices of proposed action.

(1) Agreement with Recommendation. If the SrCE agrees, he or she will so indicate on the notice and release the letter advising the claimant of the proposed termination or reduction.

(2) Disagreement with Recommendation. If the SrCE disagrees, he or she will return the case to the CE with instructions for further action.

c. Status of Payments. Compensation and medical benefits should not be terminated or reduced during the 30-day period. Payment should continue until any evidence submitted by the claimant has been reviewed and a formal decision has been issued.

2-1400-8 Responses to Pre-Termination and Pre-Reduction Notices

Responses to Pre-Termination and Pre-Reduction Notices. This paragraph discusses the claimant's response to a notice of proposed termination or reduction. Submission of additional evidence or arguments does not constitute a request for reconsideration under 5 U.S.C. 8128, nor does it affect the exercise of the claimant's appeal rights once the final decision is issued. The CE should take the following actions based on the claimant's response:

a. No Reply. If the claimant does not respond within 30 days, the CE should prepare the notice of decision.

b. Interim Reply. A claimant may state that he or she intends to submit additional evidence but cannot do so within the 30-day period. The CE should advise the claimant that the OWCP will issue a decision at the end of the 30-day period and that the claimant may submit the evidence later, in support of a request for reconsideration of the final decision. If the evidence reaches the file before the decision is released, either within or beyond the 30-day period, the CE must consider and act upon it accordingly.

c. Additional Evidence. If the claimant submits additional evidence or argument, the CE must evaluate it and undertake additional development where indicated.

(1) Repetitious, Cumulative, or Irrelevant Evidence. Such evidence does not require further development. The CE should prepare a notice of decision which finds that the submission is repetitious, cumulative, or irrelevant and recommends termination or reduction. Exhibit 5 shows a sample decision.

(2) Insufficient Evidence. If the evidence submitted does not overcome the evidence of record and does not result in the need for further development, the CE should prepare a notice of decision recommending termination or reduction of benefits. Exhibit 6 shows a sample decision.

(3) Sufficient Evidence. If the evidence submitted overcomes the evidence on which the proposed action was based, the CE should prepare a letter to the claimant for the CE's signature advising that benefits will continue. Exhibit 7 shows a sample letter.

d. Further Medical Development. If the evidence submitted requires the CE to develop the medical evidence further (e.g., it creates a conflict of medical opinion which must be resolved by referral to an impartial medical specialist), the CE should act promptly to resolve the issue.

(1) Letter to Claimant. This letter should advise that:

(a) The case is being referred because the evidence submitted by the claimant resulted in a conflict of medical opinion requiring resolution by an impartial medical specialist;

(b) The results of this referral may lead to immediate termination (or reduction) of compensation, with no second notice of proposed action; and

(c) The claimant should submit any further relevant evidence or argument within 30 days.

(2) Review by District Medical Adviser (DMA). The CE may need to consult the DMA for technical advice in evaluating medical evidence. In such instances, where the DMA's comments do not constitute "evidence upon which the decision was based", the CE need not furnish them to the claimant as part of the OWCP's decision.

(3) Second Notice Not Required. The CE need not issue a second notice of proposed action based on either the contents of the specialist's report or any delay in receiving it.

e. Outcomes. After the CE has considered any response offered to a pre-reduction or pre-termination notice and taken appropriate action, he or she should issue one of the following:

(1) A Letter Advising That Benefits Will Continue.

(2) A Notice of Decision. A copy of the notice of proposed termination or reduction should be included.

(3) A Form CA-1048 or Form CA-181 with a Cover Letter. This letter advises the claimant that the proposed reduction of compensation has been made final. It should be accompanied by a copy of the proposed reduction. Exhibit 8 shows a sample letter.

2-1400-9 Cover Letters

Cover Letters. This paragraph discusses the preparation of cover letters for disallowances conveyed by notice of decision. In death claims, Form CA-1079 is used, and in disability claims, Form CA-1042 is used. (Where entitlement to medical treatment continues, the CE should ensure that the sentence terminating further medical benefits is omitted from Form CA-1042.)

The cover letter should be addressed to the employee, with copies to the agency and any representative. If a representative is present in the case, the letter should be sent to this person with copies to the claimant and agency. Additional copies of the decision may need to be prepared, as follows:

a. Medical Providers. If medical benefits are denied, all doctors and facilities currently furnishing medical care to the claimant must be advised that the OWCP will no longer pay for treatment rendered.

b. OWCP Nurses and Rehabilitation Counselors. Registered nurses and vocational rehabilitation counselors working with a claimant at the direction of the OWCP should also be advised if compensation is terminated.

c. Office of Personnel Management (OPM). When the OWCP terminates benefits because the claimant is no longer disabled, and the case file shows that the claimant has applied for a disability annuity, the CE should notify the OPM of the termination. The OPM can then decide whether to reinstate a disability annuity which was suspended for receipt of compensation, or to accept a recently-filed application.

(1) When to Notify. The CE should include the OPM on the cover letter when:

(a) Compensation is being terminated because the medical evidence and/or actual work activity in the private sector establish that the claimant is no longer disabled; and

(b) A claim form or other information in the case file contains a CSA number, an inquiry from OPM's Compensation Group, or other indication that the claimant has applied for a Civil Service annuity.

Unless it is clear that the claimant has applied for an annuity based upon age and length of service, the CE should assume that the claimant has applied for a disability annuity. The time which has elapsed since the claimant filed the application is immaterial.

(2) Preparing Information. The CE should photocopy the notice of decision for OPM and write the CSA number in the upper right corner of the top sheet. The information should be sent to:

Office of Personnel Management
Employee Service Records Center
P. O. Box 45
Boyers, PA 16017

(3) Medical Reports. After examining the notice of decision, OPM personnel may wish to obtain certain medical reports from the compensation file. The CE should respond to such requests by sending a photocopy of the desired report(s) to the OPM.

2-1400-10. Appeal Rights

Appeal Rights. This paragraph describes the need to include the correct appeal rights with each decision, and a brief description of each of those rights.

a. Initial Disallowances. When the claim as a whole or any particular benefit is first denied, the descriptions of appeal rights as they appear on Forms CA-1042 and CA-1079 will correctly advise the claimant of his or her rights. These courses of action include:

(1) Hearing. The claimant may request a hearing if the injury or death occurred after July 4, 1986. Section 5 U.S.C. 8124 provides, however, that the hearing must be requested before any reconsideration is undertaken. The claimant may (but is not required to) submit new evidence in connection with a hearing.

(2) Reconsideration. To support a request for reconsideration, the claimant must submit new evidence or argument for error in fact or law.

(3) Review by Employees' Compensation Appeals Board. The ECAB will not consider new evidence. Therefore, any appeal to that body must proceed on the basis of the record as it stands.

b. Later Disallowances. If a benefit has previously been denied, the CE must ensure that the claimant is not advised in error of the right to a hearing where reconsideration has already been undertaken, or where the claimant has already had a hearing on the issue in question. A description of the procedures involved in requesting and processing various forms of appeal is found in FECA PM 2-1600.

2-1400-11 Issuing Decisions

Issuing Decisions. This paragraph addresses the form of final decisions and the steps in reviewing and releasing them. After preparing the decision, to include a copy of the evidence upon which the decision was based (e.g., the referee specialist's report), the CE should do the following:

a. For Decisions Released by CE. Complete items 27, 28, and 29 on the Form CA-800, enter status changes into the CMF, file the original signed decision in the case record, and release the copies of the decision.

b. For Decisions Released by SrCE. Route the decision and case file to the SrCE for review, signature, and release, ensuring that the status changes are entered into the CMF.

(1) The SrCE should complete items 27, 28, and 29 on the Form CA-800 when the decision is released. The original signed decision is filed in the case record.

(2) If the SrCE or other reviewer has provided numerous additional comments or has extensively edited the decision, the CE should revise the decision to incorporate all findings and conclusions in the text before release.

2-1400-12 Convictions for Fraud and Imprisonment for Other Felonies

Convictions for Fraud and Imprisonment for Other Felonies. This paragraph addresses the effects of such convictions on benefits under the FECA.

a. Background. Public Law 103-112, enacted on October 21, 1993, prohibited individuals convicted of fraud related to claims under the FECA from receiving benefits under the Act. Public Law 103-333, enacted on September 30, 1994, amended the FECA by adding a new section 5 U.S.C. 8148, which provides for (a) the termination of benefits payable to beneficiaries who have been convicted of defrauding the program, and (b) the suspension of benefits payable to beneficiaries imprisoned as a result of felony conviction.

b. Source of Advice. District office staff may be advised by the DOL Office of Inspector General (OIG), the Inspection Service of the United States Postal Service, employing agencies, or other persons, including United States Attorneys' offices, if a person receiving or claiming benefits under the FECA is convicted of filing a false claim or statement (i.e., submitting a false Form CA-1032) or otherwise defrauding the FECA program, or is convicted of another felony resulting in imprisonment.

c. Nature of Conviction. On receiving such information, the CE should determine the exact nature of the conviction and the provision of section 5 U.S.C. 8148 which applies.

(1) Paragraph (a) (or Public Law 103-112, for convictions between October 21, 1993 and September 30, 1994), addresses only convictions for fraud in connection with claims under the FECA. It requires termination of all benefits, including those for dependents. The definition of fraud is found in section 18 U.S.C. 1920, as shown in Exhibit 9.

(2) Paragraph (b) addresses convictions and imprisonments for felonies unrelated to claims under the FECA, and it allows for payments to dependents.

d. Documentation. Before any action is taken to terminate or suspend compensation, the file must contain: a copy of the indictment or information; a copy of the plea agreement, if any; a copy of the document containing a guilty verdict; and/or a copy of the court's docket sheet. Such documents must not only contain evidence establishing that the person was convicted, but also that the conviction is related to the

claim for, or receipt of, any benefits under the FECA.

e. Effective Date.

(1) In fraud cases, compensation should be terminated effective the date of the conviction, which is the date of the verdict or, in the case of a plea bargain, the date the claimant made the plea in open court (not the date of sentencing or the date court papers were signed). The Office of the Inspector General and the Regional Solicitor may be able to help obtain documents and/or determine the date of the conviction.

(2) In cases involving convictions for felonies unrelated to claims under the FECA, but which result in imprisonment, the CE will need to suspend or adjust benefits effective the date of imprisonment. The CE should advise the claimant by letter of the action taken, the reason for it, and the need to notify OWCP upon release from prison so that benefits can be adjusted if warranted.

f. Termination in Cases Involving Fraud.

(1) District office staff who learn that such legal action is under way and that a conviction may result should ask the investigatory body to keep them advised of the proceedings so that benefits can be promptly terminated if the conviction occurs. Where a conviction appears imminent, it may be advisable to terminate periodic roll benefits and pay compensation on the daily roll to help avoid overpayments.

(2) No pre-termination notice is required before issuing a formal decision, which should be prepared for the District Director's signature. The decision should take the form of a letter which terminates further entitlement to FECA benefits and contains appeal rights. See the sample letter shown as Exhibit 10.

g. Payments in Cases with Felony Conviction/Imprisonment.

(1) If the claimant has eligible dependents, payment should be calculated by applying the percentages of section 8133(a)(1) through (5) to the claimant's gross current entitlement, i.e., 50 percent of gross current entitlement to the spouse if there is no child, or 45 percent to the spouse if there is a child (children), with 15 percent to each child, not to exceed 75 percent of gross current entitlement.

The CE should manually calculate the entitlement using the appropriate percentage as stated above and set up the payment using the gross override function with appropriate deductions for health benefits and optional life insurance. Adjudication and status codes should remain the same. The check should be made payable to the beneficiary or guardian, in the case of a minor.

(2) If the decision concerning entitlement is pending when the claimant is convicted and sent to prison, and compensation is due for a period of time prior to imprisonment, payment for that period may not be made until the claimant's release. Direct payment may be made to dependents for periods of disability during imprisonment, however.

(3) When the claimant is released from prison, the benefits must be restored to the usual rate, i.e., 75 percent of the pay rate, assuming that at least one eligible dependent still exists. Should this change be delayed, a simple adjustment may be made; it will not be necessary to declare overpayments for amounts paid to dependents, or ask the dependents to return checks received after the claimant is released from prison.

h. Tracking and Notification to National Office. Each office should designate one person to handle such cases, preferably the same person designated to track information related to investigations (see PM Chapter 2-0402i). Copies of all decisions terminating or suspending entitlement under the FECA must be sent to the National Office, as well as a statement showing the dollar amount of the gross FECA entitlement and the amount paid to the dependents while the claimant is imprisoned.

2-1400 Exhibit 1: Sample Notice of Proposed Termination

File Number:
Employee:

NOTICE OF PROPOSED DECISION

Issue: The issue is whether your injury-related disability continues, thus entitling you to further compensation for wage loss.

Requirements for Entitlement: For you to be entitled to continuing compensation payments, the medical evidence in your case must establish that you are still disabled for work. If so, the medical evidence must further show that your disability is still related to your work injury, and not some other medical condition. The benefits of the Federal Employees' Compensation Act are not payable after work-related disability has ended.

Background: As a Letter Carrier with the U.S. Postal Service in Rome, New York, you sustained a low back sprain on November 5, 1990. This injury occurred when you lifted an overloaded mailbag before setting out on your route. The Office of Workers' Compensation Programs accepted your case for lumbosacral sprain and paid compensation after continuation of pay ended.

Discussion of Evidence: On December 28, 1995, Dr. David Smith, your attending physician and a board-certified orthopedist, submitted a report of his examination of you on that date. Dr. Smith stated that you continued to be totally disabled due to the injury of November 5, 1990. However, Dr. Smith did not support this opinion with the results of any tests or objective findings from physical examination.

We asked Dr. Smith to describe the basis for his finding of continued total disability. In a letter dated January 15, 1996, Dr. Smith recited your complaints and stated that since no other intervening injury has occurred, your current disability is related directly to the injury of November 5, 1990.

Because Dr. Smith's reports lack supportive findings, we referred you to Dr. William Jones, a board-certified orthopedist, for a second opinion examination. The material sent to Dr. Jones prior to the examination included a Statement of Accepted Facts and copies of all medical reports in your file.

In a report dated April 4, 1996, Dr. Jones reported that he examined you on April 3, 1996 and that he found no objective findings to support disability. X-rays taken revealed no abnormality of the lumbosacral spine and physical examination showed no muscle spasm, tenderness, or limitation of motion of the low back. Dr. Jones noted that while Dr. Smith supported total disability, Dr. Smith's reports contained no objective findings in support of that conclusion.

Basis for Decision: While Dr. Smith reported total disability, his opinion is not supported by objective findings or adequate rationale. Therefore, his opinion is of diminished probative value.
Dr. Jones had a Statement of Accepted Facts and copies of all medical evidence of record. He took x-rays and performed a thorough physical examination of you. On this basis, he stated that there were no objective findings to support your complaints and that you were capable of performing your work without restrictions.

Given Dr. Jones' thorough examination of you and support for the conclusion reached, his report represents the weight of medical evidence with respect to continuing injury-related disability.

Conclusion: It is recommended that compensation be terminated for the reason that the weight of the medical evidence of record establishes that you have no continuing disability as a result of the injury of November 5, 1990.

CLAIMS EXAMINER

DATE

Dear CLAIMANT NAME:

Under the provisions of the Federal Employees' Compensation Act (5 U.S.C. 8101 et seq.) and the program's regulations (20 C.F.R. 10.1 et seq.), we propose to terminate your compensation payments for wage loss on account of the injury identified above. The basis for this action is described in the Notice of Proposed Decision dated May 10, 1996, a copy of which is enclosed. Also enclosed is a copy of the report of Dr. William Jones dated April 4, 1996, which serves as the basis for the proposed termination.

If you disagree with the proposed action, you may submit additional evidence or argument relevant to the issue described in the Notice.
Send any such evidence or argument to this office within 30 days of the date of this letter. We will not terminate your compensation during this 30-day period, but if no response is received within 30 days, we will terminate your compensation at that time.

Under the regulations of the Office of Personal Management (OPM), an employee who recovers from a compensable injury within one year is entitled to be restored to the job held when injured, or equivalent. Such an employee is expected to apply for reemployment with his or her agency immediately upon recovery. An employee who takes more than one year to recover is entitled to priority consideration, provided he or she applies for reemployment within 30 days after compensation ends.

You may obtain further information about these rights from your agency or the OPM. You may also wish to contact your agency or the OPM for advice on continuing any health insurance and/or life insurance coverage you may have.

Sincerely,

SENIOR CLAIMS EXAMINER

Enclosures

2-1400 Exhibit 3: Sample Notice of Proposed Reduction

File Number:
Employee:

NOTICE OF PROPOSED DECISION

Issue: The issue is whether you remain totally disabled, and if not, whether the position of Mechanical Drafter is medically and vocationally suitable for you.

Requirements for Entitlement: For you to be entitled to continuing compensation payments, the medical evidence in your case must establish that you continue to be totally disabled from performing all work due to your work injury, and not some other medical condition. Compensation for total disability is not payable when the claimant is capable of performing gainful work according to the factors set forth in section 8115(a) of the Federal Employees' Compensation Act.

Background: You sustained multiple fractures on October 27, 1989 when you fell from a scaffold while performing your duties as a Welder for the Pacific Naval Shipyard in North Bay, Oregon. You have received periodic compensation payments for temporary total disability since continuation of pay ended.

Discussion of Evidence: In a report of examination dated July 26, 1995, Dr. Mark Dwyer, an orthopedist who had treated you since your injury, stated that you were partially disabled as a result of the employment injury. However, Dr. Dwyer referred you to Dr. Esther Parks, a Board-certified orthopedist, for further evaluation.

You then submitted a report dated September 12, 1995, from Dr. Edward Lyon. In this report, Dr. Lyon stated that he had treated you since August 7, 1995, and opined that you were still totally disabled as a result of your work-related injury. However, Dr. Lyon's opinion contained no objective findings or medical reasons for his statements.

In a report dated September 17, 1995, Dr. Parks stated that she had fully examined you, that she agreed with Dr. Dwyer's assessment, and that you were capable of performing employment with restrictions against standing more than four hours per day and lifting over 25 pounds. The Pacific Naval Shipyard advised that it had no work which you could perform given the restrictions imposed.

You were then referred for vocational rehabilitation services. The Rehabilitation Counselor assigned to your case reported that you had experience in drafting and used blueprints in your work as a Welder. You had also taken two mechanical drafting courses of eight weeks' duration each (two nights per week) while working as a Welder.

Basis for Decision: The Rehabilitation Counselor worked with you to secure employment as an entry-level Mechanical Drafter. However, you did not obtain employment at the companies to which you applied. In a final report dated February 4, 1996, the Rehabilitation Counselor advised that you had not obtained employment as a Mechanical Drafter but that you qualified for and could perform this work. The Rehabilitation Counselor also advised that the position of Mechanical Drafter is available in your commuting area and that entry-level pay for this position is $9.50 per hour.

The Dictionary of Occupational Titles (DOT) describes the position of

Mechanical Drafter (code 007.281-101) as follows:

Drafts detailed working drawings of machinery and mechanical devices, indicating dimensions and tolerances, fasteners and joining requirements and other engineering data. Drafts multiple view assembly and subassembly drawings as required for the manufacture and repair of mechanisms.

The DOT describes the job requirements as follows:

Sedentary position (lifting up to 10 pounds).

Requires the ability to reach, handle, finger, and feel.

Must be able to see.

The work is inside 75% or more of the time.
Requires 2 to 4 years of experience and/or education.

We sent the position description and the requirements for the position of Mechanical Drafter to Dr. Parks for review and comment. In a report dated March 6, 1996, Dr. Parks stated that the position was within your injury-imposed work restrictions, and she saw no reason why you could not perform the job.

The computation of your gross compensation for loss of wage-earning capacity, which is based on ability to earn $9.50 per hour as a Mechanical Drafter, is shown on the attached Form CA-816.

Conclusion: It is recommended that compensation be reduced for the reason that the position of Mechanical Drafter is suitable for you, both medically and vocationally, and represents your wage-earning capacity.

CLAIMS EXAMINER

DATE

2-1400 Exhibit 4: Sample Letter Conveying Proposed Reduction

Dear CLAIMANT NAME:

Under the provisions of the Federal Employees' Compensation Act (5 U.S.C. 8101 et seq.) and the program's regulations (20 C.F.R. 10.1

et seq.), we propose to reduce your compensation for wage loss on account of the injury identified above to reflect your wage-earning capacity. The enclosed Notice of Proposed Decision dated March 19, 1996 describes the basis for this action.

Also enclosed are copies of the final rehabilitation report dated February 6, 1996, the reports of Dr. Esther Parks dated September 17, 1995 and March 6, 1996, and Form CA-816, which shows how we have computed your wage-earning capacity.

If you disagree with the proposed action, you may submit additional evidence or argument relevant to your capacity to earn wages in the position described in the Notice of Proposed Decision.

You should send any such evidence or argument to this office within 30 days of the date of this letter. We will not reduce your compensation during this 30-day period. If no response is received within 30 days, however, we will reduce your compensation at that time.

Sincerely,

SENIOR CLAIMS EXAMINER

Enclosures

2-1400 Exhibit 5: Sample Notice of Decision--Cumulative Evidence

File Number:
Employee:

NOTICE OF DECISION

Issue: The issue is whether the proposed termination of your compensation benefits should be made final.

Requirements for Entitlement: For you to be entitled to continuing compensation payments, the medical evidence in your case must establish that you are still disabled for work. If so, the medical evidence must also establish that your disability is still due to your work injury, and not to some other medical condition. The benefits of the Federal Employees' Compensation Act are not payable after work-related disability has ceased.

Background: On May 15, 1996, this office issued you a Notice of Proposed Termination of Compensation on the basis that your injury-related disability had ceased. The contents of the Notice are incorporated by reference. You

were given 30 days to submit additional relevant evidence or argument if you disagreed with the proposed action.

Discussion of Evidence: In response, you submitted a report dated May 27, 1996 from Dr. David Smith, your attending physician. In the report, Dr. Smith stated that he had treated you since the date of injury, that you continue to complain of low back pain, and that he continues to believe that you are totally disabled as a result of your work injury.

Basis for Decision: Like his previous reports, Dr. Smith's report lacks objective medical findings to support his conclusion that you are totally disabled as a result of your work injury. Therefore, his report is considered cumulative evidence. Dr. Smith's report is of less probative value than the report of Dr. Jones, to whom this office referred you for a second opinion examination. Dr. Jones' report still represents the weight of the medical evidence in your case because it supplied medical reasons for his conclusion that you are no longer totally disabled.

Conclusion: It is recommended that the proposed termination of your compensation benefits be made final effective June 29, 1996 for the reason that the weight of the medical evidence of record establishes that your injury-related disability ceased no later than that date.

CLAIMS EXAMINER

DATE

2-1400 Exhibit 6: Sample Notice of Decision--Insufficient Evidence

File Number:
Employee:

NOTICE OF DECISION

Issue: The issue is whether the proposed reduction of your compensation benefits should be made final.

Requirements for Entitlement: For you to be entitled to continuing compensation payments, the medical evidence in your case must establish that you continue to be totally disabled from performing all work due to your work injury, and not some other medical condition. Compensation for total disability is not payable when the claimant is capable of performing gainful work according to the factors set forth in section 8115(a) of the Federal Employees' Compensation Act.

Background: On March 21, 1996, you were notified of the proposed reduction of compensation to reflect your wage-earning capacity as a Mechanical Drafter. The contents of that Notice are incorporated by reference. You were given 30 days to submit additional relevant evidence or argument if you disagreed with the proposed action.

Discussion of Evidence: In response, you submitted a report dated March 28, 1996 from Dr. Thomas Goff, an orthopedist, stating that you were totally disabled from performing gainful employment. Dr. Goff gave a brief history of injury, recited your complaints of pain and inability to work, and concluded that based on these complaints you were obviously incapable of employment. The report does not reflect a thorough examination of you. It recites your complaints without providing any objective findings to support either those complaints or the physician's conclusion that you are totally disabled.

Basis for Decision: The report of Dr. Goff is of diminished probative value in that he is not a board-certified orthopedist and his opinion is not supported by medical findings showing that you are totally disabled. The weight of the medical evidence is represented by the reports of Dr. Esther Parks, your attending physician. The weight of the medical evidence establishes that you are partially disabled and capable of performing the duties of a Mechanical Drafter.

Conclusion: It is recommended that the proposed reduction of your compensation benefits be made final effective May 4, 1996 for the reason that the weight of the medical evidence establishes that the position of Drafter, Mechanical, is medically and vocationally suitable in accordance with the factors set forth in 5 U.S.C. 8115(a).

CLAIMS EXAMINER

DATE

2-1400 Exhibit 7: Sample Letter Conveying Final Notice of Reduction

Dear CLAIMANT NAME:

This letter is to advise you that the proposed decision to reduce your compensation, as conveyed by letter of April 12, 1996, has been made final. The basis for this action is as follows:

The additional evidence which you submitted is not sufficient to

warrant modification of the decision that the position of Mechanical Drafter represents your wage-earning capacity on the basis of its medical and vocational suitability. The reasons for this conclusion are described in the enclosed copy of the Notice of Decision dated June 16, 1996.

The enclosed Form CA-1048 describes your entitlement to compensation and your rights to hearing, reconsideration, and appeal should you disagree with this decision.

Sincerely,

SENIOR CLAIMS EXAMINER

Enclosures

2-1400 Exhibit 8: Sample Letter Conveying Final Decision--New Evidence Establishes Continuing Entitlement

Dear CLAIMANT NAME:

This letter pertains to the Notice of Proposed Decision issued by this office on May 15, 1996.

You submitted a medical report from Dr. Harold Washington dated May 31, 1996. This report establishes that you remain totally disabled as a result of your injury of November 5, 1985.

[*Or, in a case involving further development as a result of the evidence submitted by the claimant:* The report of Dr. Paul Connors, the referee medical specialist to whom you were referred, establishes that you remain totally disabled as a result of your injury of November 5, 1985. A copy of Dr. Connors' report dated August 3, 1996 is also enclosed.]

Therefore, we have decided not to terminate your compensation payments. Until further notice, they will continue on the same basis as in the past.

Sincerely,

SENIOR CLAIMS EXAMINER

Enclosures

2-1400 Exhibit 9: Definition of Fraud (18 U.S.C. 1920)

(b) CRIMINAL PENALTIES-(1) Section 1920 of title 18, United States Code, is amended to read as follows:

"§1920. False statement or fraud to obtain Federal employee's compensation

"Whoever knowingly and willfully falsifies, conceals, or covers up a material fact, or makes a false, fictitious, or fraudulent statement or representation, or makes or uses a false statement or report knowing the same to contain any false, fictitious, or fraudulent statement or entry in connection with the application for or receipt of compensation or other benefit or payment under subchapter I or III of chapter 81 of title 5, shall be guilty of perjury, and on conviction thereof shall be punished by a fine of not more than $250,000, or by imprisonment for not more than 5 years, or both; but if the amount of the benefits falsely obtained does not exceed $1,000, such person shall be punished by a fine of not more than $100,000, or by imprisonment for not more than 1 year, or both".

(2) The table of sections for chapter 93 of title 18, United States Code, is amended by amending the item relating section 1920 to read as follows:

"1920. False statement or fraud to obtain Federal employee's compensation".

(c) EFFECTIVE DATE.-The amendments made by this section shall take effect on the date of the enactment of this Act. The amendments made by subsection (a) shall apply to claims filed before, on, or after the date of enactment of this Act, and shall apply only to individuals convicted after such date of enactment.

2-1400 Exhibit 10: Sample Letter Denying Benefits Due to Fraud

Dear Claimant:

We have been informed that on DATE, you were found guilty of [*or* pleaded guilty to] defrauding the Federal Employees' Compensation Act (FECA) program. More specifically, you were found guilty of [*or* pleaded guilty to] BRIEFLY STATE SPECIFIC CIRCUMSTANCES.

Section 5 U.S.C. 8148 states that "Any individual convicted of a violation...relating to fraud in the application for or receipt of any benefit" under the FECA shall forfeit entitlement to such benefit.

Thus, because of your conviction as outlined above, you are not entitled to receive further benefits under the FECA. The OWCP will pay for the authorized medical treatment you received prior to the date of this decision. However, the OWCP will not pay for further medical treatment. Compensation benefits are terminated effective DATE. Any checks received after that date must be returned to this Office.

A description of your rights to review and appeal of this decision are enclosed.

Sincerely,

District Director

Enclosure

cc: Employing Agency

2-1500 RECURRENCES

Paragraph	Subject	Date	Trans. No.
	Table of Contents	05/03	03-02
1	Purpose and Scope	01/98	98-04
2	Policy	01/95	95-07
3	Definitions	01/95	95-07
		05/97	97-10
4	Claims for Recurrence	01/95	95-07
5	Recurrence of Medical Condition	01/95	95-07
		05/03	03-02
6	Recurrent Disability for Work		

	Within 90 Days of Return to Duty	01/95	95-07
7	Recurrent Disability for Work After 90 Days of Return to Duty	01/95	95-07
		05/97	97-10
		05/03	03-02
8	Compensation for Recurrent Disability	08/00	00-11

2-1500-1 Purpose and Scope

1. Purpose and Scope. This chapter describes policies and procedures for developing claims for recurrent medical conditions and recurrent disability. It also addresses return to work issues related to recurrences. The Disability Tracking System is addressed in FECA PM 2-0601.

2-1500-2 Policy

2. Policy. The purpose of this paragraph is to describe the policies of the Office of Workers' Compensation Programs (OWCP) with respect to claims for recurrence of medical condition and recurrence of disability. OWCP's regulations at 10.121 address the evidence which must be submitted to support such a claim.

For recurrences of medical conditions, the claimant has the burden of proof to establish the relationship of the claimed recurrence to the injury. For recurrences of disability, the claimant has the additional burden of establishing that the claimed disability for work has resulted from the accepted condition. The burden exists whether the claimant returns to regular or light duty; in Terry L. Hedman, 38 ECAB 222, the Board stated that, "As part of this burden the employee must show a change in the nature and extent of the injury-related condition, or a change in the nature and extent of the light duty requirements". By administrative determination, the extent of the burden varies according to how much time has elapsed since return to duty.

Cases with approved recurrences of medical conditions should be considered for OWCP nurse services. Cases with approved recurrences of disability for work should be referred for OWCP nurse and vocational rehabilitation services and brought under case management procedures (see FECA PM 2-600, 2-813, and 2-814) so that the best possible medical management and/or early return to work may be realized.

2-1500-3 Definitions

3. Definitions. The purpose of this paragraph to define recurrences for medical care and recurrences of disability.

a. Recurrence of Medical Condition. This term is defined as the documented need

for further medical treatment after release from treatment for the accepted condition when there is no work stoppage. Continued treatment for the original condition is not considered a renewed need for medical care, nor is examination without treatment.

b. Recurrence of Disability. This term includes certain kinds of work stoppages which occur after an employee has returned to work after a period of disability.

(1) It includes a work stoppage caused by:

(a) A spontaneous material change, demonstrated by objective findings, in the medical condition which resulted from a previous injury or occupational illness without an intervening injury or new exposure to factors causing the original illness;

(b) A return or increase of disability due to an accepted consequential injury; or

(c) Withdrawal of a light duty assignment made specifically to accommodate the claimant's condition due to the work-related injury. This withdrawal must have occurred for reasons other than misconduct or non-performance of job duties.

(2) It does not include a work stoppage caused by the following factors (see FECA PM 2-0814.12 concerning these situations):

(a) Termination of a temporary appointment, if the claimant was a temporary employee at the time of the injury;

(b) Cessation of special funding for a particular position or project (e.g., "pipeline" grants);

(c) True reductions in force (RIFs), where employees performing full duty as well as those performing light duty are affected;

(d) Closure of a base or other facility; or

(e) A condition which results from a new injury, even if it involves the same part of the body previously injured, or by renewed exposure to the causative agent of a previously suffered occupational disease. If a new work-related injury or exposure occurs, Form CA-1 or CA-2 should be completed accordingly.

However, in some occupational disease cases where the diagnosis remains the same but disability increases, the claimant may submit Form CA-2a rather than

filing a new claim. For instance, a claimant with carpal tunnel syndrome who has returned to work, but whose repetitive work activities result in the need for surgery, need not be required to file a new claim. However, in emotional stress cases a new claim should always be required.

2-1500-4 Claims for Recurrence

4. Claims for Recurrence. The purpose of this paragraph is to discuss how authorization for further medical care or additional compensation is requested. Such requests may be received on Form CA-2a or by letter.

a. Evaluating the Request. If a formal decision addressing continuing injury-related disability for work has been issued, the claimant may be requesting reconsideration rather than claiming a recurrence. A reconsideration request should refer explicitly to a prior formal decision and ask that the decision be reevaluated, while a request to reopen the case should address some material change in the employee's medical condition or employment status. Requests are sometimes unclear, however, and it is possible to have a valid claim for recurrence in a denied case if the denial was limited to a specific period of time or particular medical services, and the claim for recurrence addresses a different time period or a change in job duties.

b. Advising the Claimant. An employee who requests action from OWCP based on renewed disability for work or documented need for medical care should be asked to complete Form CA-2a, Notice of Employee's Recurrence and Claim for Continuation of Pay. The form should be filled out as follows:

(1) A claimant who is still Federally employed should complete Part A and give the form to the employing agency for completion of Part B.

(2) A claimant who is no longer Federally employed should complete Parts A and C. The form need not be forwarded to the former employing agency for completion of Part B.

c. Determining Whether a Decision is Necessary. Claims for recurrence require adjudication except when:

(1) The claimant is still receiving continuation of pay (COP). Claims for recurrence of disability for work during this time almost always occur within 90 days of return to duty, and thus are considered causally related to the initial injury, as long as no intervening injury occurred. (See paragraph 5 below.)

(2) The recurrence is for medical care only and the claim is still in open

status.

(3) Neither wage-loss compensation nor payment for medical expenses is claimed at present.

In these instances, the CE should file down the form and remove the disability tracking record from the automated system. The CE should note on the form or in a short memo to file why no action is being taken.

d. Advising the Employing Agency. Whether or not the employee is still employed by the Federal agency for which he or she worked at the time of injury, or is carried on its rolls, the Claims Examiner (CE) must provide the agency with copies of any correspondence about a claim for recurrence.

e. Authorizing Benefits. Generally, neither medical treatment nor compensation should be authorized unless the record contains Form CA-2a with supporting information. The CE may authorize an emergency medical examination, however, without waiting for a Form CA-2a.

2-1500-5 Recurrence of Medical Condition

5. Recurrence of Medical Condition. The purpose of this paragraph is to address the evidence needed to adjudicate claims for recurrent medical care.

a. Within 90 Days of Release from Medical Care (as stated by the physician or computed from the date of last examination or the physician's instruction to return PRN). The CE may accept the attending physician's statement supporting causal relationship between the claimant's current condition and the accepted condition, even if the statement contains no rationale, unless:

(1) Clear evidence of an intervening injury appears in the file, in which case factual bridging information should be requested if the necessary information was not submitted with Form CA-2a. (See FECA Program Memorandum 203 for a definition of an intervening injury);

(2) An intervening decision, such as denial of continuing disability on the basis of a referee or second opinion specialist's report which constitutes the weight of medical evidence, has negated this relationship; or

(3) The case was originally accepted for temporary aggravation of a pre-existing condition. In this instance, reasoned opinion supporting causal relationship to the work injury should be required.

(4) The renewed claim involves a different diagnosis from the accepted condition.

b. After 90 Days of Release from Medical Care (again, as stated by the physician or computed from the date of last examination or the physician's instruction to return PRN). The claimant is responsible for submitting an attending physician's report which contains a description of the objective findings and supports causal relationship between the claimant's current condition and the accepted condition.

(1) The medical evidence needed to establish causal relationship is outlined in FECA PM 2-805. It should be as conclusive as the evidence required to establish the original claim.

(2) The CE must evaluate the medical evidence in terms of any intervening injuries or newly acquired medical conditions as described on Form CA-2a. If the information provided with Form CA-2a is not sufficient to obtain a clear picture of the employee's activities and health during the period since release from medical care, the CE should request clarification or additional information as indicated.

(3) As with recurrences of medical conditions within 90 days of release from care, additional medical support for the claim will be needed if an adjudicatory action has negated the original finding of causal relationship, or the original acceptance involved a temporary aggravation of a pre-existing condition.

c. Recurrence Claims for Injuries in which a Destructive Surgery or Permanent Damage has been accepted. Destructive surgeries are normally not authorized except in cases of severe debilitating injury or disease, after all other medical and therapeutic options for relief have been exhausted. Permanent damage usually follows such procedures. If a recurrence be claimed following a destructive surgery that was approved or where permanent damage has been accepted, the claim can be adjudicated without significant development, regardless of the time that has elapsed since the return to work.

2-1500-6 Recurrent Disability for Work Within 90 Days of Return to Duty

6. Recurrent Disability for Work Within 90 Days of Return to Duty. The purpose of this paragraph is to describe the evidence needed to adjudicate claims for recurrence of disability for work filed shortly after return to light or full duty. Recurrences claimed due to withdrawal of light duty are addressed in paragraph 7a below.

a. Burden of Proof. The claimant is not required to produce the same evidence as for a recurrence claimed long after apparent recovery and return to work. Therefore, in cases where recurring disability for work is claimed within 90 days or less from the first

return to duty, the focus is on disability rather than causal relationship.

b. Disability for Work. Assuming that requirements described in paragraph 5 above concerning causal relationship are met, the CE should ask the employee to submit a Form OWCP-5 and/or a narrative statement from the attending physician which describes the duties which the employee cannot perform and the demonstrated objective medical findings that form the basis for renewed disability for work. The CE should obtain a copy of the employee's current position description if it is not already in file and consider assignment of a Field Nurse to the case.

c. Case Management. The CE should consider a second opinion referral when a recurrence of disability is accepted if the claimant is not under the care of a specialist, or if the claimant had previously been released from treatment and disability for work was not expected to recur, or if a previous history of non-work-related disabling medical condition exists and the injury was a relatively minor one. In such cases, the CE should ask the second opinion specialist to address the questions of continuing causal relationship and whether any residuals exist which prevent return to light or full duty.

2-1500-7 Recurrent Disability for Work After 90 Days of Return to Duty

7. Recurrent Disability for Work After 90 Days from Return to Duty. The purpose of this paragraph is to address the evidence needed to adjudicate a claim for recurrence of disability for work for periods after 90 days from return to duty. This evidence differs according to whether the claimant returned to light or full duty. It does not matter whether the case is open or closed.

a. Claimants Performing Light Duty. The reason for claiming the recurrence may be medical, or it may stem from withdrawal of a light duty assignment or other issue affecting the suitability of the work performed. The claimant's work limitations may be well established and stable, or they may be changing in the recovery process.

(1) Burden of Proof. Claimants who are performing light duty are not considered fully recovered from their work-related injuries. This is true whether or not they have been rated for LWEC. Therefore, the claimant's burden of proof is mainly to establish that any increase in disability for work is due to the accepted injury, rather than another cause (see Terry L. Hedman, 38 ECAB 222). However, an increase in pain does not constitute objective evidence of disability (see Sally S. Weinacht, Docket No. 91-1035, issued November 12, 1991).

(2) Medical Issues. The CE should obtain a Form OWCP-5 and a narrative statement from the attending physician which describes the duties which the employee cannot perform and the demonstrated objective medical findings that form the basis of renewed disability for work. This information should be evaluated in light of any intervening injuries or subsequently acquired medical

conditions reported on Form CA-2a. The CE should obtain a copy of the employee's current position description if it is not already in file.

(3) Suitability Issues. If the claim for recurrence of disability for work is based on modification of the claimant's duties, or on the physical requirements of the job, the claimant should be asked to describe such changes, and the employing agency should be asked to comment.

(4) Withdrawal of Light Duty With No Previous LWEC. If the employing agency has withdrawn a light duty assignment made specifically to accommodate the claimant's condition due to the work-related injury (i.e., a RIF or closure of the facility is not involved), and the withdrawal did not occur for cause, the CE need only establish continuing injury-related disability for regular duty to accept the recurrence and begin payment of benefits.

To do so, the CE will need to ensure that the file contains an accurate description of the nature and extent of injury-related disability. If it does not, the CE will need to obtain this information from the attending physician and/or second opinion specialist. After accepting the recurrence, the CE should refer the case for vocational rehabilitation services.

(5) Withdrawal of Light Duty With Existing LWEC Determination. When the employing agency has withdrawn a light duty assignment, which accommodated the claimant's work restrictions and a formal loss of wage-earning capacity (LWEC) decision has been issued, the decision will remain in place. There is no basis for disturbing a formal LWEC unless one of the three accepted reasons for modifying an LWEC applies. These are: (1) the original rating was in error; (2) the claimant's medical condition has changed; or (3) the claimant has been vocationally rehabilitated, either through vocational training or self-rehabilitation, and the wage-earning capacity has increased as a result. The above guideline applies even when a "0%" LWEC is in place.

FECA PM 2-0814.12 addresses situations where employment is terminated due to a RIF or closure of a facility.

b. Claimants Performing Full Duty. Where the employee had returned to full duty for more than 90 days, substantial evidence must show that the recurrence of disability for work is directly related to the original injury.

(1) Burden of Proof. It is the employee's burden to submit factual and medical evidence in support of the claimed recurrence. It is not assumed that any subsequent incapacity involving the injured part of the body is the result of the original injury solely because the original injury was accepted.

(a) Factual evidence includes the items requested on Form CA-2a, i.e., a description of the condition and any changes in duties during the intervening period, and a description of any intervening injuries and medical treatment for them.

(b) Medical evidence includes a description of objective findings, reasoned medical opinion supporting causal relationship, and a discussion of any similar pre-existing or intervening condition affecting the same part of the body.

(2) Evidence. In addition to the medical and factual information requested on Form CA-2a, the CE should send Form CA-1027, Request to Private Employer for Employment History, to confirm the dates of any private employment, the type of employment, and the reason for its termination.

2-1500-8 Compensation for Recurrent Disability

8. Compensation for Recurrent Disability. The purpose of this paragraph is to describe the steps needed to pay compensation in a case where a recurrence of disability for work has been accepted. The employee should submit Form CA-7 to claim compensation. The following guidelines should be observed:

a. Use of COP. Where fewer than 45 days of COP were used, the remaining days may be authorized if less than 45 days have elapsed since the date of first return to duty.

b. Compensation Factors. The claimant may be entitled to a recurrent pay rate (see FECA PM 2-900). If the claimant worked for a private employer, the CE will need to obtain confirmation from the employer of the pay rate reported by the employee in Part C of Form CA-2a.

c. Certification. The CE and certifier are responsible for ensuring that the record contains sufficient medical and factual evidence to establish a causal relationship between the medical condition underlying the recurrent disability for work and the original accepted condition.

d. Schedule Awards. A schedule award and compensation for recurrent disability may be paid for the same injury (though not, of course, at the same time). If the schedule award is being paid in a lump sum, however, compensation is not payable for the duration of the schedule award, though the date of recurrence may be established during that time.

2-1600 REVIEW PROCESS

Paragraph	Subject	Date	Trans. No.
	Table of Contents	**06/97**	**97-12**
1	**Purpose and Scope**	**06/97**	**97-12**
2	**Authority**	**06/97**	**97-12**
3	**Definitions**	**06/97**	**97-12**
4	**Order and Number of Appeals**	**12/91**	**92-09**

2-1600-1 Purpose and Scope

1. Purpose and Scope. This chapter outlines the appeal rights of claimants who have been issued formal decisions by OWCP. These rights include hearing, reconsideration, and review by the Employees' Compensation Appeals Board (ECAB). This chapter summarizes the authority, responsibilities and definitions which apply generally to hearings, reconsiderations and appeals.

Applications for hearings are processed by the Branch of Hearings and Review within the National Office of DFEC, and the applicable procedures are discussed in Chapter 2-1601. Applications for reconsideration are handled by District Office personnel as outlined in Chapter 2-1602. Applications for review by the ECAB, which is an entirely separate entity from OWCP within the Department of Labor, are discussed in Chapter 2-1603.

2-1600-2 Authority

2. Authority.

a. Decision. 5 U.S.C. 8124(a) provides that the Director of the OWCP, under delegation from the Secretary of Labor, shall determine and make a finding of facts and make an award for or against payment of compensation after:

(1) Considering the claim presented by the beneficiary and the report submitted by the immediate superior; and
(2) Completing such investigation as is considered necessary. In this connection, see FECA PM 2-1400.

b. Hearing. Section 5 U.S.C. 8124(b) states that a claimant not satisfied with a formal decision is entitled to a hearing by an OWCP representative if the request is made within 30 days of the date of the decision. This provision, which applies to injuries

occurring on and after July 4, 1966, includes the stipulation that any such request must be made before reconsideration under Section 5 U.S.C. 8128(a) is undertaken.

Apart from the hearing provided under 5 U.S.C. 8124(b), OWCP also provides the opportunity for an oral pre-recoupment hearing on the issues of fault and waiver, to anyone who is notified of an overpayment of benefits and requests a hearing within 30 days. See FECA PM Part 6.

c. Reconsideration. Section 5 U.S.C. 8128(a) provides that OWCP may review and reconsider an award for or against payment of compensation at any time on the Director's own motion or on application from the claimant and may:

(1) End, decrease, or increase the compensation previously awarded; or

(2) Award compensation previously refused or discontinued.

d. Appeal. Effective July 14, 1946, the ECAB was established by Federal Security Order No. 58 and given "all necessary and appropriate powers" to hear and decide appeals taken from determinations made in claims filed under the FECA. The ECAB and its function were transferred to the Department of Labor by Reorganization Plan No. 19 of 1950 (39 Stat. 742). Formal decisions of OWCP, except decisions concerning the amounts payable for medical services and decisions concerning exclusion and reinstatement of medical providers, are subject to review by the ECAB (20 C.F.R. 10.137).

e. Finality of Review. Section 5 U.S.C. 8128 provides that the action of the OWCP in allowing or denying a payment under the FECA is:

(1) Final and conclusive for all purposes and with respect to questions of law and fact; and

(2) Not subject to review by another official of the United States or by a court of mandamus or otherwise. (OWCP is required, however, to respond to any writs of mandamus which may be issued. Such writs direct that action be taken within a specified period of time without directing the particular action to be taken.)

2-1600-3 Definitions

3. Definitions.

a. Claimant. This term includes any individual who has applied directly for benefits

under the FECA. Attorneys, physicians, and other parties who have provided services or supplies to an individual applying for such benefits are not claimants within the meaning of the FECA.

b. Application. This term includes any written communication from a claimant or representative which requests a hearing, reconsideration or appeal of a formal decision; no special form is necessary.

(1) A claimant who expresses or implies disagreement with a formal decision without requesting a specific action should be advised of the basis of the decision and reminded to exercise rights of appeal if further action is desired.

(2) Any file in which a complaint about a formal decision is received should be reviewed informally to assess whether the action leading to the complaint was correct. The CE should determine through correspondence with the claimant whether the inquiry in effect constitutes a request for exercise of appeal rights.

c. Formal Decision. Chapter 2-1400 discusses disallowances in detail. To be considered a formal decision, any notice of decision or compensation order must:

(1) Notify the claimant of the action and the reasons for it;

(2) Comply with the statutory requirements of 5 U.S.C. 8124(a); and

(3) Be released at the appropriate level of authority.

All notices of decision, compensation orders, Letters CA-1048, CA-1066, and CA-1050, and Forms CA-180 and CA-181 are considered formal decisions on claims for monetary compensation, and may be appealed. Letters or compensation orders denying review of a prior decision, or denying modification of a prior decision, may be appealed to the Employees' Compensation Appeals Board. The district office must notify the claimant in each case of his or her further rights.

2-1600-4 Order and Number of Appeals

4. Order and Number of Appeals. Appeals may be requested in any order, except that a hearing may not be held after the case has been reconsidered. There is no limit to the number of times a claimant may request reconsideration and submit additional evidence.

In providing information to claimants concerning their rights, the CE should refrain from suggesting that one form of appeal is appropriate in a given case, either as part of the decision or in any later conversation or correspondence.

2-1601 HEARINGS AND REVIEWS OF THE WRITTEN RECORD

Paragraph	Subject	Date	Trans. No.
	Table of Contents	01/99	99-07
1	Purpose and Scope	09/95	95-37
2	Policy	10/92	93-02
3	Applications	10/92	93-02
4	Review of the Case	10/92	93-02
		06/97	97-12
5	Review of the Written Record	10/92	93-02
		01/99	99-07
6	Arranging for Hearings	01/99	99-07
7	Conduct of Hearings	10/92	93-02
8	Reaching a Determination	01/99	99-07
9	Cases Returned from H&R	01/99	99-07

Exhibits

1	Letter Acknowledging Request	08/94	94-35
2	Letter Acknowledging Receipt of Case File	01/99	99-07
3	Notice of Hearing to Claimant	01/99	99-07
4	Notice of Hearing to Employing Agency	01/99	99-07

5	Request for Comment from Employing Agency	01/99	99-07
6	Request for Comment from Claimant	01/99	99-07

2-1601-1 Purpose and Scope

1. Purpose and Scope. This chapter describes the processing of requests for hearings. The procedures include review of the case file, arrangements for the hearing, conduct of the hearing, and issuance of the decision. Additionally, procedures are described for handling requests for review of the written record. These functions, along with pre-recoupment hearings in overpayment cases (see FECA PM Part 6), are the responsibility of the Branch of Hearings and Review (H&R) within DFEC's National Office.

2-1601-2 Policy

2. Policy. This paragraph describes the scope of claimants' entitlement to hearings and reviews of the written record.

a. Right to a Hearing. Where the injury or death occurred on or after July 4, 1966, the claimant is entitled to a hearing before an Office representative after a final decision and before reconsideration under Section 5 U.S.C. 8128. For injuries or diseases prior to that date, the Employees' Compensation Appeals Board has ruled that claimants are not entitled to a hearing as a matter of right but that the OWCP has the discretionary authority to grant a claimant's request for a hearing regardless of the date of injury or death (Rudolph Bermann, 26 ECAB 354). A claimant is also entitled to a pre-recoupment hearing following a preliminary determination that an overpayment of compensation has occurred. However, the claimant is not entitled to a hearing under 5 U.S.C. 8124(b) after a final decision concerning an overpayment is issued.

b. Right to a Review of the Written Record. In place of an oral hearing, a claimant is entitled to a review of the written record (subsequently referred to as "review") by an Office representative. Such review will not involve oral testimony or attendance by the claimant, but the claimant may submit any written evidence or argument deemed relevant.

c. Issues for Consideration. The hearing or review will usually be limited to those issues which were addressed by the district office (DO) in the contested decision. Other issues may be addressed at the discretion of the Office representative. If a claimant wishes to expand the claim, he/she should be given the option of holding the expanded claim in abeyance pending issuance of the hearing/review decision, or postponing the

hearing/review pending resolution of the expanded claim by the DO.

2-1601-3 Applications

3. Applications. This paragraph addresses requests for hearings and reviews. While they should be directed to H&R, some may be received in the DO. They should be handled as follows:

a. District Office. Requests received in the DO should be handled as priority mail. The request for hearing or review should be date-stamped, but the DO need not retain the envelope used for mailing by the claimant. The Claims Examiner (CE) or Supervisory Claims Examiner (SCE) should review the case to determine whether a final decision has been reached.

(1) If not, the CE or SCE will advise the claimant that a hearing or review can be requested only if a final decision has been reached and outline the steps needed to obtain such a decision.

(2) If so, the DO will forward the request for hearing or review, together with the case file, to H&R. (The request and case file should be sent even if the request was filed more than 30 days after the final decision or if a reconsideration was undertaken.)

b. Branch of Hearings and Review. Where the request for a hearing or review is sent to H&R, the envelope will be retained and attached to the request and the case will be requested from the DO over the automated system. Every effort should be made to send the case within 48 hours of the request. H&R will acknowledge receipt of the request by computer-generated letter (Exhibit 1).

The claimant will be notified by letter when the case is received (Exhibit 2).

2-1601-4 Review of the Case

4. Review of the Case. This paragraph discusses preliminary handling of requests for hearings and reviews. On receipt of the case file, H&R staff will review it to determine whether a reconsideration preceded the request for a hearing or review, whether the request is timely, whether all necessary evidence is on record and, if so, whether it supports the decision of the DO.

a. Timeliness. The request is timely if it was mailed (as determined by the postmark) within 30 days of issuance of the district office's decision. If the claimant sent the request to the DO (instead of H&R) and the envelope was not retained, then the

request was timely filed if it was date-stamped by the DO within 30 days of issuance of the decision.

H&R may deny requests date-stamped by the DO more than 30 days after the decision was issued on the basis that the date stamp showed untimely receipt and the claimant's failure to send the request to H&R, as specified in the appeal rights accompanying the decision, made it impossible to determine timeliness from the postmark.

b. Entitlement.

(1) Hearing. If preliminary study shows that the decision was reached in accordance with established policies and that it is supported by the evidence of record, the case will be scheduled for a hearing as described in paragraph 6 below. If a review has been requested, the procedures described in paragraph 5 below will be followed.

(2) Remand. If the decision is not supported by the evidence of record or if new evidence warrants it, H&R will prepare a remand order setting the decision aside. This memorandum will include the reasons for the decision to remand and will outline the further action needed. A formal decision vacating the contested decision and a cover letter will also be prepared.

(3) Discretionary Action. If the claimant is not entitled to a hearing or review (i.e. the request was untimely, the claim was previously reconsidered, etc.), H&R will determine whether a discretionary hearing or review should be granted and, if not, will so advise the claimant, explaining the reasons.

2-1601-5 Review of the Written Record

5. Review of the Written Record. This paragraph discusses the steps involved in processing requests for review of the record.

H&R will furnish the employing agency with a copy of the claimant's request for review of the written record, together with any pertinent documentation submitted. (Medical evidence is not considered "pertinent" for review and comment by the agency and will therefore not be furnished to the agency. OWCP has sole responsibility for evaluating medical evidence.)

The agency will be allowed 20 days to submit any comments and/or documents believed relevant and material to the issue in question. H&R will furnish any comments or documents submitted by the agency to the claimant and allow 20 days for review and comment by the claimant. Following a review of the record and any evidence submitted, the Office representative shall decide the claim and inform the claimant, the claimant's representative, and the employing agency of the decision.

After requesting a review of the written record, the claimant may decide that he or she would rather have an oral hearing. Such a request may be granted if the claimant submits a written request within 30 days after H&R issues its letter to the claimant acknowledging the initial request (Exhibit 1).

2-1601-6 Arranging for Hearings

6. Arranging for Hearings. This paragraph addresses the steps involved in arranging for a hearing and discusses some of the issues which may arise in obtaining evidence.

a. Scheduling. A written notice specifying the exact date, time and place for the hearing will be mailed at least 30 days prior to the scheduled hearing. The claimant, the claimant's authorized representative, and the employing agency will be provided with such written notice (Exhibit 3). Except in unusual circumstances, hearings will be scheduled within 100 miles of the claimant's home. When the medical evidence establishes that the claimant will not be able to travel for a period of six months or more, a hearing may be scheduled at the claimant's home or at a hospital or extended care facility.

b. Employing Agency Participation. When the hearing is scheduled, the employing agency will be advised that its representative may attend the proceedings and/or receive a copy of the hearing transcript. Agency representatives attend primarily as observers and may not participate in the hearing unless the claimant or the Hearing Representative specifically requests them to do so. A notice to the employing agency (Exhibit 4) will accompany the agency's copy of the letter to the claimant scheduling the hearing.

c. Reporting Services. H&R will arrange to record the hearing, and the recording (either magnetic tape or transcription) shall be made a part of the case record. Audiovisual coverage of hearings is not permitted, and claimants may not use their own recording equipment.

d. Withdrawal and Postponement of Hearing Requests. The claimant may withdraw the request for hearing at any time by written notice, or on the record at the hearing. A request for postponement will not be granted unless the hearing can be rescheduled within the same docket, or unless either the claimant is non-electively hospitalized, or the death of the claimant's parent, spouse or child prevents his or her attendance at the scheduled hearing. To have OWCP reschedule the hearing, the claimant must present proper documentation that one of the above events has occurred.

Claimants will undoubtedly continue to request postponement for an unspecified reason or for any reason other than the extraordinary circumstances described above. Where the

request for postponement is received in sufficient time to contact the claimant prior to the scheduled hearing (i.e., 10 days for mailing or through a documented telephone contact), the Hearing Representative should advise the claimant that the postponement will not be allowed pursuant to the regulations at Section 10.622 (b). The claimant will then have the following options:

(1) to withdraw the hearing request;

(2) to attend the scheduled hearing;

(3) to reschedule the hearing at an available time within the same docket;

(4) to have a telephone hearing at the Hearing Representative's discretion; or

(5) to opt for a review of the written record by the assigned Hearing Representative.

A claimant who opts for a review of the written record must be advised by H&R that he or she has 15 days within which to submit any information or evidence the claimant wants to be considered in the review of the record. A system-generated letter will be used to document the change of format and the need for additional evidence to be submitted, if applicable.

When the claimant requests postponement for a reason not specified in section 10.622 (c) of the regulations, and it is too late to contact the claimant prior to the scheduled hearing, or H&R's efforts to contact the claimant are unsuccessful, only options (1), (4), and (5) would remain available to the claimant. The Hearing Representative must then notify the claimant as described above that the request for postponement is not approved, that options (1), (4), and (5) are available, and of the timeframes involved should he or she choose review of the written record.

e. Abandonment of Hearing Requests.

(1) A hearing can be considered abandoned only under very limited circumstances. All three of the following conditions must be present: the claimant has not requested a postponement; the claimant has failed to appear at a scheduled hearing; and the claimant has failed to provide any notification for such failure within 10 days of the scheduled date of the hearing.

Under these circumstances, H&R will issue a formal decision finding that the claimant has abandoned his or her request for a hearing and return the case to the DO. In cases involving pre-recoupment hearings, H&R will also issue a final decision on the overpayment, based on the available evidence, before returning the case to the DO.

(2) However, in any case where a request for postponement has been received, regardless of any failure to appear for the hearing, H&R should advise the claimant that such a request has the effect of converting the format from an oral hearing to a review of the written record.

This course of action is correct even if H&R can advise the claimant far enough in advance of the hearing that the request is not approved and that the claimant is therefore expected to attend the hearing, and the claimant does not attend.

f. Subpoenas. A claimant who wants a subpoena issued for the attendance and testimony of a witness, or for the production of documents which are relevant and material to any matter at issue in the hearing, must file a written request for same with H&R no later than 60 days after the original hearing request. The request must designate the witness or documents to be produced, and clearly describe the address and location of the witness or documents to be subpoenaed. The request must also explain why the testimony or evidence is directly relevant to the issues at hand, and must demonstrate that a subpoena is the best and only method or opportunity to obtain such evidence. The Hearing Representative has the discretion to decide that such facts could be established by other evidence without the issuance of a subpoena.

If H&R determines that issuance of a subpoena is reasonably necessary for the full

presentation of the case, a subpoena will be issued in the name of the Hearing Representative which compels the attendance of witnesses within a radius of 100 miles of the site of the hearing. Non-Government witnesses who are subpoenaed shall be paid the same fees and mileage as are paid for like services in the District Court of the United States where the subpoena was returnable. However, the fee for an expert witness shall not exceed the local customary fee for such service.

OWCP shall pay fees requested by witnesses who have submitted evidence into the case record at the request of the Office. The claimant shall pay fees requested by witnesses who have submitted evidence into the case record at the request of the claimant. If H&R determines that issuance of a subpoena is not reasonably necessary to present the case fully, a formal denial of the request for subpoena, with an explanation for such denial, will be included with the final decision (see paragraph 8e below).

2-1601-7 Conduct of Hearings

7. Conduct of Hearings. This paragraph describes the steps involved in the hearing itself.

a. Nature of Proceedings. Hearings will be open to claimants, their representatives, witnesses, designated agency officials, and any other persons whose presence the Hearing Representative deems necessary. The proceedings are informal and are not limited by legal rules of evidence or procedures. The testimony will be taken under oath and recorded verbatim.

b. Pre-hearing Conference. The claimant must request any pre-hearing conference to clarify the issues at least five days before the scheduled hearing date. This request must be in writing. The granting of such a conference is solely within the discretion of the Hearing Representative. If necessary, the Hearing Representative will postpone the hearing for this purpose.

c. Preliminary Matters. Before opening the proceedings, the Hearing Representative will explain to all parties present that hearings are non-adversarial in nature and that the claimant will have the opportunity to present any written or verbal evidence desired.

d. Opening the Hearing. At the beginning of the proceedings the Hearing Representative will:

(1) Note the date and time;

(2) Identify all persons present by name;

(3) Make an opening statement which outlines the issues in question and ask

the claimant if he/she concurs;

(4) Afford the claimant an opportunity to make an opening statement; and

(5) Administer an oath to all persons testifying.

e. Presentation. The claimant may offer material in any manner desired. Written evidence offered should be acknowledged and made a part of the record. During the presentation, the Hearing Representative should note any additional questions or areas for exploration and make appropriate inquiries before terminating the hearing.

f. Conclusion. When all witnesses have spoken and the Hearing Representative has obtained all necessary clarifications, the Hearing Representative will close the proceedings by noting the time of completion. At the sole discretion of the Hearing Representative, the claimant may be granted up to 30 days after the hearing for the submission of additional evidence.

2-1601-8 Reaching a Determination

8. Reaching a Determination. In this paragraph, the actions taken after the hearing are described.

a. Comments. The claimant and/or representative will be provided with a copy of the transcript. If requested, a copy of the transcript will also be forwarded to the employing agency. The employing agency will be allowed 20 days from the release of the transcript to submit any comments and/or documents believed relevant to the issue in question (Exhibit 5). Any comments or documents submitted by the agency will be forwarded to the claimant or his representative with the opportunity to submit written comments within 20 days (Exhibit 6).

b. Further Development. If additional development is needed, the case will usually be remanded to the DO. Sometimes, however, if the issue can be resolved readily, the Hearing Representative will undertake the additional development and incorporate the results into the decision.

c. Schedule Awards. OWCP adopted the third edition of the AMA Guides to the Evaluation of Permanent Impairment effective March 8, 1989; the revised third edition of the Guides effective September 1, 1991; and the fourth edition effective November 1, 1993. Awards calculated according to any previous edition of the Guides should be evaluated according to the edition originally used, and if an error is computation is found, the award should be recomputed using the original edition. If new evidence is received and a de novo decision is to be issued, the award should be calculated on the basis of the edition currently used. The date of computation by the Office, not the date of

examination by the physician, determines which edition should be used, and arguments that the incorrect version was employed to compute the award should be evaluated accordingly.

d. Novel Issues. If the hearing decision will involve a novel issue or suggest a new policy, the Hearing Representative will prepare a memorandum requesting review by the Director for Federal Employees' Compensation.

e. Final Decision. When all evidence and testimony has been evaluated, the Hearing Representative will issue a decision which affirms, reverses, remands, or modifies the DO decision. If the issuance of a subpoena was in question, the final decision should include formal findings on this matter. If the decision is adverse to the claimant, the claimant's further appeal rights will be noted. If further benefits will be payable, Form CA-1009 will be included with the decision to advise the claimant how to claim compensation and submit medical bills.

2-1601-9 Cases Returned from H&R

9. Cases Returned from H&R. Any case requiring further action should be assigned to a CE to take the required action.

a. Timeliness of Action. Substantive action should be taken within 30 days of return of the case file. If the required action cannot be completed within that time, the case should be placed under adjudication control, as outlined in FECA PM 2-400.6.

b. Reinstatement of Benefits. If the hearing decision concludes that the Office did not meet its burden of proof before reducing or terminating benefits, the following actions will be taken:

(1) The Hearing Representative will release a letter to the claimant or representative enclosing a Form CA-7 (or, in the case of death benefits, a Form CA-12) and requesting completion of the form.

(2) On receipt of the completed form, the district office should promptly reinstate benefits to the claimant at the previous level, including retroactive payment to the date of reduction or termination.

(3) If the completed form shows earnings, employment, or receipt of an annuity, the CE should obtain an election or additional information as necessary.

(4) The Form CA-7 is intended to cover the entire period during which benefits were terminated or reduced. Only one Form CA-7 need be completed. In general, further payments should be made on the periodic roll.

2-1601 Exhibit 1: Sample Letter Acknowledging Request for Hearing

Dear CLAIMANT NAME:

I am writing concerning the above captioned compensation case and the request for a hearing before an OWCP representative.

The Branch of Hearings and Review has recently requested the case file from the District Office having jurisdiction over the case. Upon receipt of the case file by the Branch, a preliminary review of all the evidence of record will be made and you will be advised of the further action being taken on the case.

Until further notice, please address all correspondence pertaining to the case to: U.S. DEPARTMENT OF LABOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, BRANCH OF HEARINGS AND REVIEW, BOX 37117, WASHINGTON, D.C. 20013-7117.

Sincerely,

CHIEF, BRANCH OF HEARINGS AND REVIEW

cc: File

2-1601 Exhibit 2: Sample Letters Acknowledging Receipt of Case File, 2 pages

SAMPLE LETTER ACKNOWLEDGING RECEIPT OF CASE FILE

REQUEST FOR ORAL HEARING

Dear RECIPIENT:

I am writing concerning the above-captioned compensation case and the request for an oral hearing before an OWCP representative.

The Branch of Hearings and Review has recently received the case file from the district office. Should it be determined that the case is not in posture for a hearing, you will be advised within 90 days of receipt of this letter. If it is determined that the case is in posture for an oral hearing, it may be up to {seven} months before you can expect the case to appear on a hearing docket.

Pursuant to 20 CFR 10.622(b), the hearing representative will attempt to accommodate any reasonable request for scheduling the oral hearing, but such requests should be made at the time of the original application for hearing, and must be made no later than 30 days from the date of this letter. Once the docket for the hearing trip is set, no changes will be made unless the hearing representative can reschedule the hearing on the same docket, or one of the following conditions applies: 1) the claimant will be hospitalized non-electively, or 2) there is a death of the claimant's parent, spouse, or child. At least thirty (30) days advance notice will be given advising you of the date, time and location of the hearing.

Should you wish to request the subpoena of witnesses for attendance and testimony at the hearing, or of records, correspondence or other documents, you must file your request no later than 60 days from the date of your initial request for hearing. Any such request must specify the witness or documents to be produced, provide the address for a witness to be notified, and provide a location of the documents to be produced. The request should also clearly explain why the testimony or evidence is directly relevant to the issues being addressed at the hearing and why the subpoena is the best and only method to obtain such evidence.

While your case is under jurisdiction of the Branch of Hearings and Review, all correspondence should be directed to the following address: Branch of Hearings and Review, P.O. Box 37117, Washington, D.C. 20013-7117.

Sincerely,

NAME OF CHIEF
BRANCH OF HEARINGS AND REVIEW

cc: File

SAMPLE LETTER ACKNOWLEDGING RECEIPT OF CASE FILE (Continued)

REQUEST FOR WRITTEN REVIEW

Dear RECIPIENT:

I am writing with regard to the above-captioned compensation case and the request for a review of the written record by an OWCP

representative.

The Branch of Hearings and Review has recently received the case file from the district office. As you have requested a review of the written record, your case file will be assigned to a hearing representative shortly.

Additionally, your employing agency will be provided a copy of your request for review of the written record and all pertinent new material. (Pursuant to 20 CFR 10.618(b), medical evidence is not considered pertinent for review and comment by the employing agency, since OWCP has sole responsibility for evaluating medical evidence, and therefore will not be furnished to the agency.)

Your employer will be allowed 20 days from the date the letter is sent to provide comments. If your employing agency does provide comments, they may come directly to you, and you will have 20 days from either the agency's certificate of service or our letter transmitting their comments to respond. Within 90 days of assignment of your case to a hearing representative, and after a review and complete study of your case file, a decision will be issued by the Branch of Hearings and Review.

While your case is under the jurisdiction of the Branch of Hearings and Review, all correspondence should be directed to the following address: Branch of Hearings and Review, P.O. Box 37117, Washington, D.C. 20013-7117.

Sincerely,

NAME OF CHIEF
BRANCH OF HEARINGS AND REVIEW

cc: File

Page 2 of 2

2-1601 Exhibit 3: Notice to Claimant -- Form CA-1127; Form CA-53

Exhibit 3, page 1 of 3: Hearing Notice to Claimant, Form CA-1127 (Link to Image)

Exhibit 3, page 2 of 3: Hearing Instructions, Form CA-53, page 1 (Link to Image)

Exhibit 3, page 3 of 3: Hearing Instructions, Form CA-53, page 2 (Link to

Image)

2-1601 Exhibit 4: Hearing Notice to Employing Agency -- Form CA-1127a (Link to Image)

2-1601 Exhibit 5: Request for Comment from Employing Agency

REQUEST FOR COMMENT FROM EMPLOYING AGENCY

Enclosed is a copy of the transcript of the hearing which was held in connection with the employee's Federal Employees' Compensation Claim. The employee's name, address, and case file number are contained in the transcript as well as the name and address of the designated representative, if any.

While the employing agency is not a party to this hearing, it has an interest in the outcome and frequently possesses information pertinent to the issues addressed. By copy of this letter, therefore, a copy of the transcript has been provided to the employing agency in accordance with the appurtenant regulation (20 CFR 10.617). The employer is reminded that the contents of this document are Confidential in nature and should be handled accordingly.

The employing agency will be allowed 20 calendar days (20 CFR 10.617(e)) from the date of this letter to submit comments or additional material for inclusion in the record and study by the Hearing Representative. Any comments or additional material the agency chooses to submit for consideration should be forwarded to the Hearing Representative at the address found at the top of this letter.

Any such submission to the Hearing Representative should concurrently be forwarded to the designated representative or, in the absence of a representative, to the claimant, and the agency correspondence to the Hearing Representative should indicate that it has complied with this requirement. Comments and/or evidence must be received within the 20 day regulatory limitation.

Participants at the hearing should carefully read the transcript. Any significant transcription errors (such as omissions, misattribution or missing portions) should be noted and corrections referencing page and line number should be returned to this office within 20 days of the date of this correspondence. It

is not necessary to return the entire transcript. If no significant errors are found, no further action is necessary.

NAME OF SIGNER
TITLE

COPY OF TRANSCRIPT MAILED THIS DATE TO THE FOLLOWING PARTIES:

ATTORNEY OF RECORD______________________________
CLAIMANT____
EMPLOYING AGENCY________________________________

2-1601 Exhibit 6: Request for Comment from Claimant

REQUEST FOR COMMENT FROM CLAIMANT

Dear NAME OF RECIPIENT:

I am writing in the matter of the Federal Employees' Compensation Claim, cited above. As you will recall, a hearing in the matter of the claim was held on DATE OF HEARING. A copy of the transcript of the hearing was provided to the employing agency in accordance with the applicable regulation.

The agency submitted its comments on the testimony recorded in the transcript for consideration by the Hearing Representative dated DATE OF AGENCY LETTER, and has certified that a copy of its comments was forwarded to you on that same date.

Should you desire to do so, you are allowed 20 calendar days from the date of this correspondence to submit your response to the Hearing Representative [See 20 CFR 10.617(e).] Any such submission should be addressed to the Hearing Representative at: U.S. Department of Labor, Office of Workers' Compensation Programs, Branch of Hearings and Review, P.O. Box 37117, Washington, D.C. 20013-7117.

If you have not received the correspondence from your employing agency cited above, please immediately notify the Hearing Representative.

Sincerely,

NAME OF SIGNER

2-1602 RECONSIDERATIONS

Paragraph	Subject	Date	Trans. No.
	Table of Contents	01/04	04-02
1	Purpose and Scope	01/04	04-02
2	Policy	05/96	96-18
3	Preliminary Processing	06/02	02-03
		01/04	04-02
4	Evidence or Argument Required	05/96	96-18
5	Special Evidence or Argument	05/96	96-18
		02/02	02-03
6	Prima Facie Denials	01/04	04-02
7	Evaluating Sufficiency of Evidence	05/96	96-18
		01/04	04-02
8	Merit Reviews	06/02	02-03
		01/04	04-02
9	Protecting Claimant's Further Appeal Rights	05/96	96-18

Exhibits

1	Sample Letter Returning Unclear Reconsideration Request	08/96	96-27
2	Sample Letter Denying an Untimely Request for Reconsideration	08/96	96-27
		02/02	02-03
3	Sample Letter Denying an Application Which is Prima Facie Insufficient to Warrant Review of the Case	08/96	96-27
4	Sample Notice of the One-Year Time Limitation for Requesting Reconsideration	01/97	97-08
		02/02	02-03
5	Sample Compensation Order Denying Application for Review	08/94	94-35

6 **Sample Compensation Order Denying Modification of Prior Order** 08/94 94-35

2-1602-1 Purpose and Scope

1. Purpose and Scope. This chapter outlines procedures for handling reconsideration requests. It describes the filing requirements, the tests for sufficiency of applications and the actions required to process them. All such requests are handled within the district office (DO) having jurisdiction of the case. The Correspondence Library includes several letters and decisions for use with reconsiderations.

2-1602-2 Policy

2. Policy. The following policy considerations pertain to all requests for reconsideration:

a. Requirements. A claimant may apply for reconsideration of a final decision regardless of the date of injury or death. While no special form is required, the request must be in writing, identify the decision and the specific issue(s) for which reconsideration is being requested, and be accompanied by relevant new evidence or argument not considered previously. The request must be made within one year of the date of the contested decision if that date was after June 1, 1987 (see paragraph 3b below).

b. Assignment and Signature Level. Each request for reconsideration must be handled by a Senior Claims Examiner (SrCE) who was not involved in making the contested decision (with one exception, described in paragraph 5a below). All reconsideration decisions, whether affirmative or negative, must bear the signature of the SrCE or higher authority.

c. Timeliness. The goal for issuing reconsideration decisions is 90 days from receipt of the request. To meet this goal, a final decision must be issued. In a case requiring further development it is not sufficient simply to vacate the previous decision and return the case to the responsible CE for further action.

2-1602-3 Preliminary Processing

3. Preliminary Processing.

a. Review of Request. The CE should determine whether a final decision has been released on the issue for which reconsideration is requested. If not, the CE should advise the claimant by letter that the case is not in posture for reconsideration. If the contested

decision or issue cannot be reasonably determined from the claimant's request, the CE should return a copy of the application to the claimant for clarification and informing the claimant that OWCP will take no further action on the request unless clarification is submitted. This action is not a denial of application and should not be reported as a reconsideration decision.)

b. Time Limitations.

(1) Decisions . The OWCP's regulations establish a one-year time limit for requesting reconsideration (20 CFR 10.607(a)). The one-year period begins on the date of the original decision. **However, a right to reconsideration within one year accompanies any subsequent merit decision on the issues. This includes any hearing or review of the written record decision, any denial of modification following a reconsideration, any merit decision by the Employees' Compensation Appeals Board (ECAB), and any merit decision following action by the ECAB**, but does not include pre-recoupment hearing decisions.

The CE should review the file to determine whether the application for reconsideration was filed within one year of a merit decision. At 20 CFR 10.607(a) it states that if a request for reconsideration is submitted by mail, the application will be deemed timely if postmarked by the U.S. Postal Service within the time period allowed. An imaged copy of the envelope that the enclosed the reconsideration request should be in the case record. If there is no such postmark, or it is not legible, other evidence such as (but not limited to) certified mail receipts, certificate of service, and affidavits, may be used to establish the mailing date. Otherwise, the date of the letter itself should be used.

(2) Decisions Issued Before June 1, 1987. No time limit applies to requests for reconsideration of these decisions because there was no regulatory time limit for requesting reconsideration prior to June 1, 1987. Therefore, a request for reconsideration may not be denied as untimely **unless** the claimant was advised of the one-year filing requirement in a later decision denying an application for reconsideration or denying modification of the contested decision. In these cases, the one-year time limit begins on the date of the decision that includes notice of the time limitation. (See paragraph 6 below.)

(3) The regulations at 20 CFR 10.607 (b) provide that OWCP will consider an untimely application for reconsideration **only if the application demonstrates clear evidence of error on the part of OWCP in its most recent merit decision.** The application must establish, on its face, that such decision was erroneous.

c. Clear Evidence of Error. The term "clear evidence of error" is intended to represent a difficult standard. The claimant must present evidence which on its face shows that the OWCP made a mistake (for example, proof that a schedule award was miscalculated). Evidence such as a detailed, well-rationalized medical report which, if submitted before the denial was issued, would have created a conflict in medical opinion requiring further development, is not clear evidence of error. *John Crawford*, 52 ECAB 395(2001); *Dean D. Beets*, 43 ECAB 1153 (1992); *Leona N. Travis*, 43 ECAB 227 (1991).

Note: The one-year time limit to file a reconsideration request does not include any time following the decision that the claimant can establish (through medical evidence) an inability to communicate and that his testimony would be necessary. See 20 C.F.R. 10.607 (c); John Crawford, 52 ECAB 395 (2001) [Appellant failed to submit any evidence to establish his inability to communicate].

d. <u>Decision</u>. An untimely application for reconsideration should be denied according to Title 20 CFR Part 10.608(b), as follows:

(1) <u>If clear evidence of error has not been presented</u>, the SrCE should deny the application by letter decision, which includes a brief evaluation of the evidence submitted and a finding made that clear evidence of error has not been shown. The claimant's only appeal from this decision is to request a review of the decision by the ECAB.

(2) <u>If clear evidence of error has been presented</u> with an untimely application, the SrCE should first deny the application by letter decision. Then a merit review on the Director's own motion should be undertaken. The FECA specifies that an award for or against payment of compensation may be reviewed at any time <u>on the Director's own motion</u>. Such review may be made without regard to whether there is new evidence or information.

If the Director determines that a review of the award is warranted (including, but not limited to circumstances indicating a mistake of fact or law or changed conditions), the Director (at any time and on the basis of existing evidence) may modify, rescind, decrease or increase compensation previously awarded, or award compensation previously denied. A review on the Director's own motion is not subject to a request or petition and none shall be entertained. See 20 C.F.R. § 10.610.

(a) The decision whether or not to review an award under this section is solely within the discretion of the Director. The Director's exercise of this discretion is not subject to review by the ECAB, nor can it be the subject of a reconsideration or hearing request.

(b) Where the Director reviews an award on his or her own motion, any resulting decision is subject as appropriate to reconsideration, a hearing and/or appeal to the ECAB. Jurisdiction on review or on appeal to ECAB is limited to a review of the merits of the resulting decision. The Director's determination to review or not to review an award is not reviewable, i.e., is not subject to appeal.

2-1602-4 Evidence or Argument Required

4. Evidence or Argument Required. All requests for reconsideration should be accompanied by one of the following:

a New Evidence Which is Relevant to the Issue. For example, the submission of a witness statement would be considered relevant if the claim had been denied because fact of injury had not been established. Such a statement would not be relevant if the claim had been denied because the claimant had not submitted medical evidence addressing causal relationship.

b. Argument for Error in Fact or Law. For example, a claimant who received a formal decision concerning an overpayment might argue that the principle of equity and good conscience had not been considered in reaching the decision. This argument would be relevant if the claimant had been found without fault, but irrelevant if the claimant had been found not without fault.

Any claimant or representative who wishes to review the file during the reconsideration process should be permitted to do so and should be allowed a reasonable period to submit new information before a decision is reached.

2-1602-5 Special Evidence or Argument

5. Special Evidence or Argument.

a. CA-1032 or CA-12 When Compensation Has Been Suspended. If compensation was suspended for failure to provide timely reports concerning the status of dependents, the beneficiary may request a reconsideration accompanied by a completed Form CA-1032 or CA-12. In this case, the CE who initially sent the form may act on the reconsideration by vacating the compensation order and restoring benefits.

b. Argument for Error in Schedule Award Cases. OWCP adopted the third edition of the AMA Guides to the Evaluation of Permanent Impairment effective March 8, 1989; the revised third edition of the Guides effective September 1, 1991; the fourth edition

effective November 1, 1993 and the fifth edition effective February 1, 2001. Awards calculated according to any previous edition of the Guides should be evaluated using the edition previously used, and if an error in computation is found, the award should be recomputed using the original edition. If new evidence is received and a de novo decision is to be issued, the award should be calculated on the basis of the edition currently used. The date of computation by the OWCP, not the date of examination by the physician, determines which edition should be used, and arguments that the incorrect version was employed to compute the award should be evaluated accordingly.

2-1602-6 Prima Facie Denials

6. Non-merit Review/Denial (without review on the merits). A timely application for review, which is not supported by additional evidence or argument for error in fact or law is insufficient to warrant a merit review of the case. According to 20 C.F.R. §10.608, in such instances the SrCE should prepare a letter decision denying the application. The claimant's only appeal from this decision is to request a review by the ECAB.

a. Original Denial Issued After June 1, 1987. If the time limit has not expired, the claimant may again request reconsideration within one year from the date of the original decision, or from any merit decision including a denial of modification, or from an ECAB decision on the merits.

b. Original Denial Issued Before June 1, 1987. The cover letter or appeal rights attached to the decision should include a notice of the one-year time limitation for requesting reconsideration. Thereafter, the claimant would have one year from the decision denying the application to again request reconsideration of the contested decision.

2-1602-7 Evaluating Sufficiency of Evidence

7. Evaluating Sufficiency of Evidence. When the request for reconsideration is accompanied by new evidence, the SrCE must determine whether it is sufficient to review the case on its merits. This step often requires study of the file to assess what material it already contains. Such examination should not be confused with merit review of the case.

a. Nature of Evidence. The following kinds of evidence are not sufficient to reopen the claim for merit review:

(1) Cumulative evidence, which is substantially similar to material on file which, has already been considered. Jacqueline M. Nixon-Steward, 52 ECAB 140 (2000)(Doctor's reports were similar to previously submitted reports).

(2) Repetitious evidence, which consists of copies of documents previously submitted or a restatement of previously considered evidence. *David J. McDonald*, 50 ECAB 185, 190(1998) (Documents previously considered by the Office).

(3) Irrelevant or immaterial evidence which has no bearing on the issue or which is frivolous or inconsequential in regard to the issue. *Linda I. Sprague*, 49 ECAB 386 (1997).

The SrCE should use caution in characterizing medical evidence as "cumulative" or "irrelevant." A rationalized supporting statement from a physician not previously of record requires a merit review when the denial rested on medical issues. However, a checked “yes” on a form report would not require a merit review just because it was from a new physician.

b. Decision. If the evidence submitted is not sufficient to require a merit review, the SrCE should:

(1) Prepare a Decision which discusses the evidence submitted and explicitly states the basis for the finding of insufficiency. **The SrCE must not include any statement suggesting that review on the merits of the claim was undertaken. Evaluative statements such as the evidence lacks substantial probative value are not appropriate where the decision denies the application for review.**

(2) Include a cover letter explaining that the application for reconsideration is denied on the basis that the evidence submitted in support of the application is not sufficient to warrant review.

(3) Release the decision over his or her own signature.

The claimant's only appeal from this decision is to request review by the ECAB. (However, see paragraph 3b above concerning contested decisions issued before June 1, 1987.)

2-1602-8 Merit Reviews

8. Merit Reviews. Where the application is accompanied by new and relevant evidence or by an arguable case for error, the SrCE will conduct a merit review of the case to determine whether the prior decision should be modified.

a. Comment by Employing Agency. As soon as the SrCE decides that an application is sufficient to warrant reconsideration of the case, he or she should send a copy of the application, together with copies of pertinent supporting documentation, to the employing agency for review and comment. See 20 CFR § 10.609.

(1) Such documentation includes any factual evidence submitted with the reconsideration request. However, medical evidence submitted with the request shall not be furnished to the employing agency, since it does not constitute documentation that is "pertinent" for review and comment by the employing agency.

(2) The cover letter to the agency should explain that it may submit comments and/or documents, but that any evidence must be received within 20 days and is subject to review by the claimant.

(3) Any evidence submitted by the agency should be forwarded to the claimant with a letter allowing 20 days for comment before a final decision is issued on the reconsideration request.

(4) The SrCE must ensure that the final decision addresses any additional evidence submitted and its disposition.

b. Development. The SrCE should investigate the evidence independently of any previous determination, as follows:

(1) If the evidence submitted is sufficient to reopen the claim but not sufficient to reach a new decision, the SrCE should develop the case and maintain jurisdiction over it until a final decision is reached.

(2) Any party from whom additional evidence is required should be asked to submit it within 30 days, so that the reconsideration request may be adjudicated within the 90-day time frame. If information requested from a claimant is not submitted in a timely manner, modification may be denied on the basis that the evidence is insufficient.

c. Decisions. After any necessary development, the SrCE should take the following steps:

(1) To deny modification of the prior decision, the SrCE will prepare a decision. Such a denial does not carry the right to a hearing/review but does carry the right to request reconsideration again, or review by the ECAB.

(2) To modify the previous decision, the SrCE will prepare and release a Decision and return the case to the responsible CE if any further action is needed. If this decision represents the initial acceptance for the claim, an acceptance letter with the attachment Now That Your Claim Has Been Accepted should be sent with the decision.

(a) If a previous decision is to be vacated and a condition, period of disability, etc. is to be newly accepted, the SrCE should prepare a vacate order and a cover letter which describes the acceptance in specific terms.

(b) If a previous decision is to be vacated in favor of reinstating the next prior decision, the SrCE should prepare an order vacating the intermediate decision and adopting the new findings. This situation will arise most often when the OWCP exercises the right to review awards on the Director's own motion.

(c) If a prior decision is to be affirmed in part and vacated in part, the SrCE will need to prepare a decision which incorporates both the previous and new findings. Again, the cover letter to the claimant should describe in detail the elements of the new decision. Such a decision does not carry the right to a hearing/review but does carry the right to again request reconsideration or review by the ECAB.

2-1602-9 Protecting Claimant's Further Appeal Rights

9. Protecting Claimant's Further Appeal Rights. The ECAB will accept appeals filed up to one year from the date of the last merit decision. If a reconsideration decision is delayed beyond one year, the claimant's right to review of the original decision by the ECAB is abrogated. In Tony J. Fosko, 35 ECAB 644, the ECAB remanded the case for a review on the merits, ruling that when the OWCP took 10 months to deny an application for review, it had effectively used up the claimant's time to appeal to the Board.

When a reconsideration decision is delayed beyond 90 days, and the delay jeopardizes the claimant's right to review of the merits of the case by the Board, the OWCP should conduct a merit review. That is, the basis of the original decision and
any new evidence should be considered and, if there is no basis to change the original decision, an order denying modification (rather than denying the application for review) should be prepared. There is no obligation to conduct a merit review on insufficient evidence if the maximum one-year time limit for requesting review by the Board will have expired within the 90 day period following the OWCP's receipt of the claimant's reconsideration request.

2-1602 Exhibit 1: Sample Letter Returning Unclear Reconsideration Request

Dear CLAIMANT NAME:

Enclosed is a copy of your letter dated DATE OF LETTER requesting reconsideration. It is not clear from your letter which decision or issues you are asking us to reconsider.

No further action will be taken on your letter. If you wish to request reconsideration of your case, you must make such a request, in writing, within one year of the date of the decision you are asking us to reconsider. Your request must clearly identify the decision and issues upon which reconsideration is being requested, and it must be accompanied by relevant evidence not previously on record, or a legal argument not previously considered.

Sincerely,

CLAIMS EXAMINER

Enclosure

2-1602 Exhibit 2: Sample Letter Denying an Untimely Request for Reconsideration

Dear CLAIMANT NAME:

This is in reference to your letter dated DATE OF LETTER requesting reconsideration of our decision dated DATE OF LAST MERIT DECISION. Your letter was postmarked [OR dated] on DATE.

As provided by 20 CFR 10.607(b), we will not review a decision unless the request to do so is filed within one year of the date of that decision. Accordingly, your request for reconsideration is hereby denied because it was not postmarked [OR dated] within the one-year time limit.

We have evaluated the evidence you submitted in support of your request to see if it constitutes clear evidence of error in the OWCP's original decision.

Such error would require the OWCP to reopen the case even though your request for reconsideration is untimely. However, an evaluation of the evidence you submitted does not show clear evidence of error on the part of the OWCP.

If you disagree with this decision, you have the right to appeal to the Employees' Compensation Appeals Board for review of the decision. This is your only right of appeal. No new evidence may be submitted to the Board. Request for review by the Appeals Board should be made within 90 days from the date of this decision and should be addressed to Employees' Compensation Appeals Board, U. S. Department of Labor,
200 Constitution Avenue, N.W., Room N-2609, Washington, D. C. 20210. For good cause shown, the Appeals Board may waive the failure to file within 90 days if application is made within one year from the date of the decision being appealed.

Sincerely,

SENIOR CLAIMS EXAMINER

2-1602 Exhibit 3: Sample Letter Denying an Application Which is Prima Facie Insufficient to Warrant Review of the Case

Dear CLAIMANT NAME:

We have reviewed your letter of DATE OF LETTER requesting reconsideration of our decision dated DATE OF DECISION.

Please refer to the information which accompanied the original decision. To require the Office to reopen your case, you must clearly identify the grounds upon which reconsideration is being requested. In addition, you must either submit relevant evidence not previously considered, or present legal arguments not previously considered.

Because your letter did not include new and relevant evidence or new legal arguments, it is insufficient to warrant a review of our prior decision at this time. Any future request for reconsideration must be made within one year from the original decision and must be accompanied by statements or evidence as described above.

If you disagree with this specific decision, namely, our denial to review our prior decision, you have the right to appeal to the Employees' Compensation Appeals Board for review of the decision. This is your only right of appeal. No new evidence may be submitted to the Appeals Board.

A request for review by the Appeals Board should be made within 90 days from the date of this decision. It should be addressed to Employees' Compensation Appeals Board, U. S. Department of Labor, 200 Constitution Avenue, N.W., Room N-2609, Washington, D.C. 20210. For good cause shown, the Appeals Board may waive the failure to file within 90 days if application is made within one year from the date of the decision being appealed.

Sincerely,

SENIOR CLAIMS EXAMINER

2-1602 Exhibit 4: Sample Notice of the One-Year Time Limitation

FEDERAL EMPLOYEES' COMPENSATION ACT APPEAL RIGHTS

If you disagree with this decision denying reconsideration of your case, you may request review by the Employees' Compensation Appeals Board. No new evidence may be submitted to the Board. Request for review by the Appeals Board should be made within 90 days from the date of this decision and should be addressed to Employees' Compensation Appeals Board, U. S. Department of Labor, 200 Constitution Avenue, N.W., Room N-2609, Washington, D.C. 20210. For good cause shown, the Appeals Board may waive the failure to file within 90 days if application is made within one year from the date of the decision being appealed.

NOTICE

Section 10.607(a)of Title 20 of the Code of Federal Regulations, which concerns the reconsideration of a decision by the Office of Workers' Compensation Programs (OWCP), provides that OWCP will not review a decision denying or terminating a benefit unless the claimant's request for review is filed within one year of that decision. This provision of the regulations became effective June 1, 1987. Therefore, even though the decision in your case was issued prior to June 1, 1987 and included the right to reconsideration, without specifying a time limit, a request for reconsideration of that decision will be denied if it is not made within one year from the date of this notice.

2-1602 Exhibit 5: Sample Compensation Order Denying Application for Review

U.S. DEPARTMENT OF LABOR

EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

In the matter of the claim for compensation under Title 5 U.S. Code 8101 et seq. of	COMPENSATION ORDER DENYING REQUEST FOR REVIEW BY THE MERITS OF THE CASE
NAME OF CLAIMANT (Claiming as widow of dec'd, etc.)	
Employed by: NAME OF AGENCY	CASE NUMBER:

A request for review was filed in the above-entitled case seeking modification of the decision therein dated DATE OF DECISION. The request for review and the evidence submitted in support thereof have been examined, and it is ORDERED that the request for review be, and it hereby is, DENIED for the following reason:

The evidence submitted in support of the request for review is found to be [cumulative, repetitious, or irrelevant and immaterial] and is not sufficient to warrant review of the prior decision.

Given under my hand at

this day of

Director, OWCP
By:

Senior Claims Examiner

2-1602 Exhibit 6: Sample Compensation Order Denying Modification of Prior Order

U.S. DEPARTMENT OF LABOR

EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

. . . .
In the matter of the claim for compensation .
under Title 5 U.S. Code 8101 et seq. of . COMPENSATION ORDER
. DENYING MODIFICATION
NAME OF CLAIMANT . OF PRIOR ORDER
.
. CASE NUMBER:
Employed by: NAME OF AGENCY .
.
. . . .

An application for review was filed in the above-entitled case seeking modification of the decision therein dated DATE OF DECISION. The case as been reviewed on its merits under Title 5 U.S. Code 8128 in relation to the application and the evidence submitted in support thereof, and it is determined that modification must be and is hereby DENIED for the following reason:

The evidence submitted in support of the application is not sufficient to warrant review of the prior decision.

Given under my hand at

this day of

Director, OWCP
By:

Senior Claims Examiner

2-1603 APPEALS

Paragraph	Subject	Date	Trans. No.
	Table of Contents	06/97	97-12
1	Purpose and Scope	09/93	93-44
2	Function of the ECAB	09/93	93-44
3	Requests for Appeal and Information about Board Procedures	09/93	93-44
4	Transfer of Case Files	09/93	93-44
5	Processing Case Files On Appeal	09/93	93-44
		06/97	97-12
6	Cases Returned to District Office	09/95	95-37
7	Representative's Fee	09/93	93-44

Exhibits

1	Sample Letter to Claimant Advising that Request for Appeal is Being Forwarded to ECAB	08/94	94-35

2-1603-1 Purpose and Scope

1. Purpose and Scope. This chapter describes the procedures for handling cases which have been requested by the Employees' Compensation Appeals Board (ECAB) for review of a final decision of the OWCP.

2-1603-2 Function of the ECAB

2. Function of the ECAB.

a. Origins. The ECAB was created as an entity separate from OWCP to give Federal employees the same administrative due process of law and right of appellate review which most non-Federal workers have under the various state workers' compensation laws. The Board consists of three members, one of whom is designated as Chairman of the Board and administrative officer.

b. Jurisdiction. The ECAB may consider and decide appeals from the final decisions of the OWCP in any case arising under the FECA. The Board may review all relevant questions of law, fact, and exercise of discretion in such cases, except decisions concerning the amounts payable for medical services and decisions concerning exclusion and reinstatement of medical providers.

c. Evidence. Only the evidence in the case record as it stood at the time of OWCP's final decision will be reviewed, and the ECAB will not consider new evidence. The Board will hear oral argument upon request, though any such argument must be based on the evidence of record.

d. Timeliness of Filing. A person residing within the United States or Canada must file application for review by the Board within 90 days from the date of OWCP's decision, and a person residing elsewhere must file within 180 days.
For good cause shown, the ECAB may waive a failure to file an application within 90 days or 180 days, but for no more than one year from the date of the final decision.

2-1603-3 Requests for Appeal and Information about Board Procedures

3. Requests for Appeal and Information about Board Procedures. Requests for appeal must be in writing and sent directly to the Board in accordance with the instructions that accompany formal OWCP decisions. Any correspondence addressed to the Board but delivered to OWCP will be forwarded to the Board immediately, unopened.

Occasionally, a written request for appeal will be addressed to OWCP. When the district office receives such a request, a Claims Examiner (CE) or Supervisory Claims Examiner (SCE) will review the case record to determine whether a final decision has been issued. If so, the request will be forwarded to the Board and the CE or SCE will release a letter informing the requestor of this action and advising that all correspondence relating to an appeal should be sent to the Board (Exhibit 1).

If a final decision has not been issued, the requestor should be advised that the Board will review only final decisions and informed of the requirements for obtaining such a determination.

Persons requesting information about Board procedures should be informed that the Board is a separate entity from the OWCP and operates under its own explicit rules of procedure, and that

any inquiries about those procedures must be directed to the Board. The ECAB is responsible for providing replies to all inquiries concerning the rules and procedures under which it operates.

2-1603-4 Transfer of Case Files

4. Transfer of Case Files. Instructions for transferring case records to the National Office are contained in FECA PM 1-501.7. After docketing a case for appeal, the Board serves upon the Director a copy of the application for review and any accompanying documents. The Director must then transfer the case to the Board within 60 days of the date of service.

The National Office requests cases docketed for appeal from the district offices over the automated system. These cases should be transferred within 48 hours. Form CA-58 should indicate clearly that the case is to be sent to the ECAB, and district office personnel should ensure that all parts of the file are sent. The address for transmittal is:

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

Cases should be transmitted for appeal only when requested by the National Office. Cases should not be transmitted based on a request for appeal sent directly to a district office. In this situation, the Board will not have docketed the case for appeal and will not accept it for review.

Once an appeal is docketed, the district office no longer has jurisdiction over the issue appealed. This is so even though the case remains in the custody of the district office for a period of time between docketing and transfer to the National Office. However, in accordance with Douglas E. Billings, 41 ECAB 880, the district office may issue decisions on matters which do not relate to or affect the issue on appeal.

2-1603-5 Processing of Cases on Appeal

5. Processing of Cases on Appeal.

a. Preliminary Review. Case contents are placed in a temporary jacket with a copy of the summary sheet. The pages are numbered in the Servicing Unit, after which the case is reviewed by an attorney from the Office of the Solicitor (SOL) and a designated person from the Branch of Regulations and Procedures. Following review, the case may be either submitted to the Board "on the record" or with a pleading prepared by SOL on behalf of the Director. The pleadings take various forms such as a Memorandum in Justification, a Motion to Remand, or a Motion to Dismiss. Cases submitted on the

record are forwarded to ECAB by the Servicing Unit. SOL forwards the cases with pleadings and represents the Director in oral argument before the Board.

b. Case Maintenance. The case jacket and summary are kept in the Branch of Hearings and Review until the Board returns the case contents. Designated members of the Branch reply to correspondence and telephone inquiries received in cases before the Board, and authorize medical care, bill payments and daily roll compensation payments if appropriate.

c. Request for Inspection or Copy of Case Record. An appellant or authorized representative who wishes to inspect or receive a copy of the case before the Board must send a request to the Board. The Board will return the case record temporarily to the Office with an order to either make it available for inspection or provide a copy of it to the person whose name and address appear on the order. This action must be taken and the case returned to the Board within 60 days from the date of the order.

d. Return of Case Record from ECAB. After the Board issues its decision, the case is returned to the Servicing Unit for review by the Branch of Regulations and Procedures before it is transferred to the district office. If further action by the district office is required, instructions are provided in a memorandum attached to the case. If further benefits will be payable, Form CA-1009 will be released to the claimant to advise him or her how to claim compensation and submit medical bills.

2-1603-6 Cases Returned to District Office

6. Cases Returned to District Office. Any case requiring further action should be immediately assigned to a CE to take the action.

a. Timeliness of Action. Substantive action should be taken within 30 days of receipt of the case record. If the required action cannot be completed within that time, the case should be placed under adjudication control as outlined in FECA PM 2-400.6.

b. Reinstatement of Benefits. If the Board has held that the Office did not meet is burden of proof before reducing or terminating benefits, the following actions will be taken:

(1) National Office staff will release a letter to the claimant or representative enclosing a Form CA-8 (or Form CA-12 in the case of death benefits) with instructions to complete the form and submit it to the district office.

(2) On receipt of the completed form, the district office should promptly reinstate benefits to the claimant at the previous level, including retroactive payment to the date of reduction or termination.

(3) If the completed form shows earnings, employment, or receipt of an annuity, the CE should obtain an election of benefits and other necessary information.

(4) The Form CA-8 is intended to cover the entire period during which benefits were terminated or reduced. Only one Form CA-8 need be completed. In general, further payments should be made on the periodic roll.

2-1603-7 Representative's Fee

7. Representative's Fee. The Board must approve all fees for work done before it. The Board does not need the OWCP case file for fee approval. The Board's docket file contains the necessary information.

2-1603 Exhibit 1: Sample Letter Advising Request for Appeal Being Forwarded to ECAB

Dear CLAIMANT NAME:

Your letter dated DATE OF LETTER requesting an appeal from a decision of this office has been forwarded to the Employees' Compensation Appeals Board for appropriate action.

All correspondence regarding your request for review by the Appeals Board should be addressed to the U.S. Department of Labor, Employees' Compensation Appeals Board, Washington, D.C. 20210.

Sincerely,

SUPERVISORY CLAIMS EXAMINER

cc: Employees' Compensation Appeals Board

2-1700 SPECIAL ACT CASES

Paragraph	Subject	Date	Trans. No.
	Table of Contents	01/07	07-02
1	Purpose and Scope	11/90	91-04
2	Policy	11/90	91-04
3	Responsibilities	11/90	91-04
4	Peace Corps	11/90	91-04
		02/93	93-11
		11/93	94-03
		09/95	95-37
		01/07	07/02
5	Volunteers in Service to America (VISTA)	11/93	94-03
6	Job Corps	11/90	91-04
7	D.C. Metropolitan Police Reserve Corps	06/95	95-26
		01/07	07-02
8	National Fisheries Observers	08/02	02-11
		05/03	03-04
		01/07	07-02

Exhibits

1	Annual Pay Rates For Computing Compensation of Peace Corps and VISTA Volunteers	11/98	99-05
		01/07	07/02

2-1700-1 Purpose and Scope

1. Purpose and Scope. From time to time laws are passed which extend benefits of the FECA to certain workers who are not regular employees of the U.S. government as defined in 5 U.S.C. 8101. Some of these workers are now considered civil employees, but benefits are limited by the legislation which provided coverage. This chapter addresses procedures for the development, adjudication, and management of claims filed under such laws.

2-1700-2 Policy

2. Policy. Claims discussed in this chapter are adjudicated according to the procedures established for Federal employees, except for the modifications and special instructions described below.

2-1700-3 Responsibilities

3. Responsibilities. Most special act cases are jacketed, adjudicated and managed in the National Operations Office (District Office 25). Some of the cases are forwarded to the appropriate district office (DO) after adjudication, and some are jacketed, adjudicated and managed in the DOs. See FECA PM 1-100.5 for case jurisdiction. Guidelines for developing claims are found in FECA PM Chapters 2-800 to 2-805.

2-1700-4 Peace Corps

4. Peace Corps.

a. Statutory Authority.

(1) The Peace Corps was established on September 22, 1961 by Public Law 87-293, known as the "Peace Corps Act." It authorizes the enrollment of qualified citizens and nationals of the United States as "volunteers" and "volunteer leaders" for service abroad in interested countries and areas, to help the people of such countries and areas in meeting their needs for trained workers, and to help promote a better understanding of the American people. Section 5 U.S.C. 8142 addresses Peace Corps claims within the context of the FECA. (2) OWCP is principally concerned with the following sections of the Peace Corps Act:

(a) Section 5(d), which provides: "Volunteers shall be deemed to be employees of the United States Government for the purposes of the Federal Employees' Compensation Act (39 Stat. 742), as amended: Provided, however, That entitlement to disability compensation payments under that Act shall commence on the day after the date of termination of service. For the purposes of that Act-

"(1) volunteers shall be deemed to be receiving monthly pay at the lowest rate provided for grade 7 of the general schedule established by the Classification Act of 1949, as amended, and volunteer leaders (referred to

in section 6 of this Act) shall be deemed to be receiving monthly pay at the lowest rate provided for grade 11 of such general schedule; and

"(2) any injury suffered by a volunteer during any time when...located abroad shall be deemed to have been sustained while in the performance of...duty and any disease contracted during such time shall be deemed to have been proximately caused by employment, unless such injury or disease is caused by willful misconduct of the volunteer or by the volunteer's intentions to bring about the injury or death of...self or of another, or unless intoxication of the injured volunteer is the proximate cause of the injury or death."

(b) Section 6, which states that all provisions of the Act applicable to volunteers shall be applicable to volunteer leaders and the term "volunteers" shall include "volunteer leaders."

(c) Section 7, which provides for the employment of a staff of civil employees to carry out the provisions and purposes of this legislation.

(d) Section 8(a), which provides (1) for appropriate training for applicants for enrollment as volunteers and volunteer leaders, (2) the enrollment period shall include the period of training, and (3) all provisos of the Act relating to volunteers and volunteer leaders are applicable to applicants for enrollment during the period of training.

(e) Section 10(a)(3), which authorizes the acceptance of voluntary service in the name of the Peace Corps and employment of such voluntary services in furtherance of the purposes of the Peace Corps Act.

(f) Sections 12 and 13, which provide for the appointment of a Peace Corps National Advisory Council and employment of experts and consultants.

(g) Section 25(a) and (b), which define the term "abroad" to mean any area outside the several states and territories and the District of Columbia for injuries and deaths prior to September 13, 1966.

Public Law 89-572 amended section 25(b) by striking the words "and territories" from the law September 13, l966 and thereafter.

In 1974, Section 8142(c)(2) of the FECA was amended to designate Peace Corps Volunteers with one or more minor children as "Heads of Household." By virtue of this amendment, these volunteers are entitled to compensation at the same rate as the Volunteer Leaders. Reports of injury will indicate whether a claimant is a

Volunteer, Head of Household, or Volunteer Leader.

b. FECA Coverage. The Peace Corps Act extends the benefits of the FECA to Peace Corps Volunteers, Peace Corps Volunteer Leaders, and Heads of Households. For the purposes of this paragraph all three groups will be referred to as volunteers.

(1) Under section 8101(1)(B) of the FECA, members of the Peace Corps National Advisory Council and the experts and consultants provided by sections 12 and 13 of the Peace Corps Act have the protection of the FECA while performing their assigned duties. However, decisions concerning these individuals will be made on a case-by-case basis, and an opinion from the Solicitor of Labor will be requested if necessary.

(2) Staff Spouses.

(a) The spouses of Peace Corps staff members serving in foreign countries have the protection of the FECA while performing service or engaged in official travel in keeping with the terms of PECTO CA-39, an airgram issued by the Peace Corps on April 23, 1964. In addition to Form CA-1 or CA-2, a copy of the travel authorization and the information outlined in Form CA-1014 will be required. Performance of duty will be determined on a case-by-case basis. The pay rate for computing compensation will be determined in the manner used for persons coming within the scope of section 8101(1)(B) of the FECA.

(3) Staff Employees. These employees fall within the definition of "employee" outlined in 5 U.S.C. 8101(1). They have full coverage of the FECA, and their claims are adjudicated in the district office having jurisdiction over the place of employment. See FECA PM 1-100.4.

c. Conditions of Coverage.

(1) Training Period.

(a) All applicants for enrollment as volunteers undergo training prior to actual enrollment. The Peace Corps provides this training at designated universities or training centers. In keeping with section 8(a) of the Peace Corps Act, applicants have the protection of the FECA while performing their training assignments or while engaged in any activity which is a reasonable incident of the training assignment.

(b) The trainees receive subsistence and quarters while in training, and transportation to and from the training sites. For this reason, their coverage under the FECA will include many activities other than the

specific training functions. Requirements for proof of "performance of duty" or "causal relation" will be the same as that required in the case of a Federal employee.

(2) Serving Abroad.

(a) In keeping with section 5(d)(2) of the Peace Corps Act, injuries of trainees and volunteers while abroad are deemed to have occurred while in the performance of duty, and any disease contracted abroad is deemed to have been proximately caused by the employment. Except for the exclusions of willful misconduct, intent to bring about injury or death of self or another, or intoxication, which appear in section 8102 of the FECA and section 5(d)(2) of the Peace Corps Act, volunteers have the protection of the FECA for all injuries sustained and diseases contracted during such service.

(b) For episodic conditions, the medical evidence must show that the episode resulted from a condition contracted abroad. Only those episodes of a recurring disease that are shown to be associated with Peace Corps service by time and location or consequence are compensable. In the case of a disease, a medical report showing that the disease was contracted while the volunteer was serving abroad is sufficient. This requirement is satisfied by a statement from the attending or examining physician, or by an Office medical adviser, stating that the disease was contracted during the period of service abroad. For certain diseases, this evaluation must include consideration of the incubation period.

(c) This broad coverage for diseases raises unusual problems with respect to certain conditions. Claims examiners should be guided by the following rules:

(i) Dental Disease. Caries, abscesses, etc., may be considered contracted abroad if comparison with the pre-induction dental examination so indicates.

(ii) Mental Illness. A psychiatric condition related to Peace Corps service will be considered compensable until the attending physician indicates that the condition or episode has resolved and that no further disability exists. If a recurrence is claimed, careful inquiries should be made to determine whether the recurrence was due to the Peace Corps experience or to pre-existing psychopathology. See MEDGUIDE in Folioviews for a discussion of mental disorders.

(iii) Intestinal Parasites. If the terminal examination indicates

the presence of intestinal parasites, further examination and treatment may be authorized. A positive skin test alone is not considered evidence of a disease.

(iv) Tuberculosis. If the terminal examination indicates the presence of tuberculosis, further examination and treatment may be authorized. A positive skin test alone is not considered evidence of a disease.

(iv) Pregnancy. In accordance with the Pregnancy Discrimination Act, FECA coverage is extended to Peace Corps volunteers for pregnancies which occur during Peace Corps service overseas and continue past the date of termination. This coverage is retroactive to April 1, 1979, the date that the Pregnancy Discrimination Act became applicable to fringe benefit programs.

Such pregnancies are to be considered in the same light as any covered injury, but FECA coverage is limited to Peace Corps volunteers. Therefore, the benefits of the Act may not be extended to the children born of such pregnancies.

Coverage of the Peace Corps volunteer extends to all pregnancy-related conditions, including miscarriages, prenatal and postnatal care of the mother. Any prenatal care is to be considered part of the treatment for the disability (pregnancy) of the volunteer, and not preventive treatment or treatment for the unborn child.

Under no circumstances, even when the health of the mother is involved, may OWCP pay for an abortion for a Peace Corps volunteer. This policy is necessary because the Peace Corps may not use any of its budget for abortion purposes. (Thus, the Compensation Fund could not be reimbursed for such expenditure.)

Compensation for loss of wages may be paid only during the time when the medical evidence of record shows that the mother is disabled for the duties she would have been performing as a volunteer due to her pregnancy or its aftereffects. Thus, at least during the early months of the pregnancy, there may be no basis for paying compensation for wage loss.

An unmarried volunteer without a wholly dependent parent is entitled to compensation at the 66 2/3 percent rate prior to the birth of the child and at the 75 percent rate after the child is born.

Medical treatment and services will be provided in accordance with the usual provisions of the Act. Thus, all provisions of 5 U.S.C. 8101(2) and (3) and 5 U.S.C. 8103 apply.

(v) Pregnancy. In accordance with the Pregnancy Discrimination Act, FECA coverage is extended to Peace Corps volunteers for pregnancies which occur during Peace Corps service overseas and continue past the date of termination. This coverage is retroactive to April 1, 1979, the date that the Pregnancy Discrimination Act became applicable to fringe benefit programs. Such pregnancies are to be considered in the same light as any covered injury, but FECA coverage is limited to Peace Corps volunteers. Therefore, the benefits of the Act may not be extended to the children born of such pregnancies.

Coverage of the Peace Corps volunteer extends to all pregnancy-related conditions, including miscarriages, prenatal and postnatal care of the mother. Any prenatal care is to be considered part of the treatment for the disability (pregnancy) of the volunteer, and not preventive treatment or treatment for the unborn child. Under no circumstances, even when the health of the mother is involved, may OWCP pay for an abortion for a Peace Corps volunteer. This policy is necessary because the Peace Corps may not use any of its budget for abortion purposes. (Thus, the Compensation Fund could not be reimbursed for such expenditure.)

Compensation for loss of wages may be paid only during the time when the medical evidence of record shows that the mother is disabled for the duties she would have been performing as a volunteer due to her pregnancy or its aftereffects. Thus, at least during the early months of the pregnancy, there may be no basis for paying compensation for wage loss.

An unmarried volunteer without a wholly dependent parent is entitled to compensation at the 66 2/3 percent rate prior to the birth of the child and at the 75 percent rate after the child is born.

Medical treatment and services will be provided in accordance with the usual provisions of the Act. Thus, all provisions of 5 U.S.C. 8101(2) and (3) and 5 U.S.C. 8103 apply.

(d) Where treatment of certain specified service-related medical conditions or injuries costs less than $1000, the Peace Corps will, at its

discretion, pay medical costs directly. If the cost for necessary treatment is $1000 or more, a claim must be filed under the FECA using normal procedures.

(i) Dental Disease.

(ii) Dermatitis. Simple skin irritation, inflammation or eruption due to allergic reaction, direct contact, radiation, light, or temperature changes may be included. Schistosomiasis, acariasis, psoriasis, pruritis, blastomycosis and other skin conditions are not included.
(iii) Tinea (ringworm). Included conditions may involve any fungal skin condition. Common areas affected by ringworm include the body, scalp, beard, feet (athlete's foot) and legs/genitals (jock itch). Tinea of the fingernails and toenails (onychomycosis) can also be included.

(iv) Minor eye irritation. Keratitis infections due to bacteria, conjunctivitis (pinkeye) and irritation from contact lenses may be included.

(v) Terminal prophylaxis following malaria exposure.

(3) Return from Service Abroad.

(a) A volunteer who returns to the United States immediately after completing service abroad will be terminated in this country. The volunteer has the protection of the FECA while traveling to the United States unless a material deviation occurs.

(b) A volunteer may also choose to be terminated at a foreign post of duty. In this case the volunteer is paid the money to which he or she is entitled as well as the cost of travel from the foreign post of duty to the United States. In most cases, the volunteer will return to the United States by an indirect route. After termination, the volunteer has the protection of the FECA only during that part of the trip when on the direct or most usually traveled route between the foreign post of duty and the United States. The facts about any deviation from this route must be developed carefully. The question will be determined according to the usual criteria for cases involving travel status. See FECA PM 2-804.

d. Medical Records.

(1) The Peace Corps maintains a complete medical file for its volunteers. The file usually includes the results of the pre-employment and termination examinations and a record of medical care received during service. This medical information is useful in adjudicating claims for compensation, particularly in those cases involving disease.

(2) With each compensation case, the Peace Corps is to submit its original medical file for the volunteer. To save time and expense, neither the Peace Corps nor OWCP will make copies of these records, which should be kept in the case file. The manner in which each record has been assembled by the Peace Corps will not be disturbed. The Peace Corps will ask for the temporary return of a medical record if needed at a later date. Such requests are to be honored without reservation.

e. Reporting of Injuries and Deaths.

(1) Volunteers are required to report injuries in the manner required by Section 10.100 and 10.101 of the FECA regulations. The Peace Corps will keep Form CA-1 or CA-2 during the period of the volunteer's enrollment. At the time of separation, it is to be submitted to OWCP if it then appears that:

(a) The volunteer requires medical care for the cure or relief of the injury; or

(b) The injury is causing disability for which compensation may be payable.

(2) With Form CA-1 or CA-2, the Peace Corps will submit the volunteer's medical record and other appropriate information, including the dates of enrollment and separation, and the dates of service abroad. They will also state what benefit the claimant seeks or needs.

(3) Based upon information in the volunteer's medical and personnel folders, headquarters staff of the Peace Corps will complete the reverse of Forms CA-1

and CA-2.

(4) The headquarters staff of the Peace Corps is to report deaths of volunteers in the same manner as is required for Federal employees.

f. Disability Claims.

(1) The Peace Corps will not usually furnish Form CA-7 to a volunteer. The Claims Examiner should send Form CA-7 to the volunteer if it appears that entitlement to compensation exists.

(2) The Employing Agency Portion of Form CA-7 need not be completed. Therefore, the claimants should be told to return these forms directly to OWCP.

(3) The date of the volunteer's separation will be the date pay stops, which should be shown in the appropriate block on Form CA-1 or CA-2. Entitlement to compensation for temporary or permanent disability begins on the date following the date of separation.

(4) 5 U.S.C. 8118 does not apply to volunteers because they do not earn annual or sick leave and are not entitled to continuation of pay (COP).

(5) Compensation for disability will, in all cases, be computed on a weekly basis. Because volunteers do not usually have a standard work week, 5 U.S.C. 8114 will not be applied. Volunteers are entitled to CPI increases in compensation as provided by 5 U.S.C. 8146a.

(6) The three-day waiting period provided by 5 U.S.C. 8117 applies to these cases in the same manner as it applies to Federal employees.

g. Death Claims.

(1) When a death is reported by telegram or Form CA-6, the CE should promptly send Form CA-1064 and Form CA-5 to the next of kin, and Form CA-1063 to the employing agency.

(2) The Attending Physician's Report on the reverse of Form CA-5 need not be completed, and claimants may be advised to return this form directly to OWCP.

(3) Compensation for death will be computed on a monthly basis, just as it is for Federal employees.

h. Pay Rate. In keeping with Section 5(d)(1) of the Peace Corps Act, the monthly pay rate for volunteers is the lowest rate provided for Grade 7 of the general schedule established by the Classification Act of 1949. The monthly pay for volunteer leaders and heads of household is the lowest rate provided for Grade 11 of the general schedule. The annual pay rates for computing compensation are found in Exhibit 1.

Section 5 U.S.C. 8101(4), which provides that the pay rate may be based on pay at date of injury, date of recurrence or date of disability, does not apply to Peace Corps volunteers.

i. Correspondence. All compensation claims and correspondence concerning injuries to Peace Corps personnel are to be submitted to the Cleveland District Office (09). All correspondence sent to the Peace Corps should be addressed as follows:

Chief, OWCP Liaison
Office of Health Services
Peace Corps
1990 K Street, N.W., Room 6480-A
Washington, D.C. 20526

5.Volunteers in Service to America (VISTA).

6.Job Corps.

a. Statutory Authority. The Economic Opportunity Act of 1964 (EOA) and 5 U.S.C. 8143 provide coverage for enrollees in the Job Corps. They are deemed to be civil employees of the United States within the meaning of the term as defined in 5 U.S.C. 8101.

b. FECA Coverage.

(1) Job Corps enrollees are trained through Conservation Centers and through Urban Centers. The duty of operating the Conservation Centers has been delegated to the Departments of Agriculture and Interior. Injuries to employees of these Departments assigned to the operation of the Conservation Centers are to be reported and handled in the same manner as for other Federal employees.

(2) Operation of the Urban Centers has been delegated to private contractors. The employees of these contractors are not "employees" within the meaning of 5 U.S.C. 8101. They have no entitlement under the FECA.

(3) The employees of the operators of Urban Centers are not Federal officials, and they may not act as official superiors or reporting officials. With the Director's concurrence, the Job Corps has authorized the Centers' directors and their administrative officers to act in the capacity of the official superiors to sign Forms CA-1 and CA-2 and other reports relating to the injuries of enrollees. This authority may not be delegated to their subordinates. OWCP personnel should be particularly alert to this problem, being sure not to accept reports signed by persons subordinate to the Center directors and their administrative officers. Deviation from this rule is not permitted.

c. Conditions of Coverage.

(1)While at a Job Corps Center, an enrollee is under the continuous supervision and control of Job Corps officials. The Job Corps provides subsistence, quarters, clothing, medical care, training, work and recreation. For this reason an enrollee has the protection of the FECA for most incidents which occur while at the Center. Job Corps enrollees must, however, meet the same tests of compensability that apply to all other Federal employees.

(2)While away from the Center, an enrollee has the protection of the FECA if participating in an activity authorized by or under the direction and supervision of a Center official. This would include a group activity under the immediate direction of a supervisor as well as an authorized activity while the enrollee is on pass from the Center.

The record in such a case should include (1) a statement from a Center official showing whether at the time of the injury the enrollee was engaged in an authorized activity, and (2) a copy of the pass. Where a written pass was not issued, the Center official should be asked for a statement showing the inclusive dates and hours covered by the pass and the instructions or limitations relating to the activity permitted the enrollee.

(3)While on authorized pass or during travel between home and the Center, an enrollee has the protection of the FECA. In these cases, the record should include a statement from a Center official showing whether the travel or activity while on pass was authorized by or under the direction and supervision of the Job Corps.

(4)While absent from an assigned post of duty or participating in an unauthorized activity, an enrollee does not have the coverage of the Act.

(5)While at home, an enrollee (whether on "pass" or on "leave") does not have the protection of the FECA. However, an enrollee who is visiting the residence of another enrollee, with the permission of the Job Corps, would be considered to be engaged in an authorized activity, and would therefore be covered during the entire absence from the Center.

(6)Some enrollees live off the premises of their Center and commute between their home and the Center for training. The usual rules governing coverage during travel to and from work apply in "off-premises" injury situations.

(7) Injuries resulting from "horseplay" and "fighting" are frequent among the enrollees. It is the OWCP's position that most of these injuries come within the scope of the FECA. The confining nature of the employment and the long absences from home are factors which contribute to this problem. The result is that "horseplay" and "fighting" are an expected element of the employment environment. Where so indicated, the district offices should fully develop the facts in any case where it appears the exclusions of 5 U.S.C. 8102 might require consideration.

e. Medical Care after Termination.

(1) Prior to the termination of enrollment, an enrollee may not be provided medical care at OWCP expense and the Job Corps may not properly issue an authorization for examination or treatment on behalf of OWCP. Any medical bills received for treatment provided prior to termination should be sent to the Job Corps for consideration. Further, if an enrollee who has been terminated should be reinstated in the Job Corps, that agency would reassume responsibility for medical coverage of any work-related injury.

(2) The Job Corps Center may issue a Form CA-16 or equivalent letter of authorization at the time of termination, if the enrollee is under medical care for a Job Corps-related injury and if continuing treatment for that injury is necessary. The Job Corps Center may issue authorization at the time of termination even though an enrollee is not under medical care, if immediate treatment is necessary for a Job Corps-related injury. In all other situations involving separated Job Corps enrollees, the district office will issue authorization for medical care. The district office will also assume responsibility for issuing authorization if the case has been previously received and considered by OWCP.

(3) If medical care is required after termination of enrollment, the ex-enrollee

should be instructed to select a physician to render medical services. The enrollee then must furnish the Office with the provider's name and address. If the provider is qualified, the District Medical Adviser may issue an appropriate authorization to the physician.

(4) At the time of termination an enrollee may be receiving continuing medical care from a private physician which was provided at Job Corps expense. In this situation, the OWCP may pay reasonable charges for continuation of the medical care beginning on the day following termination where a claim has been approved. Payment may be made only for treatment for the approved condition. In these cases, the absence of a valid authorization will not defeat a medical expense claim which is otherwise in order.

f. Report of Injuries.

(1)Enrollees are required to report injuries in the usual manner as stated in the regulations.

(2)The Job Corps should submit Forms CA-1 and CA-2 only after the enrollee has been terminated, and only when:

(a)The condition causes disability for work for more than 14 days; or

(b)It is likely to result in a medical charge against the Compensation Fund after the enrollee's termination from the Job Corps; or

(c)It appears likely to require prolonged treatment; or

(d)It appears likely to result in future disability or permanent disability. The date of termination should appear in Block 24 of the CA-1, and in Block 34 of the CA-2.

g. Disability Claims.

(1) Compensation is not payable prior to termination of enrollment, in keeping with Section 106(c)(2)(C) of P.L. 88-452.

(2) The date of the enrollee's termination will be the date pay stops.

(3) 5 U.S.C. 8118 does not apply to enrollees because they do not earn annual or sick leave.

(4) Compensation for disability will be computed on a weekly basis. Because enrollees do not usually have a standard work week, 5 U.S.C. 8114 will not be applied. Job Corps enrollees are entitled to all applicable Consumer Price Index increases in compensation under 5 U.S.C. 8146a.

(5) The three-day waiting period provided by 5 U.S.C. 8117 applies to these cases in the same manner as it applies to Federal employees.

(6) Job Corps enrollees are not entitled to continuation of pay (COP) under 5 U.S.C. 8118.

h. Death Claims.

(1)An enrollee receives an allowance for dependents and may also make an allotment from Job Corps pay. A copy of the allotment should be obtained from Center officials in any death case where dependency must be established to support a claim for death benefits.

(2)In keeping with 5 U.S.C. 8134, if the death is employment-related, OWCP may pay up to $800 for funeral and burial expenses plus the cost of embalming and transporting the body in a hermetically sealed casket to the enrollee's home, as well as the $200 provided in 5 U.S.C. 8133(f).

i. Pay Rates.

(1) 5 U.S.C. 8101 and 5 U.S.C. 8114 do not apply to Job Corps enrollees.

(2) Where the injury occurred prior to November 8, 1966, compensation is computed on a monthly pay of $150 in (a) all death cases and (b) any disability case where the enrollee had not reached the age of 21. After the enrollee reaches age 21, disability compensation must be computed on an annual pay rate of the entrance salary for GS-2.

(3) Where the injury occurred after November 8, 1966, compensation is computed on an annual pay rate of the entrance salary for GS-2. (This figure will change any time the pay rates under the Classification Act of 1949 are amended.)

(4) The minimum provisions of 5 U.S.C. 8112 and 5 U.S.C. 8133(e) do not apply to Job Corps enrollees.

(5) 5 U.S.C. 8113 applies to these cases. Where so indicated, the pay rate may be redetermined in the same manner as any other Federal employee.

7. D. C. Metropolitan Police Reserve Corps. D. C. Metropolitan Police Reservists are entitled to FECA coverage if injured while serving in any sudden emergency (riot, pestilence, invasion, and insurrection) involving loss of life or property, or while serving on days of public election, ceremonies, or celebration. Each case will be considered on individual merit, and coverage will be extended only after careful study of all pertinent evidence.

a.Pay rate for compensation purposes for injuries occurring during sudden emergencies would be that comparable to a regular police officer of any rank whose duties most nearly resemble those of the injured volunteer. In non-emergencies, pay is frozen at the level of a regular police private.

b. Jurisdiction. Cases in this group will be developed and adjudicated in the Cleveland District Office (09).

8. National Fisheries Observers

a. Statutory Authority. Public Law 104-297, enacted on October 11, 1996, provides that observers on vessels that are under contract to carry out responsibilities under the Magnuson-Stevens Fishery Conservation and Management Act or the Marine Mammal Protection Act of 1972 shall be deemed to be civil employees of the United States for the purposes of coverage under 5 U.S.C. 8101.

b. Conditions of Coverage. Contract observers are employed in private industry to carry out the requirements of the above Acts, which are under the jurisdiction of the Department of Commerce. Any person claiming coverage has the burden of establishing that he or she is an observer within the meaning of section 403 of the Magnuson-Stevens Act, that the injury was sustained while in performance of duty on a vessel, and that the claimed disability or impairment is due to the on-the-job injury. Therefore, once the determination that the claimant is a civil employee is made, the guidelines described in chapters 2-800 through 2-805 should be employed in the adjudication of these claims. In particular, fisheries observers are extended coverage under the FECA only while on board the vessel, not while traveling to and from the vessel, or when performing off-vessel work while assigned to the cruise.

c. Jurisdiction. As these cases are anticipated to present unusual issues, they will be handled in one location. All claims for contract observers and their survivors will be forwarded to the Cleveland District Office (09) without jacketing. They will be assigned case file numbers with an OB- prefix, and will be adjudicated and maintained in the Cleveland District Office.

d. Other Considerations. Payment of compensation should be determined in accordance with Section 8114(d) of the FECA and PM Chapter 2-900. Increases in the pay rate due to the claimant being at sea when the injury occurred should be handled as described in 2-900-8b., Applying Increments of Pay. The increase in pay rate for sea duty should be treated in exactly the same way as premium pay, night differential pay, Sunday pay or FLSA extra pay is treated. According to section 8.b. of the chapter, the CE must obtain the dollar amount of additional pay received during the year previous to the work injury, and add it to the reported base pay to obtain the annual salary. (See Chapter 2-900-8. b.)

Due to the potential for third party liability of the vessel owner, Form CA-1045 should be released by the CE and the appropriate subrogation procedures followed. As possible entitlement to state workers' Compensation would not constitute a prohibited dual benefit, OWCP would not require an election of benefits by the claimant. This does not preclude the states from offsetting FECA benefits against any entitlement the claimant might have under the Jones Act.

ANNUAL PAY RATES
FOR COMPUTING COMPENSATION
OF PEACE CORPS AND VISTA VOLUNTEERS

Date of Injury	PC Volunteer Leaders/Heads of Households	PC Volunteer	VISTA Volunteer
09/22/61-10/13/62	$ 7,560	5,355	5,355

10/14/62-01/04/64	8,045	5,540	5,540
01/05/64-07/04/64	8,410	5,795	5,795
07/05/64-10/09/65	8,650	6,050	6,050
10/10/65-07/02/66	8,921	6,269	6,269
07/03/66-10/07/67	9,221	6,451	6,451
10/08/67-07/13/68	9,657	6,734	6,734
07/14/68-07/12/69	10,203	6,981	6,981
07/13/69-12/27/69	11,233	7,639	7,639
12/28/69-01/09/71	11,905	8,098	8,098
01/10/71-01/08/72	12,615	8,582	8,582
01/09/72-01/06/73	13,309	9,053	9,053
01/07/73-10/13/73	13,996	9,520	9,520
10/14/73-10/12/74	14,671	9,969	9,969
10/13/74-10/11/75	15,481	10,520	10,520
10/12/75-10/09/76	16,255	11,046	11,046
10/10/76-10/08/77	17,056	11,523	11,523
10/09/77-10/07/78	18,258	12,336	12,336
10/08/78-10/06/79	19,263	13,014	13,014
10/07/79-10/04/80	20,611	13,925	13,925
10/05/80-10/03/81	22,486	15,193	15,193
10/04/81-10/02/82	23,566	15,922	15,922
10/03/82-01/07/84		16,559	16,559

	24,508		
01/08/84-01/05/85		17,138	17,138
	25,366		
01/06/85-01/03/87		17,824	17,824
	26,381		
01/04/87-01/02/88		18,358	18,358
	27,172		
01/03/88-12/31/88		18,726	18,726
	27,716		
01/01/89-01/13/90		19,493	19,493
	28,852		
01/14/90-01/12/91		20,195	20,195
	29,891		
01/13/91-01/11/92		21,023	21,023
	31,116		
01/12/92-01/09/93		21,906	21,906
	32,423		
01/10/93-09/30/93		21,906	21,906
	33,623		
10/01/93-01/07/95		22,717	18,340
	33,623		
01/08/95-01/06/96		23,171	18,707
	34,295		
01/07/96-01/04/97		23,634	19,081
	34,981		
01/05/97-01/03/98		24,178	19,520
	35,786		
01/04/98-01/02/99		24,734	19,969
	36,609		
01/03/99-01/01/00		25,501	20,588
	37,744		
01/02/00-01/13/01		26,470	21,370
	39,178		
01/14/01-01/12/02		27,185	21,947
	40,236		
01/13/02-01/11/03		28,164	22,737
	41,684		
01/12/03-01/10/04		29,037	23,442
	42,976		
01/11/04-01/08/05		29,821	24,075
	44,136		
01/09/05-01/07/06		30,567	24,677
	45,239		

01/08/06-		31,209	25,195
	46,189		

2-1800 HOUSING & VEHICLE MODIFICATIONS

Paragraph	Subject	Date	Trans. No.
1	Purpose and Scope	09/94	94-41
2	Authority	09/94	94-41
3	Eligibility	09/94	94-41
4	Timeliness of Processing	09/94	94-41
5	General Criteria	09/94	94-41
6	Development of Proposals	09/94	94-41
7	Adjudication of Proposals	09/94	94-41
8	Payment for Modifications	09/94	94-41
9	Later Requests for Modification	09/94	94-41
10	Record-Keeping	09/94	94-41

2-1800-1 Purpose and Scope

1. Purpose and Scope. This chapter furnishes guidelines and procedures for considering requests for housing and vehicle modifications. Such medical rehabilitation services help the claimant to become independent and, consequently, reduce the need for future services and their associated costs.

2-1800-2 Authority

2. Authority. Medical rehabilitation personnel recognize that the recovery of severely disabled individuals is maximized by returning them to a home environment and/or self-sufficiency environment that provides the greatest degree of independence and mobility possible. Therefore, housing and vehicle modifications come under the authority of 5 U.S.C. 8103(a) which provides for services, appliances and supplies prescribed or recommended by a qualified physician, which the Secretary considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation.

2-1800-3 Eligibility

3. Eligibility. To be eligible for housing or vehicle modifications, the claimant must be severely restricted in terms of mobility and independence in normal living functions, on a permanent basis, due to the work-related injury. Examples are impairments that require the use of a prosthesis, wheelchair, leg braces, crutches, canes and self-help devices. Such medical conditions include quadriplegia, paraplegia, total loss of use of limbs, blindness and profound deafness bilaterally.

When a request is received for housing or vehicle modifications, the Claims Examiner (CE) should review the record within five working days of receipt to ensure that the original acceptance of the case was proper, and that the disability for which the benefit is claimed is related to the accepted injury and meets the eligibility requirements described above. If the claimant is not eligible, a formal denial should be issued over the signature of the Senior Claims Examiner (SrCE).

2-1800-4 Timeliness of Processing

4. Timeliness of Processing.

a. A severely disabled person who is given accommodations early to increase mobility and independence should in all likelihood achieve a greater degree of functioning than one who must wait for necessary modifications to be approved. Therefore, requests for housing or vehicle modifications should be processed without delay.

b. Where the injury is severe, such as one to the spinal cord resulting in paralysis, the claimant or family and treating specialists should be contacted early in the treatment, so the need for modifications can be determined and plans started as soon as possible. The use of a nurse would be beneficial under these circumstances.

2-1800-5 General Criteria

5. General Criteria.

a. Vehicle Modifications:

(1) Modifications to a vehicle must be established as necessary and desirable for increased mobility or independence by a recommendation of a physiatrist or other medical specialist appropriate to the type of injury sustained.

(2) Modifications of the present vehicle must be explored before considering

a new purchase.

(3) Modifications must be consistent with the claimant's pre-injury standard of living and should approximate that standard insofar as practical. If accessories and equipment are needed for the claimant's present vehicle, the OWCP will modify it if it is practical to do so, as determined by the type of vehicle, its age and condition, and the type of equipment needed.

(4) If it is established that the claimant cannot drive his or her present car due to the inability to place a wheelchair in it without assistance, or if it is not practical to modify the present vehicle, OWCP will pay for a suitable car or van (if necessary), taking credit for the value of the claimant's existing car or van.

(a) If the claimant purchases a used car, the Office will pay the depreciated price of a baseline, otherwise comparable, used car or van of comparable age and condition, with equipment required for the accepted disability. The claimant is responsible for paying the difference between the new or used vehicle allowed by OWCP and the car or van actually purchased and additionally equipped as the claimant desires.

(b) If the claimant purchases a new car or van, the Office will pay the discounted price of a base line vehicle of suitable size, plus options required for the effects of the injury and any necessary after-market add-ons, such as hand controls. Wherever possible, optional equipment should be factory installed.

(5) If a car or van must be purchased by OWCP, it will be the least expensive model with the required standard or optional equipment. Hand controls or other special devices will be added to it. If the claimant desires a model which is more costly because of nonessential factors, or desires accessories not required for the injury, he or she must pay the difference in price. For example, if the cost of a radio were included in the price of the car, the Office would subtract its cost. The Office will pay only the discounted price for the lowest priced model of a suitably sized car or van with the necessary modifications. The claimant will pay any difference between the lowest priced model with required options and a more expensive model that he or she desires.

(6) Modifications and the additional costs of a new vehicle (when warranted) over the value of the present vehicle will be paid for by OWCP.

(7) Vehicle modifications should be no more expensive than necessary to accomplish the required purpose. Special hand and foot controls and any items which need not be built in should be removable for transfer to other vehicles.

(8) Vehicle modifications may include what are normally considered comfort or convenience accessories, if documented by the medical specialist as necessary for the effects of the compensable disability. In specific cases, it would be appropriate to make payment for such equipment as air conditioning, power brakes, power steering, automatic transmission, power door locks, power windows, rear defogger, citizens band radio, or six-way power seat.

(9) Equipment furnished for a vehicle by OWCP should be maintained and repaired at OWCP expense and may be replaced after normal wear and tear. Equipment required for the injury will be repaired and maintained at OWCP expense. Other parts of the vehicle will be repaired, maintained and replaced at the owner's expense even if OWCP paid for the vehicle. Replacement equipment for the present vehicle or similar equipment will be provided on a replacement vehicle if the claimant can establish that the vehicle should be replaced, normally based upon the age, mileage and condition.

(10) The claimant is required to provide proof of adequate insurance and proper registration of the vehicle in the state of residency. Claimants are required to carry fire, theft, comprehensive and collision insurance on vehicles paid for in whole or in part by the Office, unless the equipment furnished is worth under $200.

(11) The Government is entitled to reimbursement for the value of the modifications when relinquished or no longer needed by the claimant, if the value of the modifications exceeds $5000 at that time. The value of a vehicle purchased for a claimant, or of automotive accessories such as power steering, automatic transmission and power door locks, will be determined by the lowest current Blue Book figure when the vehicle is sold, traded, or no longer needed by the claimant. If the value is less than $5000, the claimant will not be required to reimburse OWCP or return the vehicle.

b. Housing Modifications for Home-owners.

(1) Housing modifications must be recommended by a physiatrist or other medical specialist appropriate to the accepted employment condition as necessary and desirable for increased mobility or independence.

(2) Modifications to a house must be consistent with the claimant's pre-injury standard of living and should approximate that standard insofar as practical. The purpose of the Law is not to provide an enrichment program in proportion with the severity of the injury sustained. To do so would extend the program beyond the intent and scope of the Act which is to provide an adequate substitute for an employee's loss of earning ability to provide for his or her living needs. For example: If a claimant must purchase or build a new home because the current

residence would not be safe to modify, the new residence must be comparable in size (i.e., square feet of living area) and quality to the currently owned home. Or, if new doors and special door knobs must be installed in the claimant's residence, the quality of the hardware and finish of the doors, the hardware itself, and any molding should be comparable to those being replaced.

(3) The claimant should be encouraged to fully explore modifications to a present house before he or she decides to purchase or build a new house. If the claimant elects to purchase a new home or build a new structure, for any reason other than that it would be structurally unsound to attempt to modify the present house, it must be made clear that the Office is responsible only for the modifications to the new purchase or to the plans for the new house which are necessitated by the work injury. The one and only situation which warrants that the Office be involved with helping to purchase or build a new home is that it would be impossible to make the necessary modifications to the present home without causing structural damage to the house.

(a) For example, OWCP will not find that the purchase of or building of a new home is warranted when the cost of modifying the present home is "too high." As long as the needed modifications can be achieved without structural damage to the property, the OWCP will cover the cost. Or, if the claimant finds that it would be aesthetically undesirable to make an addition to his or her present home, this would not be considered sufficient reason for the Office to assist in the purchase or construction of a new house.

(b) The claimant is required to establish with written certification from at least two professional sources that his or her present home is structurally unmodifiable. Such certification from an architect or a building contractor must include a full explanation of why the present home is structurally unmodifiable.

(c) Where the present home cannot be modified without structural damage, OWCP will be responsible for the difference between the cost of the new house and that of the existing house. For example: If the claimant owns a house worth $100,000 with a mortgage at the time of sale of that house of $85,000, his or her position at the time of purchasing or building the new home should be that he or she owes $85,000 on the new mortgage. The OWCP does not purchase the house but will make up the difference up to the worth of the present residence, i.e., $100,000. In such a case, the responsibility of OWCP would also include housing modifications and modifications to the architectural plans.

(4) If the claimant lived in his or her own house at the time of injury and makes the decision to buy or build a new home for reasons other than those described above, OWCP will pay the cost of modifying a suitable house. However, the Office will not pay moving expenses. If the claimant decides on his or her own to purchase or build a new house, the Office will only pay any extra expenses in altering the plans and for building modifications to the new house.

(5) Modifications will be no more expensive than necessary to accomplish the required purpose. In remodeling a bathroom, it may be feasible to remove and reinstall an existing sink to wheelchair height, rather than discard it and buy a new sink. The cost effectiveness of modifications to meet a temporary need, when the physician anticipates a prolonged recovery, should be considered against long-range tangible and intangible benefits, such as facilitating recovery, reducing the length of hospitalization or confinement in other care facilities and reducing the need for an attendant.

(6) Modifications may include what are normally considered to be comfort or convenience accessories, if needed for the effects of the compensable injury. In specific cases, heating, air conditioning and air filtration devices may be necessary based on the nature of the accepted condition. For example, such items might be required for an individual with a respiratory or cardiac ailment, and the physician recommending the accessories would be responsible to explain such needs.

(7) Equipment furnished by OWCP for the present house or new house will be maintained, repaired and replaced as needed after normal wear and tear at OWCP expense.

(8) The claimant is required to provide proof of adequate insurance. Claimants must carry renter's or homeowner's insurance that reflects the present value of their house, unless the modifications were furnished at a cost under $1000.

(9) The Government is entitled to reimbursement for the value of any housing modifications when relinquished or no longer needed by the claimant if the value at that time exceeds $5000. In disposition of modified property any enhanced value over $5000 must be returned to the Government. For example, if an elevator is installed in the claimant's house and the house is later sold, the Office should be reimbursed from the proceeds of the sale for the current value of the elevator, if it exceeds $5000. The current value may be determined in any reasonable, equitable manner, such as estimates from real estate sources or by comparing recent sale prices of similar houses without the special equipment.

No reimbursement to the claimant should be made for any reduction in the value

of the house resulting from modifications which may inconvenience prospective purchasers.

c. Housing Modifications for Renters.

(1) In a rental property, all modifications proposed must be recommended by a physiatrist or other medical specialist appropriate to the accepted employment condition, just as in a property owned by the claimant. The proposal must be reviewed by the claims examiner and approved as necessary and desirable for increased mobility or independence.

(2) If the claimant is renting and the owner of the property will not permit necessary modifications, other living arrangements may be subsidized, such as paying moving expenses to other rented quarters as comparable as possible to the present residence. OWCP should also pay any difference in rent. However, a claimant who is renting his or her living quarters should not expect any assistance from OWCP for purchasing or constructing a new house.

(3) Modifications to an apartment must be in keeping with the standard of the decor of the current or pre-injury apartment accoutrements. For example, if the claimant's apartment has two sinks in the master bath and the claimant needs a special sink for wheelchair access, both of the sinks will be replaced or modified in order to preserve the symmetry of the room. If the tile in the bathrooms or kitchen needs to be replaced in order to accomplish the modification proposed, the new tile should be of a quality equal to that which must be replaced.

On the other hand, just as in a privately-owned residence, cost-effectiveness and practicality are essential criteria to be used when considering proposed modifications. If an existing sink can be reinstalled at another height (see this chapter paragraph 5.b.[5]) to achieve the required modification, this is preferable to discarding it and replacing it with a new sink.

(4) Similarly, when a claimant lives in a rented walk-up apartment prior to the injury and can no longer climb stairs, the difference in rent may be paid for the most nearly comparable elevator apartment available. The CE must ensure that the proposed apartment is equivalent to the pre-injury living quarters in terms of living area, amenities and community desirability.

2-1800-6 Development of Proposals

6. Development of Proposals.

a. If the claimant is eligible for vehicle modifications, the CE should request him or

her to submit a detailed proposal.

(1) The claimant should be advised that an existing vehicle will be modified whenever feasible, but that any new or used vehicle purchased must be at the discounted price of a baseline vehicle of the least expensive suitable size, taking credit for the trade-in value of the claimant's present vehicle. The additional expense of a higher priced vehicle or personal preference options will normally be the claimant's obligation. (See paragraph 5.a.(4)(a) above.)

(2) Proposals should include the following information:

(a) A medical report to show the specific job-related physical limitation resulting in the need for the modifications requested. This should come from a physician who is a recognized authority in the appropriate medical specialty.

(b) An itemization of all vehicle modifications proposed. Where substantial modifications are required, the detailed changes should be recommended by a medical rehabilitation professional familiar with the needs of the disabled. When the cost for modifications exceeds $1000, the professional proposing the modifications must ensure that his or her report justifies the need for and adequacy of the proposed modifications.

(c) Vehicle modifications proposals must include the year, make, model and body style of the present vehicle, the number of miles it has been driven, and a description of its general mechanical condition, including any repairs currently needed or anticipated.

b. The CE should require a claimant requesting housing modifications to submit a detailed written proposal.

(1) The claimant should be advised that housing modifications proposed should be of a quality and finish level consistent with his or her present residence but not superior to it. The claimant should also be advised that if it is established that it is not structurally feasible to modify the present residence, a move to a comparable residence which could be properly modified should be considered. While it is the claimant's own decision, the OWCP will not pay for modifications that would compromise the soundness of the structure of the residence.

(2) Proposals should include the following information:

(a) A medical report to show the specific job-related physical limitation resulting in the need for the modifications requested. This should come from a physician who is a recognized authority in the

appropriate medical specialty. Generally, this should be a physiatrist, but may be an orthopedist, neurologist or other appropriate specialist. Reports from a physical therapist or occupational therapist may also be helpful in determining the need for modifications.

(b) An itemization of all modifications proposed. Where substantial modifications are required, the detailed changes should be recommended by a medical rehabilitation professional familiar with the needs of the disabled. When the cost for modifications exceeds $1000, the professional proposing the modifications must ensure that an on-site review is performed to justify the need for and adequacy of the proposed modifications. The CE will review the itemized proposal and determine whether the specified modifications are warranted. This would be an appropriate time for discussions with the assigned Rehabilitation Specialist or the Staff Nurse, whichever is applicable. Reasonable fees will be paid for the medical rehabilitation professional's visit to the home and detailed recommendations. Reasonable fees will also be paid for preliminary architect's sketches when significant structural changes requiring architectural services are needed. No fee will be paid for attorneys or similar representatives engaged by the claimant to assist with a proposal. Approved representative's fees remain the claimant's obligation, as discussed in Chapter 2-1200.

(c) If the claimant lives in rented premises, a statement from the property owner authorizing the proposed changes.

(d) Two or more price bids on the modifications proposed. If construction work is required, the claimant should be asked to submit a binding estimate of the cost from at least two reputable contractors. No fee will be paid for such bids, since they are customarily supplied to prospective purchasers free of charge. If special accessories or devices are requested, the CE should stipulate that the price given by the vendor includes any necessary installation. The bid selected will be the lowest of any acceptable alternative means of achieving the desired result. The lowest prices will be accepted unless there is sound reason for a higher price, such as increased durability.

2-1800-7 Adjudication of Proposals

7. Adjudication of Proposals.

a. The detailed proposal will be evaluated jointly by the CE, District Medical Advisor and Rehabilitation Specialist within five working days of receipt. Any aspect of

the proposal which fails to meet the criteria of paragraph 5, above, will be deleted or changed. It will be helpful to use the telephone to discuss changes in the proposal with the claimant, medical rehabilitation team and architect, as appropriate, to avoid delays inherent in the process of denying it and having it revised and resubmitted. The CE might also seek the input of the Staff Nurse whenever he or she feels it would be appropriate. If the claimant insists on modifications which are not found to be necessary, he or she should be advised that the proposal will be denied, in whole or in part.

b. The CE's recommendations for approving proposals will be routed to the SrCE, regardless of the cost involved. If the recommendations are approved, the SrCE will release a formal decision stating the modifications and costs which have been approved. If the recommendations are denied, in whole or in part, the SrCE should issue a formal decision. If the recommendations require further development, the case should be returned to the CE with appropriate comments and instructions.

c. If the proposal is approved, the CE should advise the claimant of the following terms and ask him or her to sign a statement which acknowledges understanding of and agreement with them:

(1) If and when the vehicle, item or modification is no longer needed, the claimant will be entitled to retain it if the value (or enhanced value) is less than $5000. If the value of a vehicle or discrete object is greater than $5000, it becomes the property of the Government. If the value of an enhancement is greater than $5000, the amount above $5000 must be reimbursed to the Government.

(2) If a house has been modified, the claimant must notify OWCP before any move which may result in a claim for further housing modifications. A claimant who sells a modified house is liable for modifying any future residence absent a claims-related reason for the move and prior OWCP approval of it (see paragraph 10 below).

2-1800-8 Payment for Modifications

8. Payment for Modifications.

a. Bills for housing and vehicle modifications must be approved by the CE.

b. Bills including installation work or construction work must be accompanied by the claimant's statement showing that the work covered by the payment has been accomplished satisfactorily. Construction expenses should be paid promptly as the job progresses, to coincide with "draws" on the claimant's construction contract.

2-1800-9 Later Requests for Modification

9. Later Requests for Modification. After a vehicle or house has been modified, the claimant may request modification of a different vehicle or house.

a. Vehicle. It is expected that even a vehicle which is regularly maintained will eventually require replacement. Its value should be determined by the lowest current Blue Book figure when the vehicle is sold, or the actual purchase price, whichever is higher, and the amount should be subtracted from the cost of the amount payable by the Office for the new vehicle.

b. House. Payment for modification of a different house by the Government may be authorized under very limited circumstances. Any subsequent move must be undertaken for a reason related to the claim, and detailed rationale should be provided before the move is to occur. Acceptable reasons include the need to obtain more sophisticated medical care and/or to accept reemployment, but not personal preference for a different locale. If the reason given is deemed acceptable, the CE should document the file to reflect this decision so that any expenditures in modifying the new house can be justified.

2-1800-10 Record-Keeping

10. Record-Keeping. Since all housing and vehicle modification decisions are made by the district office, the District Director must maintain a record of all cases in which such a decision was made. The record should contain the case number, the claimant's name, the date of the request and the decision, whether the request was approved or denied, and the dollar amount of the approved modification.

FECA PM PT 2 3/27/96